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Infant Abduction from Healthcare Facilities:

Prevalence, Explanation, and Risk Mitigation

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Abstract

Hospitals and healthcare facilities employ a combination of technology and staff training to mitigate external threats to patient safety and well-being. One of these threats is infant abduction—a rare but salient concern for hospital staff charged with the protection of vulnerable patients. Though only 140 such events have occurred in the U.S. over the past six decades, there remains a need for vigilance and the implementation of security protocols that are effective but not unduly burdensome on patients and families. Moreover, while hospitals presently use a wide range of processes and techniques to help prevent infant abductions, these facilities must frequently revisit these procedures and consider implementing new and innovative technologies to update their risk-mitigation measures and crisis response plans. Abduction simulations can help hospitals identify vulnerabilities, particularly those that are unknown to staff and can be exploited through the manipulation of human factors. This report provides a summary of (1) the literature on the prevalence and characteristics of infant abductions from healthcare facilities, (2) the theory and research from criminology on the factors associated with infant abduction, and (3) some best practices proposed by experts to help inform healthcare professionals, patients, and policymakers in Texas and nationwide.

Keywords: healthcare, victimization, infant abduction, technology, patient safety

Introduction

In 2022, there were 359,094 entries in the FBI's National Crime Information Center (NCIC) database for missing children under age 18, and 2,386 of these cases have been identified as abductions by someone not a custodial parent (NCIC, 2023). Though raw data on the specific characteristics of all cases involving the abduction of infant children are not publicly available, a recent report from the National Center for Missing & Exploited Children (NCMEC, 2022) provides an overview of the 336 confirmed infant abductions that occurred between 1964 and 2022. This report showed that Texas and California have the highest prevalence of infant abduction, with 44 such events happening in each of these two states. Additionally, the NCMEC (2022) report found that 140 of these infants (42%) were abducted from healthcare facilities, and the abductor impersonated a nurse or other healthcare worker in nearly 73% of these cases. Previous reports on this topic have revealed that the number of infant abductions from hospitals increased during the 1980s (Ankrom & Lent, 1995) but declined markedly in the 1990s and thereafter (Burgess et al., 1995, 2008; NCMEC, 2022).

Typically, an infant abduction is committed by a female perpetrator of childbearing age who is married/cohabitating and lives in the same community where the crime occurs (Mertens, 2006; NCMEC, 2022). The abduction itself is frequently planned, sometimes for months, with the perpetrator visiting maternity wards or nurseries at more than one facility to become familiar with the routines of healthcare staff and the parents of potential abductees (Ankrom & Lent, 1995; Baker et al., 2002). Approximately 59% of hospital abductions occur from the mother's room, and the abductor may impersonate a nurse, lab technician, social worker, or photographer and use deception and manipulation to gain access (NCMEC, 2022). Though these events are often premeditated, specific infants are infrequently targeted, and many abductions are crimes of

opportunity in which the perpetrator exploits situational vulnerabilities when they arise (Burgess et al., 1995; Lord et al., 2001; Vincent, 2009). Though these characteristics are present in most hospital abductions, they are not universal; some abductors are male, are unmarried, have accomplices, are a parent or family member of the child, and employ no impersonation or other deception (Baker et al., 2002; NCMEC, 2022).

The Joint Commission, a national organization that accredits healthcare organizations and programs in the U.S., has determined patient abductions—regardless of patient age—to be "sentinel events" that require an immediate investigation and a root cause analysis. The results of these investigations will be evaluated, and the suitability of sanctions will be determined:

> Sentinel events are a subcategory of adverse events. A *sentinel event* is a patient safety event (not primarily related to the natural course of a patient's illness or underlying condition) that reaches a patient and results in death, severe harm (regardless of duration of harm), or permanent harm. Sentinel events are not only events that occur during the treatment or care of individuals. Physical and verbal violence, abductions, and power failures are all potential sentinel events that can affect the health care organization and its patients. (The Joint Commission, 2024, p. 2)

Hospitals are charged with safeguarding patient safety, and the Joint Commission requires healthcare facilities to have effective staff training and critical incident response procedures in place to ensure that physical security is maintained, patients are protected against external threats, and sentinel events are prevented (Shogan, 2002; Vincent, 2009). To this end, healthcare institutions have implemented a variety of proactive measures, emergency response plans, and physical safeguards to reduce opportunities for infant abduction and decrease the likelihood of successful crime completion (e.g., Burns, 2003; Elgart & Gaffney, 2009; Hale & Incao, 2002; Miller, 2007; Pandya et al., 2023; Webster et al., 2021). Because hospitals are incentivized to preserve their accreditation and public reputations, they must continuously revisit these practices to ensure that they are effective (Hiner et al., 2012; Smith, 2009; Wyld, 2010).

Problem Statement and Research Objective

Though an exceptionally rare occurrence, the abduction of an infant from a medical facility represents a central concern for patients, families, and healthcare personnel. Accordingly, the aim of this report is to (1) summarize existing knowledge about the features of these unique events, (2) review the relevant theory and research from criminology and criminal justice on how infant abductions from hospitals may be understood, and (3) highlight the ways that healthcare facilities can bolster their protective efforts toward the successful prevention of infant abductions. Overall, this report is intended to supplement existing practice and provide relevant and timely insights about a salient threat to patient safety that has received remarkably little empirical attention in the recent literatures from medicine, nursing, security management, and criminology. In this way, the goal of the present report is to be an informational resource that policymakers, administrators, practitioners, and members of the public can use to better understand this important yet understudied security risk.

Characteristics of Infant Abductions from Healthcare Facilities

Reports published by the NCMEC have provided a profile of a typical infant abduction incident, as most abductions from hospitals share several key features (Burgess et al., 2008; Mertens, 2006). For instance, among incidents in which the abductor used impersonation or deception to gain access to the healthcare facility, nearly all abductors posed as a nurse or other healthcare worker (73%) or as a relative, friend, or acquaintance of the family (14%); other impersonations (e.g., as a photographer, seller, social worker, or INS agent) are far less common (NCMEC, 2022). Both in and out of hospitals, most infant abductions—approximately 62%—are committed by female perpetrators ages 20-39, though infant abductors younger than age 19 and older than age 40 have been reported. Only seven of the 336 infant abduction incidents profiled

in the NCMEC's (2022) report were perpetrated by males. Since 1987, there have been 21 cases of fetal abduction (i.e., cesarean abduction), which represents 6% of all infant abductions (see also Burgess et al., 2016; Welner et al., 2024). According to the NCMEC, the mother died in 19 of these 21 events, and the infant died in nine of these incidents. Among all infant abductions, however, the death of the infant occurs in less than 3% of cases (NCMEC, 2022).

Snow's (2008) comprehensive text presents an overview of the phenomenon of infant abduction, and it includes a narrative of a prototypical case:

> On March 10, 2007, at Covenant Lakeside Medical Center in Lubbock, Texas, a woman dressed in blue, flowered hospital scrubs, and claiming to be a nurse, came into the room of newborn infant Mychael Darthard-Dawodu. The woman had been in the room several times before to check on the baby. Mychael weighed six pounds and had jaundice, a common condition that wouldn't be dangerous as long as she remained in the hospital. According to police reports, the woman came into the baby's hospital room and "told the family they needed to take the baby for some tests and left the room." The baby's mother watched anxiously as the woman left with Mychael.
>
> After about 15 minutes, the mother became concerned and inquired about her baby girl. Hospital personnel soon realized that the woman was not a nurse, but rather an imposter, and that an infant had been abducted. They immediately locked down the hospital. But it was too late. Security cameras would later show the imposter, carrying a large purse in which they believe she had hidden the infant, leave the hospital and get into a red, Dodge pickup truck. Although Mychael had been wearing a security bracelet, the police later found it in a trash can. The authorities had members of Mychael's family view the video, but no one recognized the woman. (p. 19)

The incident was resolved a day later when the child was located unharmed 100 miles away in Clovis, New Mexico, in the possession of a 21-year-old woman unknown to the family. The perpetrator, who had no significant criminal history, reportedly had recently suffered a second miscarriage and was severely depressed (Snow, 2008; Wyld, 2010). As in many other cases, the child was located through the help of a tip from a member of the public, which was prompted by the extensive media coverage that followed the abduction.

Except in cases of fetal abduction (Burgess et al., 2016; Welner et al., 2024; Yutzy et al., 1993), the perpetration of violence against the infant or mother is uncommon (Baker et al.,

2002). The study by Baker and colleagues (2002) profiled 30 infant abduction incidents that involved some form of physical violence, and they found that the abductor almost always inflicts violence on one or both parents; the death of the infant is rare outside of cesarean abductions. In fact, this pattern helps to highlight key dimensions of abductors' motivation, which typically involves a strong desire to have a child but an inability to conceive (Ankrom & Lent, 1995; Goodwin, 2001), psychological trauma stemming from a miscarriage or other loss (Snow, 2008), or a perceived need to reestablish or solidify a strained romantic relationship (Ankrom & Lent, 1995; Baker et al., 2002; Snow, 2008; Vincent, 2009). In rare instances, a newborn can be abducted by the child's own unfit parent (Snow, 2008). In most cases, however, the abductor is a stranger to the family whose circumstances have led her to plan and execute an abduction in a desperate attempt to fulfill her own psychological needs:

> According to the NCMEC, sometimes the infant abductor is driven by a desire to experience vicariously the birth of a child she is "unable to conceive or carry to term." She is desperate to "bask in the rapture of baby love—to feel adored and needed." Just as many expectant mothers tell others the "good news," the typical infant abductor truly believes that "…she is about to give birth, and she fully expects everyone to accept the reality she has attempted to create." (Ankrom & Lent, 1995, p. 14)

In some instances, the abduction of an infant can be the final stage of a condition called pseudocyesis—a feigned or false pregnancy in which a woman feels such an intense desire for motherhood that she begins to believe that she is pregnant (Burgess et al., 1995). This belief can be attended by certain physical symptoms of pregnancy (e.g., weight gain) as well as various preparatory behaviors, including alerting family and friends, scheduling medical appointments, planning maternity leave, and purchasing supplies. These preparations can eventually culminate in the abduction of a newborn from a hospital:

> As the ninth month approaches, anxiety increases over the need to produce a baby. In this phase, abductors plan where they are going to get a baby. They begin to search for a baby. Continuing the deceptive ploy, they devise some kind of legitimate reason for being near the baby, using a false identity such as that of a nurse, social worker, or lab technician in the hospital; or as a visiting nurse, photographer, or babysitter in the home. (Burgess et al., 1995, p. 32)

The goal of the crime is to get away with the infant successfully, though the likelihood that the infant will be found is quite high; in only 16 of the 336 infant abduction incidents that occurred between 1964 and 2022 is the child still missing (NCMEC, 2022). Though infant abductors occasionally abandon or surrender the children willingly, those with pseudocyesis often flaunt the baby openly without guilt or regret and are usually discovered and reported by an anonymous tipster or a suspicious friend or relative (Burgess et al., 1995).

Criminological Theory and Infant Abductions

Though child abductions are rare events, there exists a small but noteworthy empirical literature on these incidents and the characteristics of perpetrators and victims (e.g., Collie & Shalev Greene, 2017, 2019; Erikson & Friendship, 2002; Miller et al., 2008; Shutt et al., 2004), including unsuccessful abduction attempts (Gallagher et al., 2008). This research has emphasized that abductions of infants are qualitatively different from abductions of older children; for instance, infant abductions are more likely to be committed by female perpetrators and non-family members, and a deep-seated emotional need to have a child is a common motive in infant abductions that is not often seen in cases involving older victims (Boudreaux et al., 1999; Lord et al., 2001; Shelton et al., 2016). However, because all child abductions are uncommon, most of these analyses are descriptive and atheoretical (Miller et al., 2008), and scholars infrequently attempt to apply conventional understandings of crime to child abduction (cf. Collie & Shalev Greene, 2016). While very limited prior work has explicitly incorporated infant abduction within

existing criminological work, theoretical insights from the field of criminology and criminal justice can be helpful to better understand infant abductions.

A perspective that is particularly applicable to the phenomenon of infant abductions is Agnew's (1992) general strain theory, which describes crime as the product of maladaptive responses to stressful events, traumas, and other negative experiences (see also Agnew, 2001, 2013). Specifically, the inability to achieve a valued goal, the loss of something of value, and/or the introduction of a negative stimulus can present strains or stressors that, for some people and in certain contexts, produce negative emotional states (Ganem, 2010; Jang, 2007; Moon et al., 2009). These negative emotions (e.g., anger, frustration, depression), which might become severe or overwhelming, can create pressure within individuals that demands some form of corrective action, and crime can be one such form of coping behavior. Though this deviance may involve retaliatory violence against the specific people who caused the strain (see, e.g., Brezina, 1996; Hay & Evans, 2006; Mazerolle et al., 2000), in other instances individuals' behavioral responses may be more diffuse or unfocused, representing a general reaction to the negative emotional state itself. In this way, criminal coping may be an attempt to feel better amid overwhelming anger or sadness (Meldrum et al., 2023; Ngo & Paternoster, 2016; Piquero et al., 2010).

As previously discussed, newborn abductions from hospitals are not random events but rather are carefully organized acts that are usually perpetrated in response to specific intense emotional stressors (Lord et al., 2001; Vincent, 2009). Indeed, the inability to conceive, the loss of a child, or a strained romantic relationship have been identified as key antecedent factors for infant abduction, and it is logical to conclude that these experiences foster the profound negative feelings and sense of desperation that trigger the decision to plan an abduction (Ankrom & Lent, 1995; Goodwin, 2001; Wyld, 2010). Moreover, when effective social supports are absent and the

individual is unable to access conventional coping resources, the desire to have a child may become so overwhelming that she may develop a kind of psychosis that drives her to view abduction as the only solution (Burgess et al., 1995; Snow, 2008). Thus, unlike abductions of older children that may be motivated by other factors, infant abduction fits well within the framework of Agnew's general strain theory, as this behavior seems uniquely linked to the heightened negative emotions that stem from a traumatic experience, devastating loss, or other stressful event tied to the perpetrator's motherhood or family status.

Another perspective that may help explain infant abduction events is routine activities theory, which posits that crime is most likely to occur when several key factors converge in time and space: (1) a motivated offender, (2) a suitable target, and (3) the absence of capable guardianship (Cohen & Felson, 1979). Much criminological research has found support for this perspective, and it is frequently employed to understand why criminal motivation leads to crime only in certain instances (e.g., Bernburg & Thorlindsson, 2001; Miller, 2013; Sasse, 2005), why certain locations and individuals are more likely than others to be targeted for victimization (Boudreaux et al., 2001; Clodfelter et al., 2010; Hollis et al., 2013; Partin et al., 2022; Pratt et al., 2010), and the types of preventative efforts that are most beneficial (Breetzke & Cohn, 2013; Randa et al., 2022; Sampson et al., 2010; Tillyer & Eck, 2011). Though inhibiting the motivation of abductors is beyond the capacity of hospital systems, this framework holds relevance for policy and practice in healthcare facilities, as it implies that effective prevention strategies hinge on improving guardianship and reducing target suitability (Collie & Shalev Greene, 2016).

Assessing and Enhancing Hospital Security Responses

Legal scholars and healthcare professionals have long advocated in favor of additional advancements in security response and training to better prevent infant abductions (e.g., Carroll, 1999; Goodwin, 2001; Miller, 2007; Stephenson, 1995). Case studies of specific hospitals have revealed various innovations which have been introduced to reduce patient risk (Burns, 2003; Elgart & Gaffney, 2009; Hale & Incao, 2006; Hiner et al., 2012; Mertens, 2006), and medical facilities in the U.S. generally have more robust security systems than those in place in some other countries (see, e.g., Batool et al., 2023). However, when hospitals' prevention and response efforts are subjected to simulation drills to assess their effectiveness, the findings from these tests can be troubling (Pandya et al., 2023; Saad & Ahamed, 2007). For example, an infant abduction simulation in an unnamed hospital revealed several key concerns:

- Access to the maternal unit was gained through tailgating with no challenge from staff.
- Access to the mother's room, despite being in close proximity to the midwives' station, went unchallenged.
- Staff did not engage or challenge abductor despite a team member identifying concern. Activation of local policy was slowed due to handover time. Lack of awareness of who has called who.
- Communications between staff members occurred through non-secure social media applications. Security cameras ineffective due to relay of images to a different location.
- Escape from the unit made easy by unlocked corridors. Certain staff groups unsure of their role. (Quayle et al., 2021, p. A30)

In light of these results as well as the findings from surveys of hospital personnel (Smith, 2009; Webster et al., 2021), practitioners and experts in security technology and management have devised a set of recommendations for improving physical safeguards, enhancing staff responses, educating parents, and patching vulnerabilities at key points of potential failure without overly burdening patients (Cesario, 2003; Shogan, 2002; Tiwari et al., 2012; Wyld, 2010).

Infant Identification and Alarm Systems

Case studies of individual hospitals' security methods frequently highlight their use of alarm and infant identification systems, with many facilities using wireless location trackers embedded in a bracelet or a tag on the umbilical cord stump (Burns, 2003; Elgart & Gaffney, 2009). These devices, which frequently employ radio frequency identification (RFID), also can have alarm transmitters that sound if the infant is brought outside of an approved area within the hospital. Though some experts have expressed concerns that RFID systems can be hacked and disabled (Saad & Ahamed, 2007), others have highlighted the benefits of integrating these systems within a facility's broader security infrastructure to maximize their effectiveness:

> The most established brand in the market today is the "Hugs" system. It is marketed by Ottawa, Ontario-based Xmark, which today is a wholly-owned subsidiary of VeriChip. The Hugs system works by having an active, tamper-proof RFID tag attached as an ankle bracelet on the baby's leg. The tag constantly checks in with readers, reporting every ten seconds that it is present and functioning. The Hugs system can be tied into the hospital's security system, set to activate security cameras, trip electronic door locks, and shut down elevators for a "lockdown" of the facility in the event of an alarm. The Hugs bracelet is also designed to set off an alarm if it is loosened or cut off from the newborn's ankle. (Wyld, 2010, p. 468)

Other infant identification efforts are less preventative and more precautionary. For instance, facilities may take digital photos, footprints, saliva (see Tesini, 2009), and/or cord blood DNA immediately after birth, which can be used to confirm identity in cases where the newborn is separated from the mother (Hale & Incao, 2006; Shogan, 2002). Some experimentation with facial recognition software also has been conducted (Tiwari et al., 2012). Through all of these responses, hospitals can reduce target suitability and increase the likelihood that any abduction attempt will be quickly thwarted.

Monitoring and Restricting Access and Transportation

Beyond infant identification methods, trackers, and RFID systems, hospitals also can employ prevention measures that involve monitoring movements, restricting outsider access to controlled areas within facilities, and implementing strict rules regarding patient transportation procedures. Monitoring the movements of all staff, patients, and visitors via a functioning CCTV system represents one of the most basic yet critical ways of observing suspicious persons in real time, documenting emergency events as they occur, and deterring abductions (Cesario, 2003; Hale & Incao, 2006). CCTV cameras are particularly useful near stairwells and street-level access points (Shogan, 2002). Other physical safeguards can prevent unauthorized access to specific areas via self-closing doors and locks that use push-button codes or electronic locks rather than physical keys that can be lost, stolen, or copied (Cesario, 2003; Mertens, 2006; Shogan, 2002). Since maternity wards are high-traffic areas, facilities should restrict as much as possible the spaces that outside visitors are permitted to access, assign photo ID badges to all visitors, and ensure that every individual entering and exiting the area is screened one at a time to avoid "tailgating" or "piggybacking"—a common way that malicious actors gain access to restricted areas (Quayle et al., 2021; Webster et al., 2021).

Physical Layout

Some experts have made recommendations regarding the layout, design, and structure of physical spaces to enhance monitoring and supplement other security practices. Indeed, the geography of the maternity ward itself may render patients vulnerable to victimization, as certain features of the space can place nurses, security guards, and other capable guardians farther away from potential targets and provide perpetrators with opportunities to commit an abduction unobserved (Webster et al., 2021). Some of these issues can relate to the location of the front

desk vis a vis entrance points, but problems also can arise when nurses' stations are too distant from elevators, blind hallways, and back entrances:

> The nurses' station should be an open area that is centrally located on the unit. The doors to patient rooms should be visible by direct line of sight or via monitoring devices. Private postpartum patient rooms are strongly recommended, as all visitors to that room will be known to the patient. The nursery should have very limited access, ideally requiring the person entering the nursery to pass through a restricted area such as the nursing station. Nursery doors should have self-closing hardware and remain locked at all times. Panic buttons can be installed to summon help in a timely manner should the nurse witness a suspected abduction in progress. (Cesario, 2003, p. 240)

Additionally, because the transportation of infants within the facility can pose a concern, special care should be taken to ensure that multi-floor units are as self-contained as possible, and maternity wards should not be near major building exits (Hale & Incao, 2006).

Staff Training and Patient Education

Security experts and medical practitioners have long stressed the importance of effective patient and family education as a primary mechanism of infant abduction prevention (e.g., Carroll, 1999; Hale & Incao, 2006; Stephenson, 1995). Not only must healthcare personnel wear conspicuous color photo ID badges that patients can easily recognize (Carroll, 1999; Cesario, 2003), but parents should be made aware of infant security best practices; these include, for example, never leaving the baby unattended (Hale & Incao, 2006), knowing how to identify legitimate hospital staff using cues other than their wardrobe (Webster et al., 2021), and being suspicious of nurses who request to take the infant out of the recovery room (Hiner et al., 2012; Miller, 2007; Shogan, 2002). As part of the standard security protocol, parents also should be briefed about the profile of the typical infant abductor so that they will know to stay vigilant, especially since these events are so uncommon that the possibility of an abduction is rarely at the forefront of new parents' concerns. Existing data on successful infant abductions do not include

"near misses" (Cesario, 2003; Gallagher et al., 2008), and parents must be alerted to the key role that their own efforts can play in ensuring the protection of their newborns.

Finally, beyond providing patients and families with education, hospital staff also must be properly trained to mitigate risks, identify suspicious persons, and respond effectively in abduction situations (Miller, 2007; Stephenson, 1995). As previously discussed, abduction simulation drills have revealed that untrained staff are unable to follow proper security protocols (Quayle et al., 2021; Pandya et al., 2023), thus highlighting the crucial role that dedicated and personalized training must play in emergency response. Though ongoing staff education in this regard is essential (Hale & Incao, 2006; Mertens, 2006; Shogan, 2002), realistic drills sometimes can be difficult to conduct because they involve serious disruptions to normal hospital operations and patient care, including shutting all entrances and exits (Webster et al., 2021). Further, those administering staff training must work to overcome "alarm complacency" and "alarm fatigue" that can arise due to false alarms caused by equipment malfunctions and user error (Hiner et al., 2012; Webster et al., 2021). Most importantly, as technological safeguards can fail, nurses should not merely assume that all visitors have good intentions but rather trust their intuitions and immediately report any suspicious behavior that they observe (Hale & Incao, 2006).

Conclusion

As the Joint Commission has emphasized and numerous experts have echoed, the abduction of an infant from a healthcare facility is a sentinel event that poses a grave risk to patient safety and warrants intense scrutiny when it occurs. Prior research on infant abduction incidents has revealed some noteworthy patterns regarding the profile of a typical infant abductor, and insights from criminological theory can help policymakers, practitioners, and members of the public better understand the stressors experienced by perpetrators as well as the

salience of target hardening and capable guardianship for successful crime prevention. Though some hospitals have documented the various precautionary and emergency response procedures that they have implemented, recent evidence also suggests that additional measures are needed to enhance physical security, better monitor access to restricted spaces within facilities, improve patient education, and implement consistent and effective personnel training. The primary goal of this report is to meaningfully contribute to and encourage these important efforts and help ensure that infant abduction remains a rare occurrence.

References

Agnew, R. (1992). Foundation for a general strain theory of crime and delinquency. *Criminology*, *30*(1), 47-88. https://doi.org/10.1111/j.1745-9125.1992.tb01093.x

Agnew, R. (2001). Building on the foundation of general strain theory: Specifying the types of strain most likely to lead to crime and delinquency. *Journal of Research in Crime and Delinquency*, *38*(4), 319-361. https://doi.org/10.1177/0022427801038004001

Agnew, R. (2013). When criminal coping is likely: An extension of general strain theory. *Deviant Behavior*, *34*(8), 653-670. https://doi.org/10.1080/01639625.2013.766529

Ankrom, L. G., & Lent, C. J. (1995). Cradle robbers: A study of the infant abductor. *FBI Law Enforcement Bulletin*, *64*, 12-17.

Baker, T., Burgess, A. W., Rabun, J. B., Jr., & Nahirny, C. (2002). Abductor violence in nonfamily infant kidnapping. *Journal of Interpersonal Violence*, *17*(11), 1218-1233. https://doi.org/10.1177/088626002237403

Batool, S., Fatima, R., Nazir, H. S., Idrees, A., & Ashfaq, H. (2023). Assessment of hospital preparedness to prevent mother-baby mix-ups and abductions: Insights from public hospitals in Lahore District. *Journal of Community Medicine and Public Health Reports*, *4*(8). https://doi.org/10.38207/JCMPHR/2023/OCT040805124

Bernburg, J. G., & Thorlindsson, T. (2001). Routine activities in social context: A closer look at the role of opportunity in deviant behavior. *Justice Quarterly*, *18*(3), 543-567. https://doi.org/10.1080/07418820100095011

Boudreaux, M. C., Lord, W. D., & Dutra, R. L. (1999). Child abduction: Aged-based analyses of offender, victim, and offense characteristics in 550 cases of alleged child disappearance. *Journal of Forensic Sciences*, *44*(3), 539-553. https://doi.org/10.1520/JFS14506J

Boudreaux, M. C., Lord, W. D., & Jarvis, J. P. (2001). Behavioral perspectives on child homicide: The role of access, vulnerability, and routine activities theory. *Trauma, Violence, & Abuse*, *2*(1), 56-78. https://doi.org/10.1177/1524838001002001004

Breetzke, G. D., & Cohn, E. G. (2013). Burglary in gated communities: An empirical analysis using routine activities theory. *International Criminal Justice Review*, *23*(1), 56-74. https://doi.org/10.1177/1057567713476887

Brezina, T. (1996). Adapting to strain: An examination of delinquent coping responses. *Criminology*, *34*(1), 39-60. https://doi.org/10.1111/j.1745-9125.1996.tb01194.x

Burgess, A. W., Burgess, A. G., Dowdell, E. B., Hartman, C. R., Nahirny, C., & Rabun, J. B. (1995). Infant abductors. *Journal of Psychosocial Nursing and Mental Health Services*, *33*(9), 30-37. https://doi.org/10.3928/0279-3695-19950901-06

Burgess, A. W., Carr, K. E., Nahirny, C., & Rabun, J. B., Jr. (2008). Nonfamily infant abductions, 1983–2006. *The American Journal of Nursing*, *108*(9), 32-38. http://doi.org/10.1097/01.NAJ.0000334972.82359.58

Burgess, A. W., Dillon, M. A., Chiou, K. Y., & Hulsopple, S. B. (2016). Fetal abduction: Comparison of two cases. *Journal of Psychosocial Nursing and Mental Health Services*, *54*(11), 37-43. https://doi.org/10.3928/02793695-20161024-07

Burns, A. L. (2003). Protecting infants in healthcare facilities from abduction: A facility's search for a sound infant security system. *The Journal of Perinatal & Neonatal Nursing*, *17*(2), 139-147. https://doi.org/10.1097/00005237-200304000-00006

Carroll, V. (1999). Infant abduction: Lowering the risk. *AWHONN Lifelines*, *3*(6), 25-27. https://doi.org/10.1111/j.1552-6356.1999.tb01145.x

Cesario, S. K. (2003). Selecting an infant security system: Assessing the needs of your facility. *AWHONN Lifelines*, *7*(3), 236-242. https://doi.org/10.1177/1091592303255720

Clodfelter, T. A., Turner, M. G., Hartman, J. L., & Kuhns, J. B. (2010). Sexual harassment victimization during emerging adulthood: A test of routine activities theory and a general theory of crime. *Crime & Delinquency*, *56*(3), 455-481. https://doi.org/10.1177/0011128708324665

Cohen, L. E., & Felson, M. (1979). Social change and crime rate trends: A routine activity approach. *American Sociological Review*, *44*(4), 588-608. https://doi.org/10.2307/2094589

Collie, C. J. R., & Shalev Greene, K. (2017). Examining offender, victim and offence characteristics in cases of stranger child abduction: An exploratory comparison of attempted and completed cases using publicly available data from the UK. *Aggression and Violent Behavior*, *35*, 73-82. https://doi.org/10.1016/j.avb.2017.06.005

Collie, C. J., & Shalev Greene, K. (2016). Stranger child abduction and guardianship: Accompaniment and surveillance in attempted and completed cases. *Crime Prevention and Community Safety*, *18*, 284-308. https://doi.org/10.1057/s41300-016-0002-3

Collie, C. J., & Shalev Greene, K. (2019). Examining modus operandi in stranger child abduction: A comparison of attempted and completed cases. *Journal of Investigative Psychology and Offender Profiling*, *16*(2), 91-109. https://doi.org/10.1002/jip.1523

Elgart, L., & Gaffney, A. (2009). Advancing patient safety through process improvements. *Journal for Healthcare Quality*, *31*(5), 8-13. https://doi.org/10.1111/j.1945-1474.2009.00041.x

Erikson, M., & Friendship, C. (2002). A typology of child abduction events. *Legal and Criminological Psychology*, *7*(1), 115-120. https://doi.org/10.1348/135532502168423

Gallagher, B., Bradford, M., & Pease, K. (2008). Attempted and completed incidents of stranger-perpetrated child sexual abuse and abduction. *Child Abuse & Neglect*, *32*(5), 517-528. https://doi.org/10.1016/j.chiabu.2008.02.002

Ganem, N. M. (2010). The role of negative emotion in general strain theory. *Journal of Contemporary Criminal Justice*, *26*(2), 167-185. https://doi.org/10.1177/1043986209359558

Goodwin, A. B. (2001). Striving for a secure environment: A closer look at hospital security issues following the infant abduction at Loyola University Medical Center. *Annals of Health Law*, *10*, 245-288. https://lawecommons.luc.edu/annals/vol10/iss1/9

Hale, K., & Incao, D. (2002). Infant security education: A multidisciplinary approach. *AWHONN Lifelines*, *6*(3), 234-239. https://doi.org/10.1111/j.1552-6356.2002.tb00087.x

Hay, C., & Evans, M. M. (2006). Violent victimization and involvement in delinquency: Examining predictions from general strain theory. *Journal of Criminal Justice*, *34*(3), 261-274. https://doi.org/10.1016/j.jcrimjus.2006.03.005

Hiner, J., Pyka, J., Burks, C., Pisegna, L., & Gador, R. A. (2012). Preventing infant abductions: An infant security program transitioned into an interdisciplinary model. *The Journal of Perinatal & Neonatal Nursing*, *26*(1), 47-56. https://doi.org/10.1097/JPN.0b013e31824003a2

Hollis, M. E., Felson, M., & Welsh, B. C. (2013). The capable guardian in routine activities theory: A theoretical and conceptual reappraisal. *Crime Prevention and Community Safety*, *15*, 65-79. https://doi.org/10.1057/cpcs.2012.14

Jang, S. J. (2007). Gender differences in strain, negative emotions, and coping behaviors: A general strain theory approach. *Justice Quarterly*, *24*(3), 523-553. https://doi.org/10.1080/07418820701485486

Lord, W. D., Boudreaux, M. C., & Lanning, K. V. (2001). Investigating potential child abduction cases: A developmental perspective. *FBI Law Enforcement Bulletin*, *70*, 1-10.

Mazerolle, P., Burton, V. S., Jr., Cullen, F. T., Evans, T. D., & Payne, G. L. (2000). Strain, anger, and delinquent adaptations specifying general strain theory. *Journal of Criminal Justice*, *28*(2), 89-101. https://doi.org/10.1016/S0047-2352(99)00041-0

Meldrum, R. C., Kevorkian, S. S., & Lehmann, P. S. (2023). Childhood adversity, depression, and digital self-harm. *The Social Science Journal*. Advance online publication. https://doi.org/10.1080/03623319.2022.2159648

Mertens, S. (2006). Fight infant abduction before it happens. *Nursing2020 Critical Care*, *1*(3), 16-17.

Miller, J. (2013). Individual offending, routine activities, and activity settings: Revisiting the routine activity theory of general deviance. *Journal of Research in Crime and Delinquency*, *50*(3), 390-416. https://doi.org/10.1177/0022427811432641

Miller, J. M., Kurlycheck, M., Hansen, J. A., & Wilson, K. (2008). Examining child abduction by offender type patterns. *Justice Quarterly*, *25*(3), 523-543. https://doi.org/10.1080/07418820802241697

Miller, R. S. (2007). Preventing infant abduction in the hospital. *Nursing*, *37*(10), 20-22. https://doi.org/10.1097/01.NURSE.0000291964.38539.29

Moon, B., Morash, M., McCluskey, C. P., & Hwang, H. W. (2009). A comprehensive test of general strain theory: Key strains, situational-and trait-based negative emotions, conditioning factors, and delinquency. *Journal of Research in Crime and Delinquency*, *46*(2), 182-212. https://doi.org/10.1177/0022427808330873

National Center for Missing & Exploited Children. (2022). *Analysis of infant abduction trends*. https://www.missingkids.org/content/dam/missingkids/pdfs/ncmec-analysis/Infant%20Abduction%20Trends_10_10_22.pdf

National Crime Information Center. (2023). *2022 NCIC missing person and unidentified person statistics*. Federal Bureau of Investigation. https://www.fbi.gov/file-repository/2022-ncic-missing-person-and-unidentified-person-statistics.pdf

Ngo, F. T., & Paternoster, R. (2016). Toward an understanding of the emotional and behavioral reactions to stalking: A partial test of general strain theory. *Crime & Delinquency*, *62*(6), 703-727. https://doi.org/10.1177/0011128713510077

Pandya, J., Guzman, J., Roblin, P., & Daniel, P. (2023). Improving hospital preparedness for pediatric abductions. *Prehospital and Disaster Medicine*, *38*(S1), s216-s217. https://doi.org/10.1017/S1049023X2300554X

Partin, R. D., Meldrum, R. C., Lehmann, P. S., Back, S., & Trucco, E. M. (2022). Low self-control and cybercrime victimization: An examination of indirect effects through risky online behavior. *Crime & Delinquency*, *68*(13-14), 2476-2502. https://doi.org/10.1177/00111287211061728

Piquero, N. L., Fox, K., Piquero, A. R., Capowich, G., & Mazerolle, P. (2010). Gender, general strain theory, negative emotions, and disordered eating. *Journal of Youth and Adolescence*, *39*, 380-392. https://doi.org/10.1007/s10964-009-9466-0

Pratt, T. C., Holtfreter, K., & Reisig, M. D. (2010). Routine online activity and internet fraud targeting: Extending the generality of routine activity theory. *Journal of Research in Crime and Delinquency*, *47*(3), 267-296. https://doi.org/10.1177/0022427810365903

Quayle, A., Harrison, N., Gaunt, K., & McGuffie, R. (2021). Infant abduction: Live simulation drills explore the risk in the maternity unit. *International Journal of Healthcare Simulation*, *1*, A30. https://doi.org/10.54531/UNLG4542

Randa, R., Reyns, B. W., & Fansher, A. (2022). Victim reactions to being stalked: Examining the effects of perceived offender characteristics and motivations. *Behavioral Sciences & the Law*, *40*(5), 715-731. https://doi.org/10.1002/bsl.2599

Saad, M. K., & Ahamed, S. V. (2007). Vulnerabilities of RFID systems in infant abduction protection and patient wander prevention. *ACM SIGCSE Bulletin*, *39*(2), 160-165. https://doi.org/10.1145/1272848.1272901

Sampson, R., Eck, J. E., & Dunham, J. (2010). Super controllers and crime prevention: A routine activity explanation of crime prevention success and failure. *Security Journal*, *23*, 37-51. https://doi.org/10.1057/sj.2009.17

Sasse, S. (2005). "Motivation" and routine activities theory. *Deviant Behavior*, *26*(6), 547-570. https://doi.org/10.1080/01639620500218260

Shelton, J., Hilts, M., & MacKizer, M. (2016). An exploratory study of residential child abduction: An examination of offender, victim and offense characteristics. *Aggression and Violent Behavior*, *30*, 24-31. https://doi.org/10.1016/j.avb.2016.06.009

Shogan, M. G. (2002). Emergency management plan for newborn abduction. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, *31*(3), 340-346. https://doi.org/10.1111/j.1552-6909.2002.tb00056.x

Shutt, J. E., Miller, J. M., Schreck, C. J., & Brown, N. K. (2004). Reconsidering the leading myths of stranger child abduction. *Criminal Justice Studies*, *17*(1), 127-134. https://doi.org/10.1080/0888431042000217688

Smith, A. D. (2009). Marketing and reputation aspects of neonatal safeguards and hospital-security systems. *Health Marketing Quarterly*, *26*(2), 117-144. https://doi.org/10.1080/07359680802619818

Snow, R. L. (2008). *Child abduction: Prevention, investigation, and recovery*. Greenwood Publishing Group.

Stephenson, T. (1995). Abduction of infants from hospital. *BMJ*, *310*(6982), 754-755. https://doi.org/10.1136/bmj.310.6982.754

Tesini, D. A. (2009). Development of a biometric infant identification tool: A new safeguard through innovation. *International Journal of Childbirth Education*, *24*(2), 25-28.

The Joint Commission. (2024). *Sentinel event policy (SE)*. https://www.jointcommission.org/-/media/tjc/documents/resources/patient-safety-topics/sentinel-event/camh_se_20230906_155314.pdf

Tillyer, M. S., & Eck, J. E. (2011). Getting a handle on crime: A further extension of routine activities theory. *Security Journal*, *24*, 179-193. https://doi.org/10.1057/sj.2010.2

Tiwari, S., Singh, A., & Singh, S. K. (2012). Intelligent method for face recognition of infant. *International Journal of Computer Applications*, *52*(4), 36-50. https://doi.org/10.5120/8194-1569

Vincent, J. L. (2009). Infant hospital abduction: Security measures to aid in prevention. *MCN: The American Journal of Maternal/Child Nursing*, *34*(3), 179-183. https://doi.org/10.1097/01.NMC.0000351706.81502.d0

Webster, K. L., Stikes, R., Bunnell, L., Gardner, A., & Petruska, S. (2021). Application of human factors methods to ensure appropriate infant identification and abduction prevention within the hospital setting. *The Journal of Perinatal & Neonatal Nursing*, *35*(3), 258-265. https://doi.org/10.1097/JPN.0000000000000554

Welner, M., Burgess, A., & O'Malley, K. Y. (2024). Fetal abduction by maternal evisceration (FAMAE): A forensic psychiatric syndrome. In K. A. Burgason & M. DeLisi (Eds.), *Routledge handbook of homicide studies* (pp. 296-320). Routledge. https://doi.org/10.4324/9781003399476-16

Wyld, D. C. (2010). "Security theater" in the pediatric wing: The case for RFID protection for infants in hospitals. In Elleithy, K. (Ed.), *Advanced techniques in computing sciences and software engineering* (pp. 467-470). Springer. https://doi.org/10.1007/978-90-481-3660-5_80

Yutzy, S. H., Wolfson, J. K., & Resnick, P. J. (1993). Child stealing by cesarean section: A psychiatric case report and review of the child stealing literature. *Journal of Forensic Sciences*, *38*(1), 192-196. https://doi.org/10.1520/JFS13392J

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