

Patient Safety Tip of the Week

September 4, 2012

More Infant Abductions

It's not even been a year since we did a column on infant abduction (see our December 20, 2011 Patient Safety Tip of the Week "[Infant Abduction](#)"). Last month we saw 2 more infant abductions, one successful and one thwarted. Both the recent cases were eerily similar to the one we described last year.

In the Pittsburgh case ([Mandak 2012](#)) a young woman entered the hospital wearing hospital scrubs. She apparently told one employee she worked there and was just coming off duty and told another she was the sister of a mother being discharged and was there to drive her home. She then followed a discharge nurse into the room of the mother/newborn and family thought she was a nurse's aide. The real nurse removed the security bands and left. The abductor then told the mother there was one more test that needed to be done and she would bring the infant right back. She then placed the infant in a zippered handbag in a secluded area and left the hospital with the infant. She had apparently told family she was pregnant but they were suspicious and when they heard about the abduction in the news they contacted local authorities who found the abductor and the infant unharmed.

In the California case ([Mohajer 2012](#)) a 48-y.o. woman entered a hospital stating she was there to visit a patient, then apparently posed as a nurse, entered the room of the mother/infant and told the mother to shower before the doctor came to examine her. Once the mother was out of sight she put the infant into a tote bag and attempted to carry the infant out of the hospital. The infant's security bracelet set off hospital alarms and the hospital's security/code response was able to find both the unharmed infant and the suspected abductor. In this case the abductor had also apparently told family/friends that she was pregnant.

The latter case illustrates how security systems and well-practiced "Code Pink" responses can thwart an attempted abduction. Nevertheless the first case and the one we discussed in our December 20, 2011 Patient Safety Tip of the Week "[Infant Abduction](#)" demonstrate that the security bracelet systems are not infallible. All three cases illustrate the ease with which a potential abductor can get access to a maternity unit room, convince the mother that the infant (or mother) needs to be elsewhere, and get the infant into a bag of some type, and (maybe) be able to exit the hospital with that infant.

We had always had the impression that infant abductions were rare (and they are rare). When asked by an ob/gyn department to suggest a topic for a failure mode and effects analysis (FMEA) we recommended they look at preventing switched babies or switched breastmilk (see our November 17, 2009 Patient Safety Tip of the Week “[Switched Babies](#)”) because both are likely more common than infant abductions. The best statistics on infant abductions come from the National Center for Missing & Exploited Children ([NCMEC 2012](#)). Between 1983 and early 2012 there were 130 infant abductions from healthcare facilities (out of a total of 284 infant abductions). In all but 5 cases the missing infant was located and in most cases is unharmed, though there have been cases where the infant is found deceased. Most often the infant is abducted from the mother’s room. Compared to abductions from other sites, violence toward the mother (or caregiver) is infrequent in cases of abductions from healthcare facilities.

And even though infant abductions are relatively rare, such are sentinel events as far as the Joint Commission is concerned and “never” events in most states. Yes, you can do a root cause analysis (RCA) and implement preventive interventions after such an event. But the impact on the confidence your patients and community have in your organization is huge. Needless to say it may take years to overcome the negative publicity that accompanies such events. So now is a good time for hospitals to review their security programs and perhaps even consider doing a failure mode and effects analysis (FMEA) to determine their vulnerability. Most who read the case report in our December column found themselves saying “Wow, that could probably happen here!”.

Ever since Joint Commission issued a Sentinel Event Alert in 1999 ([Joint Commission 1999](#)) that identified root causes in cases of infant abductions from hospitals and made numerous recommendations for steps to prevent such most hospitals have put in place security systems, training and protocols to both prevent such abductions and respond immediately in the event of one. But the two cases here and the one we discussed back in December clearly highlight the potential vulnerabilities at all our hospitals (and even other healthcare facilities).

We don’t have any details on any root cause analyses that may have been done in the two recent cases but many of the root causes identified in last year’s case remain important.

Probably the most important issue to address is access to the maternity units. One is struck by the boldness of the abductors and how it can help them avoid suspicion. In the one case it appears that the abductor was presumed to be the sister of the mother by the nurse and to be a nurse’s aide by the mother. Neither apparently questioned who this person was. Apparently such boldness is typical. In another case example provided in the NCMEC resources (see below) an abductor posed as a social worker from another organization and all the family members assumed she was there to help them, while hospital staff assumed she was a family member.

Be especially wary to avoid “tailgating”. That is where an unauthorized person follows an authorized person through a door to a unit. If anyone tries to do that one must be sure they have an appropriate ID badge. If not, they need to explain to the person that access

to this unit is restricted and make sure they do not enter. If they insist on entering you should immediately contact hospital security.

We suggest you observe some time how often unauthorized people access your maternity unit in a day. Alternatively, you might borrow from the “secret shopper” technique and see what happens if you send an unfamiliar person into your maternity unit.

Knowing all the entrance and exit points to your maternity unit is important. You also need to know what happens to those entrances and exits under all conditions. For example, do those locked exit doors open automatically when a code for a fire is announced? They probably do and a potential abductor may be aware of that.

The National Center for Missing & Exploited Children ([NCMEC](#)) provides some very good resources on preventing infant abductions. Among them is a profile of a typical abductor (based on analysis of over 250 cases). It is usually a female of child-bearing age who is often overweight (the latter often helps perpetuate the lie they are pregnant). The event is usually well-planned, though the actual target is more randomly selected by circumstances. The abductor often poses as a nurse or other healthcare worker. Visits to one or more hospitals to observe staff, workflows, routines, etc. are common.

So having a high level of awareness of people present on the maternity unit is critical. The NCMEC resource for healthcare workers lists many of the behaviors and questions that might help identify potential abductors.

Ensuring that all your staff wear appropriate identification badges is important. Having ID badges, perhaps color-coded, that indicate who works on the maternity unit is also a recommendation. The NCMEC even recommends periodically rotating the color-coding scheme.

But remember that your unit’s overall level of effective staffing is highly variable. Staffing is reduced at times of meal breaks or when there are unexpected absences due to illnesses. Moreover, on a busy day with several mothers in labor and maybe another needing an emergency C-section staff may be pulled in multiple directions and be focused less on the “visitors” to a unit.

Your staff must feel comfortable in challenging anyone they find suspicious. It can usually be done in a diplomatic way but they must be empowered to be more forceful. It is their obligation. You may recall a story in the past year about a well-known political figure getting into a tussle with nurses on a maternity unit. Well, those nurses were undoubtedly doing exactly what they were supposed to be doing to ensure the security on that maternity unit!

The NCMEC resources also note that diversions may be concocted to distract staff. They mention things like small fires in closets or loud arguments in waiting areas.

Infants may at times need to leave the maternity unit. They might have to go to radiology. Those getting circumcisions may go to the OR or a treatment room not on the unit. The NCMEC guideline also has good recommendations about who and what are considerations during hospital transports. Some of these are practical recommendations such as only transporting infants one at a time and requiring the infants be in bassinets during transports rather than being carried in arms.

Video surveillance systems may be helpful in deterring an attempt at abduction and in documenting an event and identifying the abductor and finding the abducted infant.

Education of both staff and the family are important in preventing infant abductions but should also be extended to help prevent incorrect identification of infants. When providing such education to mothers and family, it is important to assess their level of understanding. It is wise to do that education twice with the mother, once in the days or weeks just prior to anticipated delivery and then again immediately after delivery when the ID tags are being placed. You need to keep in mind that the mother's cognition may be impaired by drugs used during labor and delivery and she may not fully comprehend what she is being told at that time. In any case, the identification process should be reinforced on every interaction between mother and baby and staff. The NCMEC makes available [Safety Tips for Expectant Parents](#) which provide great advice for expectant parents to read prior to coming to labor and delivery. The NCMEC resources also indicate that language barriers may be a risk factor.

Your staff training and retraining is very important. Everybody needs that training, not just your nursing and security staff. Hospital switchboard operators play a crucial role in "Code Pink" but are often afterthoughts in the training sessions. Also in our December 20, 2011 Patient Safety Tip of the Week "[Infant Abduction](#)" we noted you should also consider bringing non-employees into your training. For example, you might have contracted parking lot vendors or other contracted workers who might need to know how to respond (recall that in the case in our December column the key to finding the abductor was that the parking lot attendant wrote down the license plate number of a vehicle that left without paying for parking). And, of course, your local police should be part of your training as well as part of your drills.

Doing drills is also important. But you need to do them the right way. In our December 20, 2011 Patient Safety Tip of the Week "[Infant Abduction](#)" we noted that the hospital at which the abduction occurred had done 4 such "Code Pink" drills in the two prior years and that in each of those drills the "abductor" had been able to exit the facility. So when you do drills you need to be sure your observer/evaluators know what to look for. Then you need to be sure you follow up on items that need correction. The [NCMEC resources for healthcare professionals](#) includes a good **drill critique form** with a list of items to evaluate during drills and provides a good bibliography to other resources about doing drills. One item you would evaluate is whether during the "Code Pink" appropriate people were stopped and interrogated or prevented from exiting. Even though NCMEC has developed a profile of a typical abductor, we would caution against "profiling" during a Code Pink and recommend every person be considered a potential abductor. Also,

given our comments about doors during fire alerts you might even consider doing a “Code Pink” drill immediately following a fire alert drill.

Doing a **FMEA** (failure mode and effects analysis) gets you to always consider “**what if...?**” scenarios to help you identify areas of vulnerability.

- What if...the bracelet security system failed?
- What if...the exit doors unlocked automatically during a fire alert?
- What if...staffing was low due to an unexpected absence and we now get an emergency C-section?
- What if...an infant has to go to radiology for a study?
- What if...a doctor tells us “it’s okay to let the father carry the infant to radiology”?

The whole point of a FMEA is to identify areas where unexpected circumstances might occur that could breach your safe processes.

Even if you don’t do a full formal FMEA on preventing infant abductions, it is worth becoming familiar with all the recommendations in the [National Center for Missing & Exploited Children resources](#) and the [Joint Commission Sentinel Event Alert](#). Perhaps just developing a checklist of potential vulnerabilities and looking for them might be a starting point. NCMEC provides a [self-assessment form](#) on their resources page for healthcare professionals that serves as a good place to start.

The NCMEC guidelines also provide good advice for a critical incident response, too. Particularly helpful are their suggestions about how to deal with the family, public and media should an abduction occur (or even be attempted).

Also consider that the maternity unit may not be the only target for an infant abduction. Pediatric units, outpatient clinics, and other areas could also be potential targets so you should consider your potential vulnerabilities there as well.

First and foremost **don’t get complacent!** All too often we hear “that could never happen here” and people assume that the infant security bracelet system is failsafe. Well it’s not, as evidenced in the case from our December column and in the current case that occurred at a very respected maternity hospital.

And don’t forget our November 17, 2009 Patient Safety Tip of the Week “[Switched Babies](#)”. That deals with the equally serious potential problems of getting two newborns switched and misidentified and the problem of misidentifying expressed breastmilk and giving it to the wrong infants. Like infant abductions, these are relatively rare events but have serious consequences.

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