



An Analysis of Infant Abductions



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Introduction

The taking of an infant, birth through 6 months of age, by nonfamily members is not a crime of epidemic proportion; however, from 1983 to 2002 the best estimate for the nationwide incidence of infant abductions, by nonfamily members ranges between 0 and 12 per year. Figure 0-1 reflects the number of abductions reported during those years. Prior to that time only 7 cases were reported in the news media; however, between 1983 and 2002, 217 cases were reported. The increase may be due to identification and recognition of the problem, better reporting procedures, and/or a greater willingness by healthcare-facility administrators to report abductions. It is also possible that these figures are underreported. Whatever the reason, the abduction of infants by nonfamily members is a subject of concern. As a first step to learn more about this problem the National Center for Missing & Exploited Children (NCMEC), FBI, and the University of Pennsylvania School of Nursing, participated in the U.S. Department of Justice's OJJDP funded FBI in-depth study on infant abductions that occurred from 1982 to 1992.

The five sources of data used were

- Demographic data on 119 reported cases, **from 1983 to 1992**, that came from information obtained by NCMEC.
- An FBI data-collection instrument for offenders who abducted. Using this instrument the FBI interviewed 14 abductors in-depth.
- Forty-eight abductors not interviewed by the FBI but for whom the FBI was able to complete parts of its data-collection instrument.
- A data-collection instrument developed by staff members from the University of Pennsylvania School of Nursing for family and healthcare-facility staff members who were victims of an infant abduction. This instrument was used to complete interviews with 38 family members.
- Data on 72 criminal-court-case outcomes obtained through telephone interviews and the LexisNexis™ news and information service.

Data was cross-checked for validity. Seven cases had complete data from all 5 sources; 21 had data from 4 sources; 35 had data from 3 sources; 31 had data from 2 sources; and 25 had data from 1 source, NCMEC.

REPORTED INFANT ABDUCTION CASES PERPETRATED BY NONFAMILY MEMBERS 1983-2002			
Year	Number of Cases	Year	Number of Cases
1983	5	1993	11
1984	7	1994	14
1985	7	1995	8
1986	11	1996	7
1987	18	1997	10
1988	14	1998	14
1989	17	1999	3
1990	15	2000	13
1991	17	2001	13
1992	10	2002	3

Figure 0-1

The focus of this research project can be defined by the two criteria of the age of the victim and motivation for abduction. The cases studied involved the abduction of a child 6 months of age or younger for “nontraditional motives.” The age criterion is fairly straightforward, obvious, and the reason for the common descriptive term “infant abduction.” The motivation criterion is more complicated, uncertain, and the reason for the less-used term nontraditional abduction.

The term “nontraditional” refers to child abductions **not** motivated by more commonly seen reasons such as sexual gratification, profit, ransom, revenge, and/or power. This research focused on cases apparently motivated by the need to have a child to fill a perceived void in the offender’s life.

Because motivation often is not knowable with certainty, readers must use caution when applying the findings set forth in this publication. **It cannot be assumed that the abduction of every infant is motivated by this nontraditional reason and therefore fits the dynamics set forth here.** Motivation is most reliably determined after the case is solved. It is possible that some of the nine infants included in this study sample who are still missing were not recovered because the abduction motivations were not “nontraditional.” Unless a case was believed to fit both the age and motivation criteria, however, it was not included in this research project.

This analysis presents findings from interviews and record reviews of nonfamily offenders who stole infants in those 119 reported cases from 1983 to 1992. The demographics of the 119 abductors reveal that they were predominantly women (n=112). There were a total of 12 cases where a male was either the lone abductor or charged in the case after law enforcement determined that he had worked in concert with a female abductor. Their nationality included 43 percent Caucasian, 38 percent Black, 15 percent Hispanic, and 4 percent in which this data were unavailable. Of the 62 cases with data available regarding weight, the abductors ranged from 110 to 232 pounds with a mean of 150 pounds. Their height ranged from 56 to 70 inches with the mean of 64 inches. Fifty-three percent were described as having a large build, 27 percent a medium build, 11 percent a small build, and 9 percent of the cases had no information about the abductor’s build. More than half, 53.3 percent, had been married at least once, 24.2 percent had never been married, and in 22.6 percent of the cases no data were available on the abductor’s marital status. Male infants were abducted 52 percent of the time and female infants 48 percent. The infants were recovered between 15 minutes and 416 days with three-quarters recovered in fewer than 5 days. Nine infants remain missing.

The findings include a classification of infant abduction designed for law enforcement in the investigation and apprehension of a suspect and clinical classification designed for mental-health clinicians in the assessment and diagnosis of an abductor and treatment of the victim family. Inclusion of both descriptive working classifications is predicated on the belief that this social problem needs collaboration by multiple disciplines.

When conducting this research we were privileged to interview many victim families, abductors, healthcare officials, law-enforcement officers, and court officials. We are indebted to them for their willingness to share their experiences with us. In an effort to further the reader’s understanding of this crime we have included much of what they shared in this analysis. Please note that with each recounting of an abduction or recovery we have changed the names of the persons involved to protect the privacy of these victim families.

Patterns of Infant Abductions

Infant abductions do not appear to be associated with any specific geographical area or demographic location. In this study of cases from 1983 to 1992 at least 1 abduction was reported in 35 states. Fourteen abductions had been reported in California and another 14 had been reported in Texas. In regard to demographic locations 63 percent of the abductions took place in urban areas, 27 percent occurred in medium-population settings, and 5 percent occurred in rural settings. There were no data on the type of setting in 5 percent of the cases studied. Infants have been stolen from single mothers, from two-parent families, and in healthcare facilities while residing as “boarder babies” who no one had claimed.

A review of the 119 reported cases from 1983 to 1992 identified the areas from which the children were taken.

- **Healthcare facilities** including the mother’s room, pediatric rooms, and nurseries. Abductions have also occurred at other sites on or in close proximity to the grounds of the healthcare facility.
- **Homes** including the interior of the home as well as areas in which a parent was present.
- **Other places** including malls, shopping centers, and cars.

See Figure 1-1.

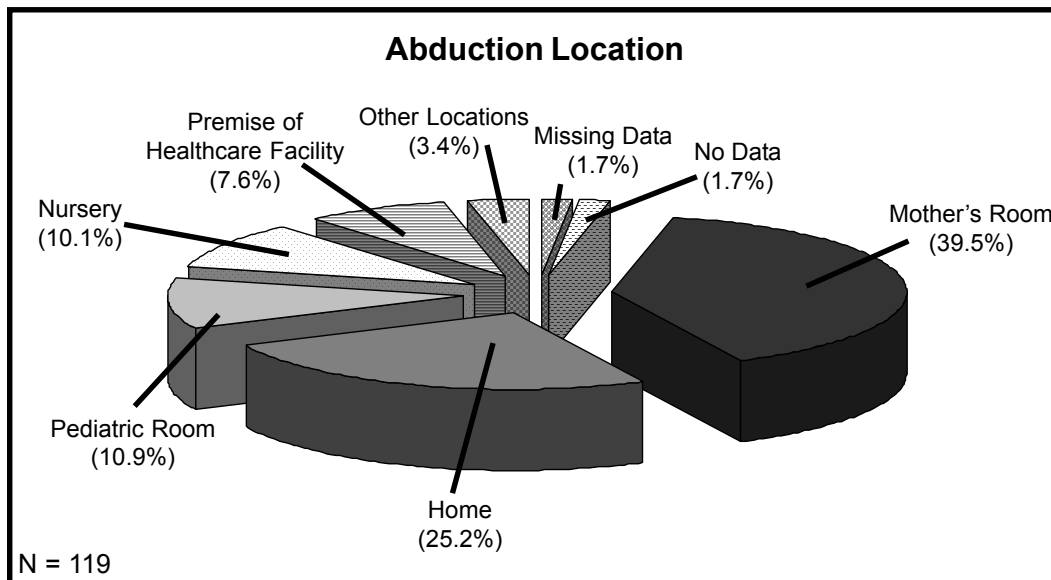


Figure 1-1

Abductions from Healthcare Facilities

Healthcare facilities (n = 81) were the locations for more than two-thirds of the infant abductions. In 47 cases, 39.5 percent, the infant was taken from the mother’s room as is illustrated in Case 1-1 on the next page.

Case 1-1

It was a proud and happy time for Ray and Jean when they had a healthy 7-pound, 3-ounce boy on Father's Day. The local television station came to the hospital to do a feature story on the birth, as he was the first infant born that Father's Day in the area. But Ray and Jean's joy soon turned to anguish. The next day, as Jean was feeding her son, a woman wearing a scrub coat and white slacks entered her room. She told Jean that she needed to weigh the infant. The woman took the infant and left the room. Several minutes later a nurse came into Jean's room, noticed the bassinet was empty, and asked where her infant was. Jean told her that another nurse had taken the infant to be weighed. The nurse, knowing that this was not hospital procedure, had all exits secured and a search of the area was conducted. Local law enforcement and the FBI were notified within an hour, the media was called, and a feature story was broadcast about the abduction on the television that evening. Jean was terrified that her son would be harmed by the abductor. She was so distraught that she could not eat or sleep. Jean and Ray could not hold back the tears as they made an appeal on local television to the kidnapper to return their son. Letters of sympathy and encouragement came pouring into the hospital, and a \$10,000 reward was offered for the safe return of the infant.

The infant was recovered two days later with his hair cut off. The 40-year-old abductor's daughter had driven the "get-away" car and helped hide the infant after the abduction. The abductor was convicted of Kidnapping and received a 12-year sentence. Her daughter received probation.

The facility's nursery was the second location site for 10.1 percent of the cases studied (n = 12).

Case 1-2

Early in her pregnancy Susan and her husband, John, knew that they were having twins. They bought everything that they would need for the infants in pairs including matching cribs, matching outfits, toys, and a double stroller. The whole family was eagerly looking forward to the birth. Three weeks before her due date Susan began to have labor pains and was taken to the hospital. The doctor decided that the infants had to be delivered by Cesarean section. The procedure was performed without complications, and Susan and John had two healthy boys. Susan was, however, very tired from the procedure and could hold the infants for only a short time before they were taken to the nursery. Very early the next morning a woman came into the nursery and identified herself as a university medical student. As this was a teaching hospital, no one was suspicious of her claim.

She wore a lab coat, ID, and stethoscope. She carried a black bag and introduced herself to the nurses on staff at the time. She knew

the routine in the nursery. She expertly handled several infants by washing her hands and changing gloves in-between handling each infant. She did assessments on two of the infants. The other nurses went about their duties and were busy with the other infants. The imposter conversed with the nurses and knew their names. She had been there for almost an hour before she had the opportunity to snatch an infant. As the nurses were busy feeding and delivering infants to the mothers' rooms, the imposter picked up one of Susan's infants, put him in her black bag, and walked away. She took the elevator down to the first-floor level and exited the hospital. When a nurse went to get the infant for feeding, she discovered that he was missing and immediately notified the other nurses and security. One nurse ran down the stairs in an attempt to catch the kidnapper and just as she got outside, she saw a red vehicle speeding out of the parking lot. Law enforcement was called and roadblocks were set up, but the abductor was already out of the area. A few minutes later the doctor and newborn-nursery manager went into Susan's room. Susan knew something was wrong the minute they entered the room. When they told Susan that one of her twins was missing, she began crying hysterically. She called John, but was crying so hard that she could not talk. The doctor took the telephone and told John to come to the hospital right away. John arrived at about the same time as law enforcement. They told John what had happened and what they were going to do. It was learned that Susan's sister had seen the abductor the night Susan delivered the twins. The abductor posed as a pregnant woman and stood in front of the nursery window looking at the infants. Susan and John felt a deep sense of powerlessness, and John stayed with Susan at the hospital until she was released. He kept the story alive in the media, distributed pamphlets, and made telephone calls. Susan was discharged four days later, and she and John waited and prayed for their son's return.

The infant was recovered 14 days later. The 36-year-old abductor was a nurse with expertise in neonatal care who had previous contact with the hospital as a traveling nurse. After taking the infant she traveled through several states in the region and was apprehended on her return to the state where she had abducted the infant.

Another location for infant abduction is a facility's pediatric room. This room was the location of 13 cases or 10.9 percent of the cases studied. In most cases the infant was hospitalized for an illness such as a feeding problem, digestive disorder, fever, meningitis, or bacterial infection.

Case 1-3

The morning hospital shift had just begun work. The day nurse, in checking her assignment of infants, noted that a 23-day-old boy was not in his crib. He had been hospitalized for a digestive disorder

and was due to be discharged that day. The night nurse had reported that the mother had been in during that shift caring for him. At first staff members thought that the mother may have taken the infant home, but a check of this proved incorrect. The infant was then reported missing, and the mother, Sheila, and her boyfriend, Jerry, were notified and immediately went to the hospital. Local law enforcement was notified and began an investigation. The news media covered the story on the evening news.

The infant was recovered the next day at the home of one of the abductors. The two female abductors were visiting relatives at the hospital on another floor when they were told of an “abandoned baby” in pediatrics. They decided to pose as employees and entered the pediatrics unit. A nurse challenged the abductors when they asked her which infant was abandoned. One of the abductors responded that the infant was not hers, should not be abandoned, and needed a home. It is theorized that the women took the infant when the nurse left the unit for dinner.

In 9 cases, 7.6 percent, the infant was abducted from some area of the premises of the healthcare facility. These locations included clinics, corridors, waiting rooms, the parking lot, and curbside.

Case 1-4

When Linda and Ken brought their 8-week-old daughter to the pediatric clinic for her check up, they were totally unprepared for what was about to happen. They arrived at the clinic at 8:30 A.M., checked in at the desk, and went to the waiting room. At 9:00 A.M. they were approached by a woman they thought was a nurse. The woman, who was wearing a nurse’s uniform, began talking to them about their daughter. She took the infant and Linda into the treatment area where the infant was given an injection. Linda and the infant returned to the waiting area where Linda was told to watch her daughter for any reactions to the shot. The imposter came back into the waiting area again and asked if she could hold the infant. Before Linda could say anything the imposter picked up the infant and said that she was going to show her to the other nurses. Linda objected, but the woman kept walking and said that she didn’t need any more children because she already had two of her own. Two or three minutes went by and Linda went to find the woman and her daughter. The “nurse” was nowhere to be found. Linda ran to tell Ken and the nurses. Law enforcement was called and, after talking with several witnesses, determined that a woman holding an infant and fitting the abductor’s description was seen getting into a car in the parking lot. The distress Linda and Ken suffered was significant. At times they would lose all hope of seeing their daughter again. They received hundreds of letters of prayer that renewed their hope and kept their spirits alive. They took every opportunity to keep the story in the news, but all they could do was wait.

Six months later the 38-year-old abductor was stopped for the unauthorized use of a motor vehicle following a tip from her own sister. The sister had called local authorities with her suspicions that the “new baby” in the family was the one who had been abducted from Linda and Ken.

Home Abductions

The home was the abduction location for 30 cases, 25.2 percent. Often the abductor would either respond to an advertisement placed in the newspaper by the family for a babysitter or the abductor would act as an extension of services offered by the healthcare facility. The incident summarized below illustrates a home abduction in which the abductor posed as a babysitter.

Case 1-5

Carol had been on maternity leave for two months and needed to return to work. As a single parent with a newborn, 4-year-old son, and 7-year-old daughter she depended on the income she made as an assistant manager at a local restaurant where she had worked for the past five years. Carol placed an advertisement for a babysitter in the newspaper. A woman called about the advertisement and set up an appointment. The next day she came to the house for an interview. Carol could not be there, so she had her mother come to the house to talk with the woman. The woman introduced herself to Carol’s mother, who was holding the infant. The prospective babysitter seemed like a pleasant, competent woman, and she was well dressed. She said that she didn’t need the money but wanted to spend her time doing something she enjoyed. She said that she had two teenage children of her own, but missed taking care of an infant. Carol’s mother wanted to see how she held an infant, so she handed the infant to the woman. At that moment the telephone rang. Carol’s mother went to the other room to answer it. As soon as she was out of sight, the woman left the house and drove off with the infant. When Carol’s mother returned to the room, nobody was there. She ran to the door just as the woman was driving away. She immediately called law enforcement, and they arrived within five minutes. Carol arrived shortly after and was told the news. She was devastated and at first blamed her mother. Her mother began having nightmares and could not sleep. Carol could barely function and had to send the other children to their father’s house to live temporarily.

The news media immediately got involved in the case. Four days later the infant was recovered through a tip. The abductor had a master’s degree in psychotherapy. She faked a pregnancy as a way to halt divorce proceedings with her husband. She pled guilty, spent more than one year in a psychiatric hospital, and was placed on probation after her release from that facility.

Other Locations

Four cases, 3.4 percent, involved infant abductions from other locations. These locations included a daycare center, shopping mall, bus station, and photo studio. The case summarized below illustrates an abduction from a shopping mall.

Case 1-6

Law enforcement received a call from a woman at a fast-food restaurant saying that her 3-month-old infant had been kidnapped. When law enforcement arrived on the scene, she told them that a woman drove off with her infant. Law enforcement obtained a description of the car and abductor. A report of the abduction, as well as a description of the car and abductor, was sent to law-enforcement agencies throughout the country. The National Center for Missing & Exploited Children contacted various agencies that deal with abducted children and worked closely with the investigators to coordinate information and leads. The media had the story out within hours of the abduction. The story was featured on all the local television stations, in newspapers, and on Fox Television's "America's Most Wanted."

During the nine-day investigation law enforcement received hundreds of telephone calls from people with leads and other information. All but about six of the leads were dead ends. The case was resolved as a result of a few calls made by neighbors of the abductor and a call from a woman with young children who was approached two weeks before the abduction by a woman who fit the description of the abductor and claimed to be a social worker. Being suspicious of that story she wrote the "social worker's" telephone number down on a piece of paper. When the caller saw the news of the abduction she remembered the event and telephoned law enforcement. The investigators traced the telephone number to a mobile-home park about 40 miles from where the abduction occurred. Several law-enforcement officers, along with a half-dozen FBI agents, converged on the mobile-home park. Just as they arrived the female suspect and her husband were getting into a truck with the infant. Law enforcement blocked the path of the truck and jumped out of their cars with weapons drawn. They took the infant without resistance and arrested the abductor.

Means to Obtain Infant

How do the abductors actually obtain the infant once they are in the healthcare facility or home? The two means identified in this study were **verbal strategies**, including conning and befriending a parent or staff member, and **physical strategies** such as simply snatching the infant or using force. See Figure 1-2.

Verbal Strategies

Conning was the major means of obtaining an infant. In 84 cases, 70.6 percent, a verbal ploy enabled the abductor to gain access into a mother's room in a healthcare facility or home. The case summarized below illustrates such a ruse.

Case 1-7

Tina and Mike had been married four years and worked hard at building up their own business. They decided that it was time to start a family. They were happy when they found out that Tina was pregnant. The due date was just before the end of December. On December 10 Tina started having labor pains, and Mike drove her to the hospital. Six hours later Tina gave birth to a girl. Two days later, while in her hospital room, Tina was holding her daughter when a woman wearing a nurse's uniform and nametag entered the room. She asked Tina how she was doing and the infant was nursing. She left the room, returned 10 minutes later, and told Tina that she had to take the infant for tests. Tina was surprised, but, believing that the woman was a nurse, gave her the infant. The "nurse" left with Tina's daughter. Twenty minutes later

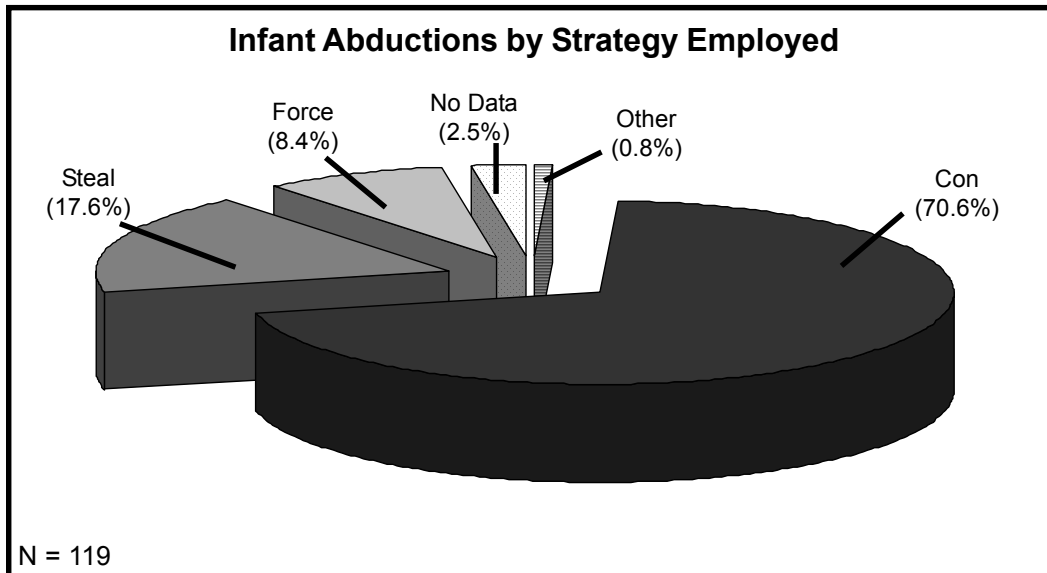


Figure 1-2

Tina called the nursery to have them bring the infant back for her feeding. Tina waited, but nobody came. She called the nursery again, and the nurse said that she thought the infant was with her. At first Tina thought that they were merely mixed up. She proceeded to the nursery, but did not see her daughter. When she returned to her room, she saw several nurses and immediately knew what had happened. She became hysterical, was given a sedative, and was moved to a private room. The nurses searched the floor with no success. They contacted the nurse supervisor and hospital security. Security then called law enforcement. By then an hour had gone by since

the abductor had taken the infant. Tina called Mike who immediately went there with his parents. They were all very upset, but supportive of Tina who was blaming herself for giving their infant to the woman. All the nurses were supportive, and the pediatrician kept telling Tina that they would find the infant. The media were informed, and they printed the story in the newspapers and aired it on television that day.

The infant was recovered 23 hours later 60 miles away at the home of the abductor. An anonymous tip, triggered by a television newscast about the abduction, was received by law enforcement and led to the recovery.

Physical Strategies

Two types of physical strategies were used. If the infant was unattended, the abductor simply stole the infant when no one was watching. This physical strategy occurred in 21, 17.6 percent, of the cases. While cons help abductors gain access, they do not always make the abduction itself easier. As a result abductors sometimes use force either alone or in combination with a con. In non-healthcare-facility abductions, force and/or threats were noted in 10 cases, 8.4 percent. In seven of those cases, eight persons, seven mothers and one father, were murdered. Two mothers were standing on a curb outside a hospital when, at gunpoint, they were forced to hand over their infant. One mother was choked and forced to give up her baby. Abductions away from the healthcare facility pose access difficulties for the offender and may account for the need to exercise force. In these cases the degree of force ranged from threatening or binding the mother to shooting and stabbing the parents.

Methods Used to Remove Infant from Location

Of the 119 cases studied, 2 methods were noted as ways to remove the infant from the abduction site. In 53 cases the abductor simply walked out of the healthcare facility or home with the infant. No attempt was made to conceal the infant. In 13 cases the infant was concealed under a coat or blanket or in a hand-carried container such as a gym bag. In 53 of the cases no information was available on how the child was removed from the premises.

One abductor wore a disguise as is illustrated in the case summarized below.

Case 1-8

After interviewing for a position as a babysitter, the woman returned wearing a motorcycle helmet, visor, ski mask, and snowmobile-style jumpsuit. She barged into the kitchen of the family's mobile home through an unlocked door. Using a semiautomatic handgun the abductor forced the mother and grandmother into the bathroom, picked up the sleeping 6-week-old infant, and fled through the front door.

The infant was recovered two hours later in the home of the abductor about five miles from the abduction site.

Impact of Abduction

In summary, the abduction of the 119 infants in this sample set into motion law-enforcement and security officers, the news media, and a significant amount of emotional distress for the families and staff members at the healthcare facility from which the infant was abducted. Parents were traumatized by the loss of their infant, and the experience often created serious and long-lasting psychological symptoms. Even in cases where the infant was found, the parents often suffered from recurring nightmares about the event. They became hypervigilant of their children, especially the child who was abducted, and overly suspicious of individuals not known to their family before the abduction. The nurses on duty when the infant was abducted from a healthcare facility suffered from trauma as well. They frequently felt blame believing that somehow they could have prevented the abduction, perhaps by being more aware of the imposter, or that they should have caught the abductor taking the infant off the unit. The experience had a long-lasting effect and created a significant amount of guilt for the nurses involved. Responses from both healthcare-facility staff and family members are discussed in greater detail in subsequent chapters.

Recovery of Abducted Infants

Of the 119 reported cases of infant abductions from 1983 to 1992, most infants were recovered within 25 miles of where they had been abducted and, as noted earlier, three-quarters of the infants were recovered in fewer than 5 days. In this chapter we examine some of the key factors for successfully recovering an abducted infant.

In this sample set of cases 92.4 percent were recovered. Nine infants remained missing. One of the most important steps in facilitating a recovery is alerting the media as soon as possible. Their ability to inform the public that an abduction has taken place, along with giving as much detailed information available about the infant including descriptive information such as age, race, color of hair and eyes, and any identifying marks on the infant will greatly assist in the recovery efforts. The more widely publicized the abduction, the more likely it is that the infant will be found. In numerous cases friends, relatives, and neighbors have called law enforcement to report the abductor after seeing a news item about the abduction. The parent(s) of the infant, as coordinated by law enforcement, should actively participate in media coverage by using television, newspapers, and radio to appeal to the public for help. Television “spots” or public-service announcements could take the form of a taped personal plea, as well as display pictures of the infant, when available, along with a description of the infant. Individuals should be asked to report any information, suspicions, concerns, or even uneasy feelings. It is important, however, to avoid making derogatory, threatening remarks about the abductor in the media as this might anger and/or frighten the abductor into possibly harming the infant or fleeing from the immediate area. The focus of any media coverage should be the safe return of the infant, **not** the arrest and prosecution of the offender for kidnapping. The words “kidnapping” and “abduction” should be avoided when addressing the media.

In cases of abductions from healthcare facilities it is important for the nursing staff to notify their security department at the first sign that an infant is, or may be, missing. Security should immediately contact law enforcement and their local FBI office. Delays in “sounding the alarm” can make a difference in the recovery process by preventing a quick recovery and delaying the investigation. It is better to err in assuming that an infant has been abducted than to waste valuable time confirming, beyond a reasonable doubt, that the infant is missing. Sometimes delays in reporting are a function of rejecting the thought that someone has actually stolen an infant. This is a normal initial reaction to not being able to locate an infant. Fear of reporting the incident may also cause a slower response. These typical response processes must be amended to effect a more rapid response time.

Law-enforcement personnel are the key link between the abduction and outcome. Their involvement is obviously both critical and necessary in recovering the infant. They rely on immediate reporting by the victims and healthcare facilities and an accurate and detailed description of the events and perpetrator to assist them in their investigation. Criminal-investigative analysis can also assist law-enforcement personnel in determining the type of suspects to focus on for

investigation, criminal methods of operation (MOs), possible motives, crime-scene evidence, and suggested procedures for investigation. Criminal-investigative analysis describes certain personal characteristics often associated with specific types of offenders and crimes. Criminal profiling may also give prototypical age, education, psychological, and socioeconomic information about a perpetrator, as well as possible motives. Assistance with criminal-investigative analysis can be requested from the National Center for the Analysis of Violent Crime at the FBI Academy in Quantico, Virginia, by calling **703-632-4400**.

In infant-abduction cases investigators spend a significant amount of time developing and following through with leads usually provided by witnesses who saw the perpetrator or noticed something suspicious in their neighborhood. Many leads are developed by searching for women who have worked in the healthcare facility where the abduction took place or recently had a miscarriage or still-birth. These leads can result in identifying a vehicle used by the abductor, pinpointing a specific neighborhood to search, or uncovering other aspects of the crime to investigate. Most of these leads result in identifying specific suspects. Often it takes a great deal of “footwork” to canvass an area or track down a suspect. Once the suspect has been located, proper interrogation is necessary in order to obtain pertinent information that may lead to recovering the infant. Hundreds, and in some cases thousands, of hours are spent tracking down leads; making and receiving telephone calls; and interrogating/interviewing witnesses, residents, and suspects. Special telephone lines are often set up for hotline calls to investigators from individuals who may have information about the abduction/abductor. Other healthcare facilities in the area as well as clinics, welfare agencies, and other agencies that provide assistance to new mothers are contacted and advised to call authorities with any information on clients, especially new clients, who seem suspicious.

Infant Recovery

Of 93 cases in which data were available, there were 29 cases in which a law-enforcement investigation resulted in finding the abductor and subsequently the infant. Below is an example of such a recovery.

Case 2-1

Around 2 A.M. a night nurse, who had just finished feeding all of the infants in the nursery, left the area for a short break. When she returned she noted that one of the infants was missing from his bassinet. After checking with other nurses and the mother of the infant without finding him, the nurse contacted security staff members who in turn contacted local law enforcement.

At the hospital the investigating officer interviewed a witness who stated that she observed two females leaving the hospital and one was carrying an infant. A second witness, a member of hospital security who was at his post in a booth on the parking lot, said that around 2:15 A.M. he observed a female who ran from the emergency room entrance carrying an infant. He saw her cross the street where

she entered a car in which another woman was sitting. The two then drove away. The security guard had heard the law-enforcement alert over the radio in his booth and came forward with his observation. He also stated that earlier he had observed a uniformed patrol officer writing parking tickets for several vehicles that were illegally parked in the same area in which this car had been parked. The uniformed law-enforcement officer was then contacted and the four parking tickets that he wrote in the area during that time frame were reviewed. Law enforcement identified a ticket written for a vehicle that matched the description of the car that was given by the security guard.

A computer check of the parking ticket revealed a name to whom the vehicle was registered. Another check revealed that the registrant had a daughter with the same name. When law enforcement visited the address of the car's registrant they were admitted by the registrant and her husband. The officers informed the couple of the nature of their business, asked if they were the owners of the vehicle parked in the driveway, and asked if they had a daughter staying with them. The daughter then appeared and was asked if she had any idea where an infant was who had just been abducted from the local hospital. The 20-year-old daughter told the officers that the infant was at another house. The officers went to the area of the house where the young woman had appeared from and observed an infant who was lying on the floor under a dining room table. The law-enforcement officer recovered the infant and placed the young woman under arrest. The infant was returned to the hospital and identified. An interview with the infant's pediatrician noted that this 33-hour-old infant had been under close medical supervision as normal urinary and stool functioning had not yet been established.

In the example below the abductor chose a pediatric clinic site, posed as a nurse, and convinced the mother to let her take the infant "for a minute."

Case 2-2

A call came into local law enforcement around noontime from a pediatric clinic reporting a kidnapping. When law enforcement arrived they spoke with the parents and staff members at the clinic. They recorded the events as described by the parents and staff members present and took a description of the abductor. Several other people who were at the clinic when the abduction occurred were questioned as well. The parents were transported to the law-enforcement office where a composite of the female abductor was made from their description. A detailed description of the infant along with a photograph was also obtained by law enforcement. Late that afternoon the FBI was requested to assist with the investigation. The media were informed and carried the story that evening by describing the events surrounding the abduc-

tion, giving a description of the abductor, and showing a picture of the infant. The local Crimestoppers hotline number was also given for viewers to call with any information that could lead to the recovery of the child.

While investigators had few leads in the case, they began the process of trying to identify possible suspects. One suspect used to work at the clinic, but when her picture was shown to the parents they did not recognize her as the abductor. Law enforcement contacted other area clinics and healthcare facilities in an effort to obtain other suspects. FBI agents canvassed the area in search of the infant and clues. Law enforcement received several telephone calls from people who identified possible suspects. All leads were followed, without finding the infant.

The mother of the infant made an emotional plea, through the media, for the kidnapper to return her infant. Law enforcement hoped that the abductor would hear her appeal and return the infant or someone would call with information leading to a recovery. Several people and some local companies contributed money for a reward for information leading to the safe return of the infant.

As the days turned into weeks the story was placed further and further back in the pages of the newspapers and shown less and less on television. As the weeks turned into months reports about the abduction continued to dwindle in the media, and the investigation slowed to a crawl.

After six months law enforcement finally got a break in the case. The abductor was stopped on a routine U.S. Customs check as she was driving from Texas to Mexico. The vehicle she was driving had been reported as missing. Law enforcement detained her while they checked their computer for any outstanding warrants on her. She was arrested and charged with auto theft. She posted bail using a check. Law enforcement learned that the check was stolen and rearrested her before she left the area. Meanwhile law enforcement found out that she was a suspect in the kidnapping. Upon questioning she told law enforcement that she had two children, and they lived in Mexico with her husband. Law enforcement immediately contacted the Mexican Consulate and arranged to enter Mexico. Several detectives, along with United States and Mexican law enforcement, converged on the home. They took custody of both children without any resistance from the people at the house. The children were transported back to the United States, and positive identification was made through footprint comparison, as well as blood and saliva tests. It was learned that one of those children was the abducted infant, and the other child was in fact the abductor's own child. She had given birth to this child two months after she abducted the infant from the clinic.

More than 150 suspects had been questioned during the 6-month investigation. The abductor became a suspect after a neighbor called law enforcement telling them that she saw her stealing mail and thought the woman was the person who stole the infant who had been reported in the news. The abductor was found guilty of Kidnapping and sentenced to four years in prison.

In another case the abductor was identified by a victim of a previous attempted abduction. Although atypical, the case summarized below illustrates how crafty and conniving an abductor can be.

Case 2-3

A 36-year-old Hispanic woman had befriended the victim mother approximately 5 months previously when her infant was about 4 weeks old. This woman used two different ruses to obtain information in order to select a target. Ruse #1 was to approach pregnant women in the area and ask if they had a room for rent or knew of someone who had a room to rent. Ruse #2 was to pose as a representative of a company selling products door-to-door and “sell” products to the individuals. In this case the abductor used the second ruse. The abductor was at the victim’s home, where there were three separate families living in one dwelling, and was speaking with the victim mother and a neighbor. The abductor was holding the infant. The infant’s mother was comfortable with the woman and had to leave to go to the store. The mother assumed that her housemates would watch the infant for her, but, as the mother walked to her car, the abductor carried the infant out behind her as if following her to the car. Instead of going to the mother’s car, however, the abductor disappeared with the infant.

The news of the abduction was broadcast on local television stations including Spanish-language stations. When the story was broadcast, a woman who had been previously approached by this abductor remembered having contact with her. She had kept the abductor’s telephone number and contacted some family members of the victim with her information. These individuals relayed the information to the law-enforcement officer who had been assigned to stay with the victim mother at the home. This officer relayed the information to the detectives working the case, and the child and abductor were located.

In 26 of the 93 cases an associate, relative, or friend of the abductor assisted law enforcement in their investigation with the recovery of the infant. The summary below, of the law-enforcement investigation of Case 1-5 as originally reported on page 5, illustrates such an identification.

Case 2-4

Law enforcement received a call from a frantic woman reporting that her 5-week-old grandchild had just been abducted. Law enforcement dispatched an officer to the home, and he was there within minutes.

En route to the home he passed a speeding car and was tempted to give chase, but continued to drive to the house. It was learned later that the abductor was driving that car. When he arrived at the house he questioned the grandmother. She told him that a woman, who was applying for a job as the family's babysitter, walked out with the infant while the grandmother was in another room. The abductor had also taken a photograph of the newborn infant. The grandmother was able to give the officer a description of the car, as she caught sight of it just as the woman was driving off. She was also able to supply law enforcement with a good description of the abductor, and a composite was made. Eight detectives and 15 FBI agents were assigned to the case. They were supportive of the family and kept them informed about the investigation. The story was picked up by both the local and national media and given extensive coverage. A hotline was set up to receive calls from people having information about the abduction, and law enforcement received hundreds of calls. They followed all the leads that they received, but none of them resulted in a recovery.

On the fifth day law enforcement received a telephone call from an associate of the abductor and her husband. Apparently the abductor had convinced her husband that she was pregnant and had given birth to an infant. Upon the "birth" of the infant they invited some friends over to see "their new baby." The friends were suspicious, however, because the infant did not look or behave like a newborn. They found other glaring inconsistencies in the story about the "baby's birth." Having seen the news about the abduction, they reported their suspicions to law enforcement. The investigators went to the suspect's house. When they entered, they saw the photograph that the woman had taken from the scene of the crime and recognized the infant as the child who had been kidnapped. Upon further investigation they found a blank birth certificate that the woman had stolen from a hospital. They returned the child to her mother and arraigned the woman on Kidnapping charges. The charge was plea-bargained in return for a lesser sentence. She spent more than one year in a psychiatric hospital and was placed on probation after her release from that facility.

In 26 of 93 cases law enforcement received an anonymous tip regarding the abductor on a published "Tipster" hotline. The case summarized below illustrates such a recovery.

Case 2-5

A call was received by law enforcement from a local hospital reporting that an infant had been abducted from a mother's room approximately one hour earlier. The Criminal Investigation Division assumed responsibility for the case, and two detectives were dispatched to the scene. At the hospital they interviewed all the nursing and support staff members who were on duty when the

abduction occurred. The mother was also questioned, and a detailed description of the abductor and infant was obtained along with a photograph of the infant. A nursing assistant, who thought that she had seen the abductor, gave a description of the abductor which varied from the description given by the mother. This dissimilarity in the description of the abductor complicated the investigation. Law enforcement, however, decided that they would use both composites. The news of the abduction, the photograph of the infant, and both composites were released to all local media and the public. That evening the FBI was notified and joined the local authorities in the investigation.

The local newspapers and television networks featured the story on the abduction that evening. Investigators searched hospital records for patients who had recently miscarried or had a stillborn child. The hospital, local Crimestoppers organization, and the father's employer contributed to a reward fund for the safe return of the infant.

The following day the parents of the infant went on television with an emotional plea to the abductor for the safe return of their son. The national press and television networks picked up the story and featured the abduction nationwide. The next morning law enforcement and FBI investigators received a telephone tip through the Crimestoppers hotline about a woman whom the tipster suspected to be the abductor. Coincidentally two of the officers recognized the name of the suspect. Local law enforcement and the FBI went to the suspect's home and were met at the door by a woman who had a 6-week-old infant in her arms. When the investigators confronted her with the allegation that she had abducted the infant, she insisted that the child was her sister's son. At that moment they heard an infant crying in another room of the house. They followed the crying to a closet where they found a child matching the description of the abducted infant. They took custody of the infant and immediately transported the infant to the hospital where footprints were taken. The footprints matched the prints taken of the abducted infant at birth confirming that this was the infant who was abducted two days earlier. The abductor was taken into custody and charged with First Degree Kidnapping. She was found guilty and sentenced to 12 years in prison.

Below is another illustration of an identification through a "tipster" hotline.

Case 2-6

After confirming that one of their newborn infants was missing, hospital authorities called local law enforcement. An officer was dispatched to the hospital. He spoke to the evening supervisor of nursing who related the details of the abduction and gave a description of the abductor. The officer then interviewed the mother

of the kidnapped infant as well as the attending physician to obtain more information. A composite drawing of the abductor was made, and a detailed description along with a photograph of the infant was obtained. A newborn identification form was also procured from facility records. That afternoon the media were informed via law enforcement. The story was printed in the newspapers and aired on television that evening. Those stories featured the composite of the abductor and a photograph of the infant. Two detectives were assigned to the case. They conducted interviews with several hospital employees that resulted in identifying a number of suspects. One suspect, who looked like the composite drawing of the abductor, was attending a birthing class at the hospital. Another suspect was seen near the mother's room early on the day of the abduction. A doctor told detectives that he knew a patient who fit the description, was a drug abuser, and might have stolen the infant to sell for drug money. Another employee remembered two women who had stillbirths at the hospital about two months prior to the abduction. Investigators checked the records and obtained the names and addresses of all the suspects. All suspects were questioned, and their photographs were taken. The photographs were shown to the mother and all employees on duty at the time of the abduction. No one could positively identify any of the women as being the abductor.

The following day law enforcement received a telephone call from a detective in a neighboring town informing them that they had received information about a possible suspect. The detective said a woman called saying that she had seen a news report on television about a kidnapping at a nearby hospital. She went on to say that a neighbor had supposedly given birth at home the same day the kidnapping took place, but she didn't see any medical personnel arrive at the home at any time. She also thought that the woman looked like the composite drawing shown on the news broadcast. Another call was received from a man who said that he worked with someone whose ex-wife had just given birth on the same day as the abduction. He said that his coworker was very suspicious of the birth and did not believe that the infant was his. The detective called the suspect's parole officer and was told that she was on probation for forgery. The parole officer also told the detective that this woman had, on several occasions in the past, told him that she was pregnant. When the parole officer attempted to verify this the suspect would say that she had a miscarriage or lied about being pregnant. Further investigation by the detective revealed that the woman had been examined by a doctor one month prior to the abduction and was not pregnant at that time.

One of the detectives knew the suspect. He, along with two detectives from the town where the abduction took place, went to the suspect's apartment. When they arrived they identified them-

selves and told the woman that they were investigating an infant abduction. She spoke to the detective who knew her and said that she wanted to talk to him in private. She led him to a back bedroom where an infant was sleeping in a bassinet. The detective recognized the infant from the photographs of the abducted infant. The woman was then asked to accompany the detectives to the station, and they took custody of the infant. The woman waived her rights and agreed to answer their questions. She admitted to taking the infant from the hospital two days earlier. She was charged and convicted of Kidnapping and given a prison sentence.

Discussion

There is no substitute for good investigative work. It is law-enforcement personnel who gather the facts of the case, chase down leads, interview witnesses, interrogate suspects, and doggedly pursue the case.

As with most other types of crimes, investigators rely on help from the public in developing leads. Hotlines are frequently used to facilitate telephone calls from tipsters. Although this process is time-consuming and frustrating, as most tips are “dead ends,” it is often just such tips that lead to locating the abductor and recovering the infant. Information about how the abduction occurred, an accurate detailed description of the abductor, and a photograph with a detailed description of the abducted infant are critical to solving the case.

Cooperation and coordination between law-enforcement agencies should be fostered. Information about the abduction should be distributed to both state and federal law-enforcement agencies as soon as possible. Information about the abduction should be screened and coordinated prior to being released to the media. It is also important, however, that the media be informed as soon as possible. News reports about abductions are essential in informing the public of the crime. It is often the case that someone reports knowledge of the abduction or abductor after seeing the story in the news.

Infant Abduction: Facility and Nursing Staff Response

Nurses need to pray a baby is never taken from their unit, and, if it happens, people need to know the trauma it causes.

Nurse Administrator

Patterns of infant abduction and recovery clearly demonstrate the ease with which an imposter can steal an infant. From these patterns it is also clear that immediate reporting and investigation by law enforcement is necessary for the safe return of the infant. Much less visible to the public eye is the dramatic effect an infant abduction has on the healthcare facility and nursing staff members who have been victimized by this shocking crime.

The quotations presented in this analysis serve to convey the emotional and behavioral reactions of individuals interviewed for this infant-abduction study. These reactions, in combination with the data that were collected, make a convincing case that the long-term impact of an abduction incident upon a healthcare facility and its employees is commonly underestimated.

Sample

Of the 119 cases reviewed in this study, 81 infants were abducted from 73 healthcare facilities or sites in close proximity to them. Sixty-six facilities had 1 abduction, 6 facilities had 2 infants abducted, and 1 facility had 3 abductions. Attempts were made by the investigators to contact all 73 healthcare facilities through the administrator's office. The procedure included sending a letter to the administrator explaining the project and requesting an interview with staff members who worked during the time period of the abduction. Researchers followed up the letter with a telephone call to the Administrator's office. In more than half of the cases a second letter had to be sent. In most cases several calls were made to follow up on those letters. In fact

- On average, 6 calls were made to each facility.
- The single case maximum included 10 telephone calls to the administrator's office; a referral to the facility's attorney; and then 18 calls to the attorney, from whom no return calls were received.

When contact was made with the facility's administrator, usually to an administrative assistant or secretary, a referral was often made to the director of nursing, the director of security, the risk manager, and/or the facility's attorney. Interviews were conducted in both group and individual settings, depending on the facility's preference. Some facility staff members preferred a telephone interview.

As a result 51 healthcare facilities participated in the study. Four facilities insisted that they had no information and/or that no one was available who had worked at the time of the incident. Two refused to be interviewed because litigation was

pending. Sixteen facilities refused to be interviewed on general terms, as reflected in the quotes below.

- “That information is no one’s business; we won’t discuss it.”
- “We do not want to participate.”
- “This infant was not abducted.”
- “I will not discuss this case with anyone. You might help the parent.”
- “We’re liable for that child for the next 18 years. Call us in 18 years.”
- “No one can learn anything from this case. We don’t get anything from you so we won’t share information. If you want to know what happened, go and listen to one of the presentations given by the head nurse or security director at one of the [local] conferences.”

Findings

Healthcare Facilities

This section reports on interviews with healthcare-facility administrators, nurses, risk managers, and security staff members from the 51 healthcare facilities in which an infant was abducted from the mother’s room, a pediatric room, a neonatal nursery, a clinic or area adjacent to a clinic and that were willing to participate in the study.

Infant abductions occurred in facilities of all sizes. Five infants were taken from facilities with fewer than 200 beds; 23 were taken from facilities of 201-400 beds; 12

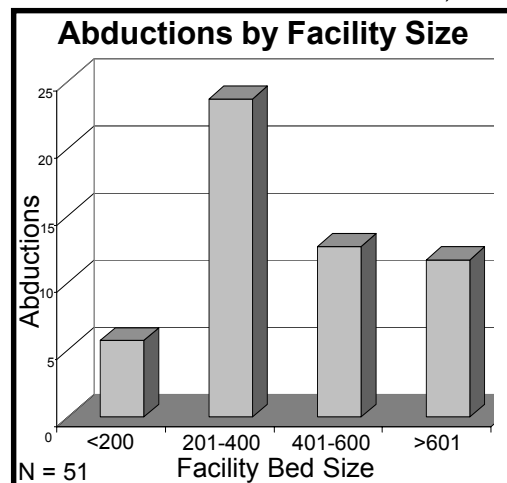


Figure 3-1

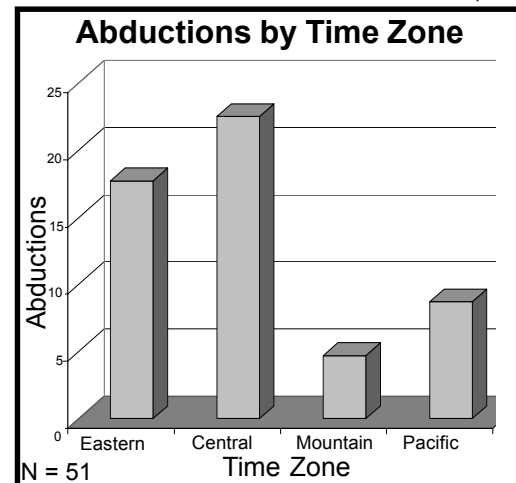


Figure 3-2

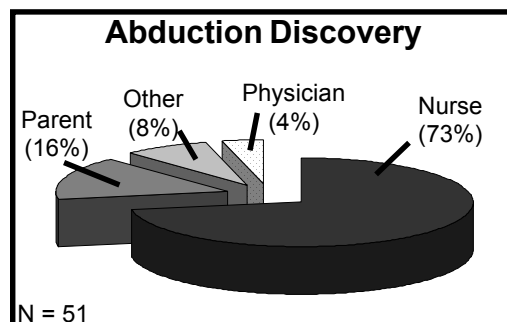


Figure 3-3

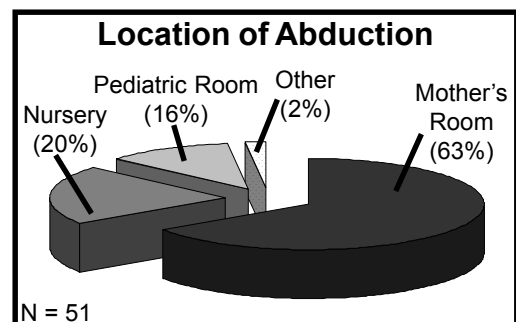


Figure 3-4

were taken from facilities of 401-600 beds; and 11 were taken from facilities of greater than 601 beds. See Figure 3-1.

Abductions occurred in all four time zones spanning the continental United States. The central and eastern time zones combined accounted for 76 percent of the abductions with 22 abductions in the central time zone and 17 in the eastern time zone. There were eight abductions in the pacific time zone and four in the mountain time zone. See Figure 3-2.

The Abduction

In 73 percent of the cases a member of the facility’s nursing staff made the initial determination that an infant was missing. These nurses thus became the people responsible for mobilizing the facility’s initial efforts to search for and recover the missing infant. Parents of the missing infant discovered the absence in 16 percent of the cases. Parents were most likely to determine the occurrence in those cases where the infant was abducted from a pediatric bed rather than the nursery. In 4 percent of the cases a physician discovered that the child was missing. In 8 percent of the cases “other persons” discovered the infant’s absence. See Figure 3-3.

In 63 percent of the cases the infant was abducted from the mother’s room in the healthcare facility. Twenty percent of the abductions were from the nursery, 16 percent were from a pediatric room, and 2 percent were from other locations. See Figure 3-4.

In 71 percent of the cases facilities reported that abductors impersonated someone else. See Figure 3-5. Of those abductors who used a pretense, 87 percent identified themselves as a facility employee to the victim’s mother; 61 percent as a nurse; 17 percent as a lab technician; 6 percent as a social worker; and 3 percent as a

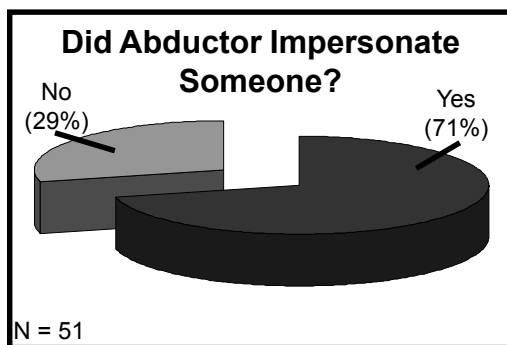


Figure 3-5

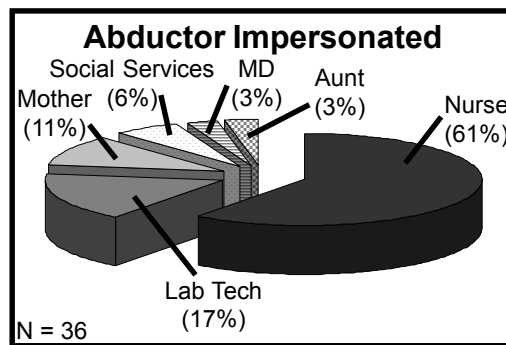


Figure 3-6

physician. Typically abductors who impersonated an employee took the infant by using the ruse that tests needed to be done, a photograph needed to be taken, or the infant was needed in the nursery. In 14 percent of these cases abductors who took infants out of nurseries or pediatric units frequently stated to nursing staff members that they were the infant’s mother or aunt. See Figure 3-6.

Management of the Facility’s Response

In the cases studied the actual abduction of the infant caused a number of departments within the facility to respond. Coordination of these department responses

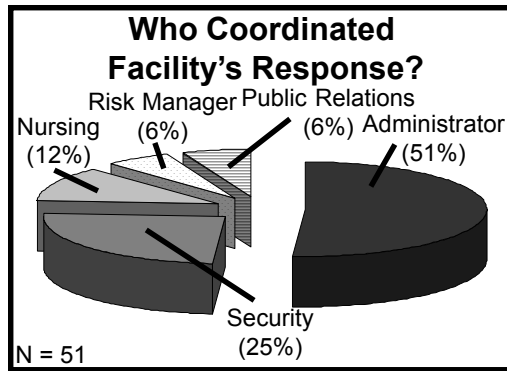


Figure 3-7

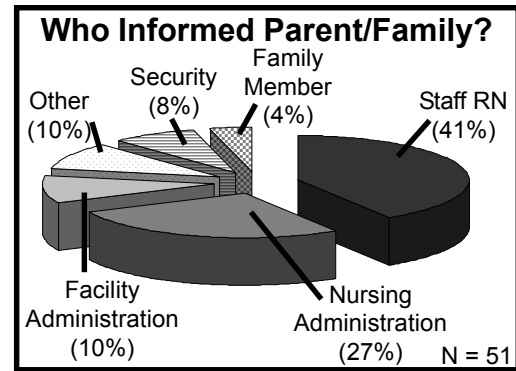


Figure 3-8

was managed by general administrative personnel in 51 percent of the cases. The Security Department coordinated the entire effort in 25 percent of the cases, Nursing Administration did so in 12 percent of the cases, Public Relations in 6 percent of the cases, and Risk Management in 6 percent of the cases. See Figure 3-7.

An example of nursing coordination of the facility's response is outlined below.

Case 3-1

I got the ball rolling. I came on at 8:20 A.M. The pediatrician was looking for the child. The baby was not in his room. I notified security; the hospital doors were locked. I went to the cafeteria thinking maybe the mother had the child [there]. I had the unit secretary call the mother's home. I began calling the night nurses for descriptions of nonemployees on the unit.

When asked "Who informed the parents that their infant was missing from the hospital," 41 percent of the facilities reported nurses had assumed that responsibility. Nursing-administration personnel did so in 27 percent of the cases. Facility administrators and security staff members did so in 18 percent of the cases, "other" and "family members" comprised the remaining 14 percent of the responses. See Figure 3-8.

In 92 percent of the cases no information was withheld from the victim parents. In 4 percent of the cases information was withheld and in 4 percent the issue was not applicable, due to quick recoveries. See Figure 3-9.

When facilities were asked to recommend whether or not information should be withheld from victim parents, 78 percent said no while 22 percent said yes. Those responding in the affirmative stated that individual circumstance and family situations should dictate the decision to withhold information. See Figure 3-10. A cross-tabulation of the data indicates that all of the facilities responding in the affirmative had been subjected to litigation as a result of the abduction.

When asked if they would take the same steps again, the majority of healthcare facilities, 86 percent, answered "yes" and indicated that their response was appropriate to the situation. Those who answered "no," 10 percent, indicated that they would make a speedier report to internal departments and/or outside agencies such as law enforcement. In 4 percent of the cases the question was not applicable. See Figure 3-11.

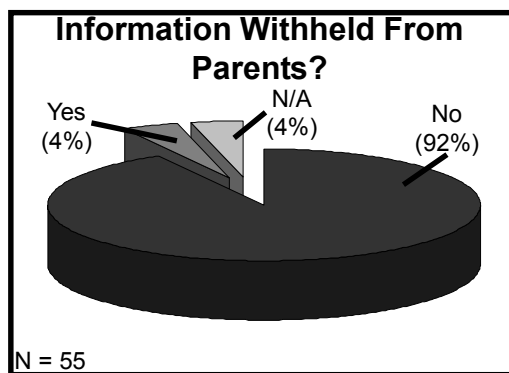


Figure 3-9

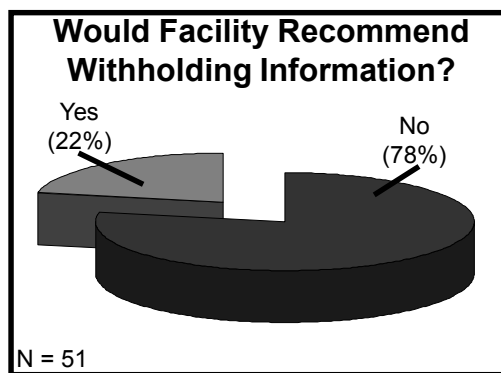


Figure 3-10

Identification of the Abductor

The cases studied involved abductions by nonfamily members only. The facilities claimed that in 22 percent of the cases the abductor was known by the parents as either a friend or recent acquaintance. In 76 percent of the cases the abductor was not known to either of the victim parents. The facility was uncertain in one case, 2 percent. See Figure 3-12.

In a related question the facility was asked if the abductor had been observed before the abduction and identified as “suspicious.” In 76 percent of the cases the facilities indicated that the abductor was **not** identified as suspicious in either behavior or appearance before the incident. This supported the experiences described by most facility personnel that the infant was taken “out-of-the-blue.” In 24 percent of the cases the abductor **was** identified as suspicious before the abduction. See Figure 3-13.

Recovery of the Infant

Twenty three of the infants were recovered within 36 hours of the abduction. Forty-five percent of the mothers were not discharged before their infant’s return. In 33 percent of the cases the mother was discharged from the facility before the infant was returned. The question was not applicable in 11 cases, or 22 percent of the sample. See Figure 3-14.

In 67 percent of the cases the facility felt that the media coverage of the abduction had **assisted** in the recovery of the infant. Thirty-one percent of the facilities indicated that the media coverage was not helpful. The media was not involved in 2 percent of the cases, one case. See Figure 3-15. Telephone tips to local law-

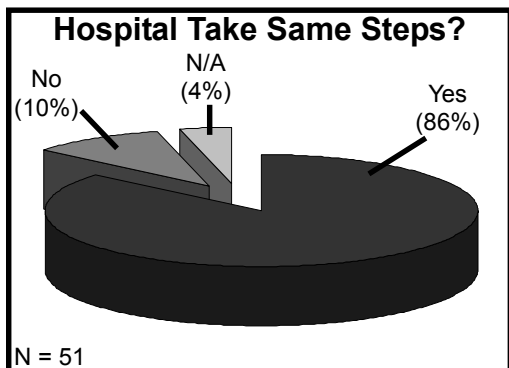


Figure 3-11

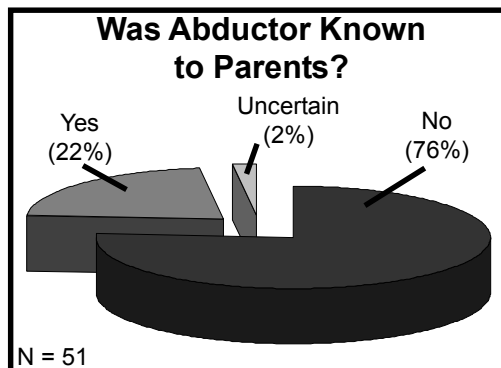


Figure 3-12

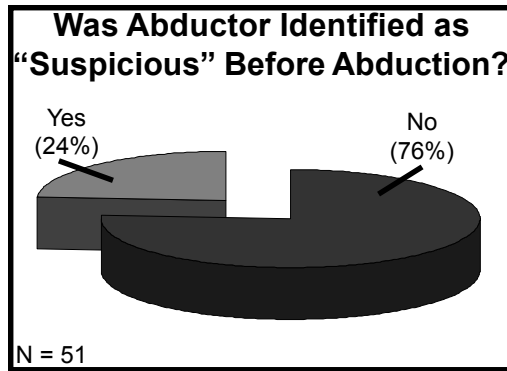


Figure 3-13

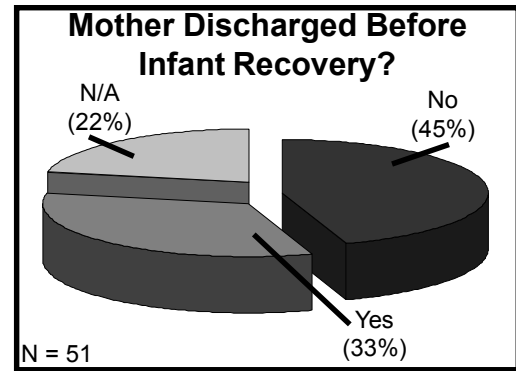


Figure 3-14

enforcement authorities was the leading factor in apprehending abductors in these cases. The regulation of the media's access to information was typically controlled by the facility through its public relations or security departments. Initial coordination by law enforcement on a strategy for developing news stories was cited as being extremely helpful and generally recommended by facility personnel.

The methods used to identify the infants upon return to the facility or parents varied. Twenty-two percent of the infants were still wearing the facility's identification. Twenty-five percent of the recovered infants were positively identified using footprints. Blood/DNA testing was used in 14 percent of the cases and photographs were used in 6 percent of the cases. Fourteen percent of the cases used other methods of identification and no data were available in 20 percent of the cases. See Figure 3-16.

Psychological Support Services

Infant abductions are thought to be stressful events. The facilities in this study were asked to describe the psychological support services that were offered to the victim and the victim's family. A minority of the facilities, 23 percent, indicated that no support services were offered. The remaining facilities, 77 percent, offered some combination of social services, counsel with a chaplain or spiritual leader, and psychiatric and psychological evaluation and counseling. In several cases the posting of an "around-the-clock" security guard outside the mother's room was deemed a "support service." The mother and father of the abducted infant were the predominant users of support services. See Figure 3-17. Still the facilities reported that all services were refused in 29 percent of the cases when the offer was made.

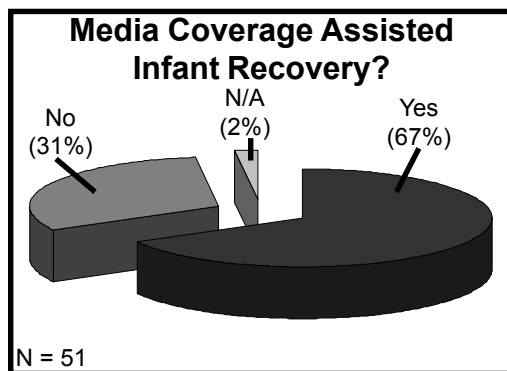


Figure 3-15

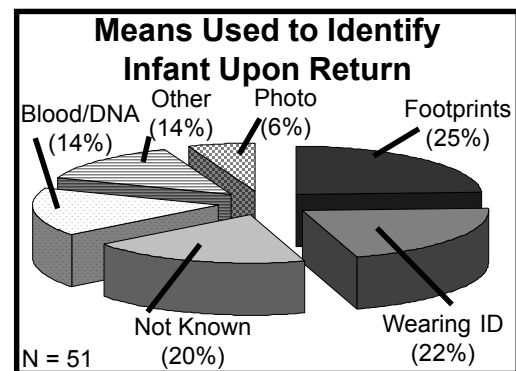


Figure 3-16

In contrast to the figures noted previously, only 59 percent of the facilities indicated that psychological support services were provided to their employees during or after the abduction incident. Of those employees who did use facility-provided support services, most saw a clinical nurse. A fewer number of employees were seen by social services or the facility's chaplain. See Figure 3-18.

In the cases where no support services were provided to facility employees it was often cited that employees had not actually given the infant to the abductor. Several facility administrators stated or implied that since the facility was not at fault the staff members should not need intervention. An administrator said

It is as I told the nursing staff, the mother gave the infant to the abductor. The mother never asked for identification, or any questions, and there is nothing you can do when a mother is going to give away her infant.

Another administrator stated

Our abductor was after a baby, she had a plan, there was nothing our nurses could have done to stop her. We are blame free.

Impact of Infant Abductions on Nurses

The news of an abduction came as a shock to all nurses who were interviewed without regard for whether or not they were on duty at the time of the discovery. These same nurses reported experiencing a variety of feelings related to distress subsequent to the incident. Among these feelings was a strong sense of powerlessness and despair. Common feelings of helplessness, hopelessness, guilt, and failure were stated to be present in the nursing staff members while the infant was missing. One nurse who later transferred to another division of the facility said

For 21 years I have been in charge and have always kept safety as a high priority. I realized it can happen anywhere. It was like my own child was taken. I never got a phone call from administration. All I could see was the black mark on my record. It was a very demoralizing experience.

The sense of distress remained for these nurses even following the recovery of the infant. The majority of nurses who had direct responsibility for the infant expressed

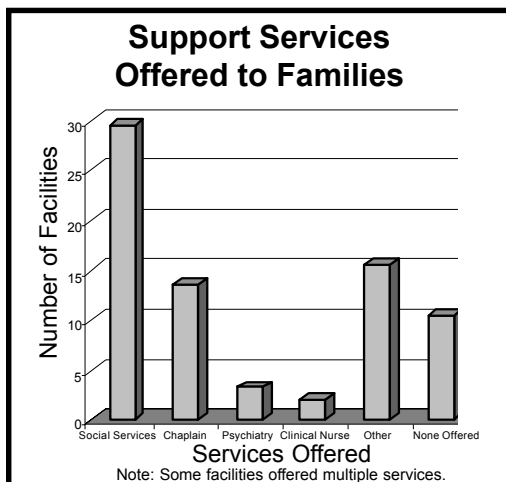


Figure 3-17

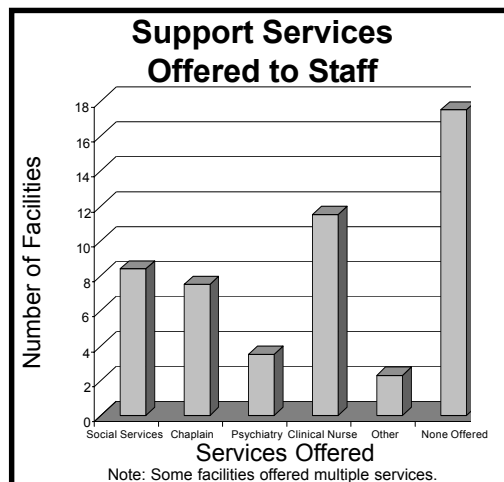


Figure 3-18

clear symptoms of posttraumatic-stress disorder (PTSD). The nurses indicated that their memory of the event was pervasive. Several examples of the **first** statements made by the nurses to the interviewers are noted below.

- "I will never forget that night as long as I live."
- "That was the worst night of my life."
- "Every time I hear of another abduction case it brings it all back to me."
- "I can never forget."

These types of responses occurred regardless of whether support services were offered. Some nurse managers reported that since the abduction the nursing staff members requested frequent updates of information regarding the nationwide incidence of infant abductions. Nurse managers said that the nurses have increasingly spent their continuing education and conference time attending sessions that address infant safety.

Whenever I see an article on infant abduction I read it all the way through. I look for any information I can find on the topic. Since the abduction, I have stopped buying my daughter clothes or hair bands with her name on them. I now know just how vulnerable and innocent children are.

A nurse administrator said

I now read anything I can on infant abduction, and I gasp every time I hear of one occurring. I thank God that it was not us again. I have learned from this abduction and it has had a large impact upon my job.

The quote below illustrates the strain that an abduction can place on the relationship between members of the nursing staff and the facility's administration. It also suggests that nurse managers can be helpful to their staff members who are suffering from posttraumatic-stress symptoms such as flashbacks, anxiety, and avoidance.

Time has been helpful in the healing of the nursing staff...the head nurse was a very competent woman. She was [the] key in reassuring the staff that they were not bad or to blame. The nursing staff would listen to her, whereas they don't always trust what administration has to say.... I know the panic that those nurses and mother had. I have five grandsons and when I turn around and can't find one, I know that panic. It is the same panic I had that night when they told me we had a missing baby.

(Of note, this nurse stated that she had purposely discarded the interviewer's telephone number, saying, "I don't want any reminders of that baby!")

Staff Changes

In seven instances the interviewees for the facilities indicated that nurses assigned to care for the victim mother resigned or transferred to another unit following the incident. One facility noted that a nurse who resigned had worked at the facility for more than 10 years. She sighted a "lack of support from administration" as the primary basis for her decision. This same nurse did return to work at the

facility after a seven-year absence when the maternity unit was modernized and relocated.

Another account of a similar reaction to an abduction was given by the head nurse of a unit.

Case 3-2

The nurse who was in charge of the nursery when the infant was taken was a male nurse, and he has had many problems dealing with his feelings of powerlessness. He felt that he should have done something to stop the abductor; his feelings of being a protector have been questioned. Because he is a man he feels that he has let the whole nursing staff down. Every day now I need to convince him that he is a good nurse and...needs to stay in nursing and on our unit.

Administration Response

Some administrators interviewed in this study indicated that they responded to the abduction incident in a manner that was designed to “protect” the facility. In several cases these administrators recalled that members of the nursing and security units were reprimanded as a result of the incident. Reportedly such actions were meant to demonstrate the institution’s commitment to correcting problems rather than to assign specific blame. In one such case the administrator stated

...[the nurse] gave the baby to the abductor. We reprimanded her severely, pressed charges, suspended her, and then reported her to the nursing officials of our state.

The same administrator indicated that his facility wrote new infant security protocols after the abduction incident. He commented on the role of the nursing department in developing these protocols.

When the nursing staff was asked for input into these new protocols, the only one they added to our list was that no negative action be taken against any nurse(s). They were very strong on that point, and it surprised me.

The implied assumption that an individual can be held responsible for an abduction was mirrored in the comment below from one of the interviewees who was a director of security.

When nursing realizes that security is part of patient care, then we won’t have any more abductions.

These responses are not representative of all administrators and security directors, yet they do provide insight into the posttrauma response that was evident in the majority of those nurses who were interviewed.

Post-Abduction Employee Morale

Facility staff members were asked about employee morale after the abduction. One third, 33 percent, rated morale as “fair”; 29 percent reported “good” morale; 18 percent felt that there had been no change; 12 percent felt that morale was poor; and 8 percent indicated that morale was excellent. See Figure 3-19. As would be expected the facilities that offered support services to their employees were more

likely to have staff members indicate that morale was excellent. Seventy-five percent of the staff members who reported excellent morale had received support services.

Regarding staff morale, it was very poor immediately after the abduction. That has since changed, especially given the number of years that have passed and the staff turnover. However, those nurses who still remember the abduction always attend every single in-service and nearby conference on the topic. You never forget.

Post-Abduction Changes in Healthcare Facilities

As a result of the abduction incident, 80 percent of the facilities interviewed made changes in the security measures in effect for the maternity or pediatric units while 18 percent have not made changes. See Figure 3-20. Note that the question was not applicable to 2 percent of the sample or one facility. The most frequently added security items were cameras and door locks. Punch-pad combination locks and key-card locks were both cited often. Alarm systems activated by tags that an infant wears and alarms on doors were also mentioned repeatedly.

A nursing administrator whose unit had undergone these types of changes stated

We have a complex security system now. We look at everything. We want to have a unit that is 100 percent secure, and we'll never have that, but it is hard because you can never let go of the abduction. Security always has to be there.

A security director voiced similar feelings

[Staff members] in the maternity unit are like residents in a small town who now have to think and remind themselves to lock their doors.

Additionally major physical changes to the maternity unit, post abduction, were reported in 80 percent of the facilities interviewed. See Figure 3-21. Such changes included total relocation of the unit to another floor or building and removal of existing entrances. A head nurse for one of the maternity units said

When the abduction took place we were in the process of rebuilding the maternity unit. Naturally, we made significant changes to our remodeling plans. We have tried to make the unit even more secure.

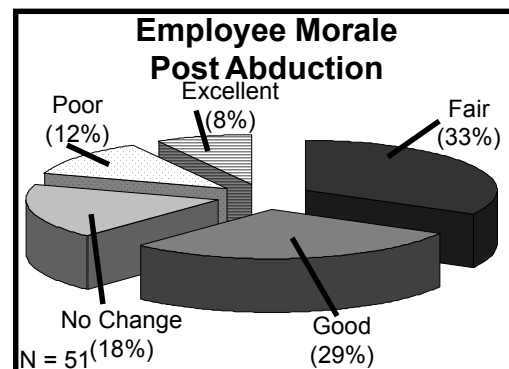


Figure 3-19

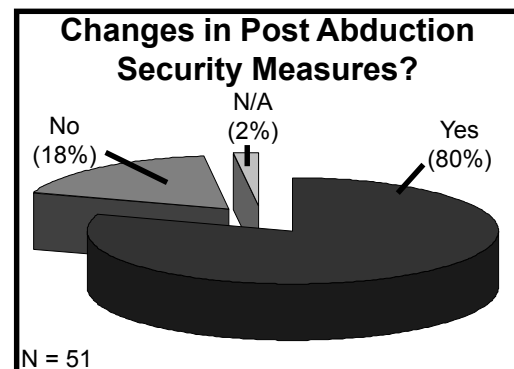


Figure 3-20

The posting of a security guard on the maternity unit immediately following the determination of an abduction was common to all of the facilities interviewed. Yet shortly after the incident, most facilities stopped this practice. Three months after the abduction 29 percent of the facilities still posted an “around-the-clock” guard. See Figure 3-22. Some nurse managers, however, remained intent on increasing the presence of security guards. One nurse stated

It was the worst night of my life. I felt so awful and scared. I had security post an armed guard on Maternity, 24 hours a day for 6 months.

Reaction of Medical Staff Members

At only three facilities from the sample did the people participating report that there had been an observable reaction by the facility’s medical staff members after the abduction. In all three of these cases the reaction was identified as being negative. For example one facility installed a punch-pad lock on the door to the nursery. While all of the physicians had access to the lock’s combination, they repeatedly placed tape over the locking mechanism to keep it from engaging. At times when the lock was engaged, they would kick the door until the lock disengaged.

At a larger institution an administrator reported a degree of skepticism on the part of one of the physicians.

This abduction affected our nursing staff enormously, and because we do 4,500 births a year we are sensitive to their needs. Regarding our medical staff...only one physician has reacted. This doctor is female and has two children of her own. She has stated that she does not trust the new security systems, and every now-and-again she will try to take a baby out of the nursery and off of maternity to test the system.

Changes in Protocols

Seventy-five percent of the facilities participating in this study initiated changes in nursing policies as a direct response to the abduction. Frequent changes were made in protocols that affect parent education, infant identification, and infant transportation. Twenty percent of the facilities reported no changes in their existing protocols. In 6 percent of the cases this was not applicable. See Figure 3-23.

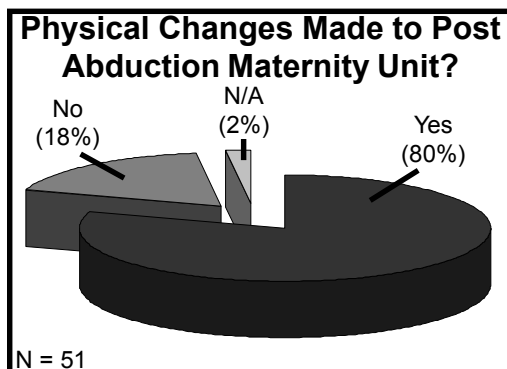


Figure 3-21

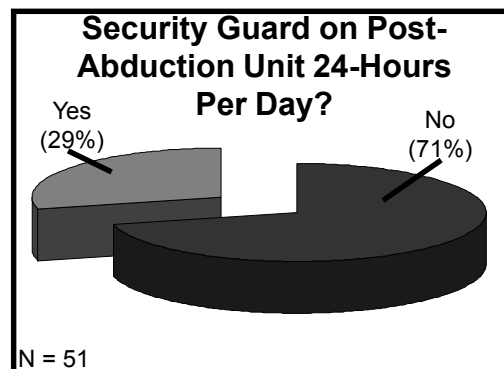


Figure 3-22

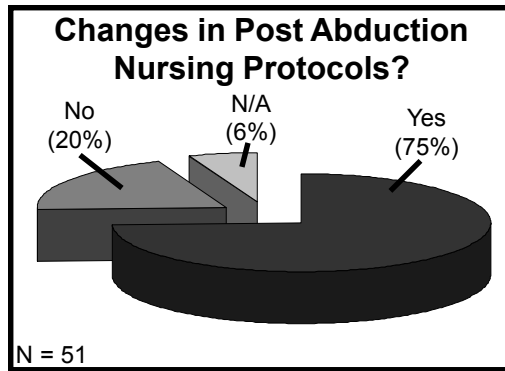


Figure 3-23

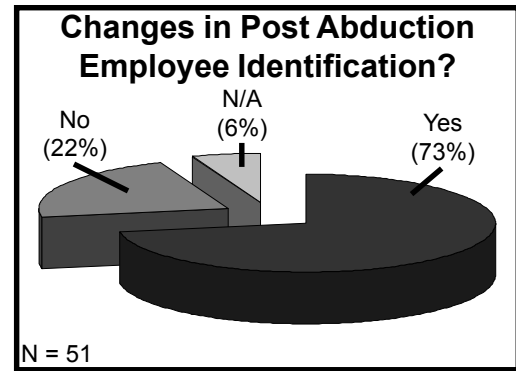


Figure 3-24

Changes in employee identification systems were made in 73 percent of the facilities as well. See Figure 3-24. The facilities that made changes all use some kind of photo-identification system. Many issue special tags that identify those who have permission to be on the maternity unit. Others require multiple IDs to allow access to the unit. Color-specific uniforms are also employed by a number of facilities as a form of identification. A nurse manager succinctly stated

Within 24 hours of the abduction I had changed and created new nursing protocols regarding infant abduction.... I had to do something to make us safe.

Conclusions

The prevention of an abduction incident and the maintenance of a secure maternity unit are the obvious objectives of any facility. The experiences of those facilities that have endured an abduction incident can and should be understood by those facilities that have not. All facilities must evaluate their protocols, training, security systems, and patient-education plans with the degree of scrutiny demonstrated by the 51 facilities that have been discussed herein. Resources that can be used in the evaluation and implementation of appropriate measures are available from

- The National Center for Missing & Exploited Children (NCMEC), **1-800-THE-LOST® (1-800-843-5678)**.
- The Joint Commission on the Accreditation of Health Care Organizations (JCAHO), **630-792-5800**.

The data gleaned from this study clearly suggest that the use of the media to convey information to the public is helpful in assuring the recovery of an abducted infant. While facilities are extremely concerned with negative presentations in the media, the benefits in these cases, recovery of the infant, outweigh the detriments of perceived bad public relations. It is necessary for the facility to cooperate with law enforcement and the victim's family to assure that media reports are frequent and directed at assisting in recovery efforts. Many facilities may find it uncomfortable to accommodate the media in a time of crisis; however, a plan to do so will certainly improve the opportunity for the positive reports that can lead to the speedy recovery of a healthy infant.

As noted earlier the researchers for this study experienced resistance from many of the facilities that were asked to participate in the study. Similarly the data revealed several facilities that were sued by families indicated that in a future incident they would withhold information from the parents of an abducted infant. These patterns of “protective” behavior are understandable, yet discouraged by researchers. In spite of the threat of legal exposure, individual patients and communities as a whole expect compassion and sensitivity from their healthcare providers. While no definitive conclusion can be made about how to prevent a lawsuit, facilities should know that the researchers for this study recommend

- Open communication with victim families and promotion of a sense of teamwork as the efforts to recover the infant unfold.
- Easy access to psychological support services for the victim family, all patients on the Maternity Unit, and all staff members involved in the care of the abducted infant.

Parent and Infant Response

The psychological harm experienced by the parents and family members interviewed for this study was significant. The three phases of response are parental, posttraumatic stress, and infant. In regards to parental response, all parents reported major distress over the experience. From the descriptions provided by parents of their trauma, we noted the four descriptive phases of parental psychological response to having an infant stolen. They are traumatic impact of the abduction news, fear and anxiety until the infant is recovered, recovery and re-bonding, and litigation and re-traumatization.

Parental Phases of Response

Traumatic Impact of the Abduction News

Parents describe the sudden traumatic impact that is registered when they had full realization that their infant was missing. Parents are flooded with feelings of terror and disbelief. Shock overtakes them at the news of the infant's disappearance. The bonding process is frozen and their most immediate recall is their last image of their infant.

Fear and Anxiety Until the Infant Is Recovered

Parents have to manage their fear and anxiety over the news of the abduction while simultaneously acting, with guidance, to recover the missing infant. Added to the terror over the fact that their infant is missing is the frantic anxiety of the search. This is a complicated phase because the parents are also interacting with a host of other people. Strangers come into their lives and ask questions that can even be suggestive that they are responsible for their infant's disappearance. This response phase lasts until there is news that the infant has been located. The time varies in length from hours to days to months.

Recovery and Re-Bonding

Parents experience great relief over the recovery of their infant. The bonding process, temporarily on hold, takes on a new dimension of threat. This threat is important because the fear of "something happening" to the child has been realized. Because the infant has been stolen, he or she is therefore vulnerable. Hypervigilance of their child ensues. The recovery also includes the long-awaited reunion with the infant. This response phase is a complex process and may be delayed because of the need for identification of the infant.

The frozen bonding state from the first two phases requires a re-bonding process in this phase. The re-bonding may take a period of time due to the length of time and the fears of the parents as to what happened to their infant.

Litigation and Re-Traumatization

Many feelings including anger, fear, anxiety, and stress are present during any type of litigation as there is a challenge to a person's sense of justice. Family members will be involved at some level for the criminal and/or civil proceedings.

A review of the sequence of the abduction is an inherent part of the litigation process. As such it constantly thrusts the family back into details of remembering what happened to them. If some sense of justice and protection from the abductor is not achieved, the family is re-traumatized and confronted with an unpredictable future regarding the actions of the accused.

Posttraumatic-Stress Response After Infant Recovery

The response of parents in the first years after infant recovery indicates a constriction of life activities, intermittent fear, and a chronic state of hypervigilance over the family. The majority of parents report posttrauma symptoms of long duration. The length of time the infant was missing was not a factor in the intensity or duration of symptoms. Symptoms include elevated startle response, trouble concentrating, disrupted sleep, fear someone will take the infant again, increase in general nightmares, and frank abduction nightmares. Parents report feeling nervous with intrusive thoughts of the abduction when reminders present themselves such as television or news reports.

On a longer term parents describe a fantasy of danger that can befall their child when nobody is in sight. The parent moves from trauma to fantasies of continual threat and abduction. They have the feeling that their children are not safe under any condition at any age.

The parents are in a double bind. In part the symptoms reveal an underlying assumption or presupposition that if they had been more vigilant and attentive, their infant would not have been taken. They are in a bind regarding giving up these now protective but hypertense behaviors for fear if they stop being vigilant their family can be invaded again.

Another distressing area is the criminal trial. In 57 cases, 35 abductors entered guilty pleas and no trial was held. In 22 criminal trial cases, 3 defendants were acquitted and 19 were found guilty. Sentencing may be difficult to understand for the families. It may be learned that the abductor has been treated as though the abduction was a momentary phenomenon. The abductor's release date also creates fear because some parents recall that when the person was confronted with having the wrong infant, she insisted that the child was "her baby." The family does not believe the abduction should be trivialized. Because the abduction can include stalking and intricate planning followed by an abductor's statement that the child is "her baby," such an abductor may continue to believe that the abducted baby is "her" child. Thus parents fear that the perpetrator is still a danger to the family — especially after release from prison.

Infant Response

The common perception is that the infants are returned unharmed and indeed few, if any, negative consequences of having been abducted are initially reported. With the advancement of investigative wisdom and the immediate use of the media, most infants are returned in a relatively short

period of time. Eleven percent of the infants, however, were abandoned prior to being found.

Although few recovered infants are seriously physically harmed, some parents reported long-term problems possibly related to the abduction. Parent response varies to the question, "Were there any problems with your infant after he or she was returned?" Observable signs included infants returned with a covering of insect bites on legs, arms, and trunk; eating problems; and a lack of cleanliness. A parent described, "My baby boy was dirty and had dirty clothes. He had been living with a homeless mother/daughter with no indoor plumbing and a hot plate. Lice were noted in his hair." Another parent described her daughter as becoming critically ill at 2 1/2 years of age with a gastrointestinal problem that the mother speculated was related to the circumstances of the abduction. Although the mother reported that the problem "went away" after using three different antibiotics, she said that she still had to watch her because "it may come back again." Another mother observed her one-day-old infant had been given regular milk prior to the child's return.

Several parents reported the child experiencing fears and flashbacks. One parent notes that her infant girl becomes terrified when she hears a "pop," as when a car backfires. "She will jump and sometimes wake up and say, 'Hold me, hold me, men shoot people in the dark.'" When an 18-month-old boy developed a high temperature, had seizures, and had to be hospitalized, his mother had a guard placed on the unit.

Sleep complaints and nightmares are frequently reported by these parents. "[My son] wakes up screaming, 'They're grabbing me, they're getting me.'" In the case of the double parental homicide the grandparents said that the infant repeatedly would wake up around 10 P.M. shaking as if from cold, screaming, and unable to be calmed. This night terror reaction was intermittent five years later. It was known that the mother had finished the 10 P.M. feeding and was preparing to return him to bed when her husband was shot and she tried to escape from the abductor. The mother was found dead in her car with keys in the ignition, a gun shot wound to the chest, and an infant burping towel on her shoulder. She was not wearing a coat despite the fact that it was December and very cold. The infant was believed to be only lightly wrapped when taken. When returned, the infant was hospitalized for two weeks with pneumonia.

A second child who was present when his mother was shot is reported by family members to have night terrors and interrupted sleeping disturbances since the abduction in 1987.

One infant was breast fed in a healthcare facility before being abducted. The 17-year-old mother continued with a breast pump for nine days until the infant was returned. She said, "Before he was taken he was a chubby baby who would eat all the time. Since he's been back he's been fussy, and I still have trouble getting him to eat. Initially he would not take the breast. He still sleeps with me. He won't sleep alone and refuses to sleep in a crib. He will wake up three times a night to check and see if I am still there."

A 1-day-old infant, abducted for 15 minutes, was observed being held in a football hold and then thrown into the bushes as security guards pursued the abductor. The mother reported that he cried the entire first night home and one year later has eating and diarrhea problems. Despite the fact that lab tests and examination are negative, the mother believes the problems come from the abductor squeezing him as she fled.

Parents also worried about sexual abuse of their infant. While three of the abducted infants in this study may have been exposed to abductors or family members of abductors who had prior arrests for sexual abuse of children, there is no evidence that any of these infants were sexually abused.

In summary parents experience the first wave of emotional distress when they are told that their infant is missing. The task at this point is containing and managing their fear and anxiety while participating in the search and recovery process. Once their infant is recovered, parents then experience a second wave of emotional distress as they observe and/or perceive a wide range of posttrauma symptoms. Re-bonding with their infant is critical. In addition infants experience their own sense of violation and trauma and behaviors may be observed and documented.

Phases of Infant Abduction

The research identified a group of women who have feigned a pregnancy when they knew that they were not pregnant and subsequently stole an infant. This chapter describes clusters of behaviors that were observed with the majority of infant abduction cases. We have descriptively identified four phases of infant abduction. This phase model allows us to plot the natural history of this behavior and directs us to preventive interventions.

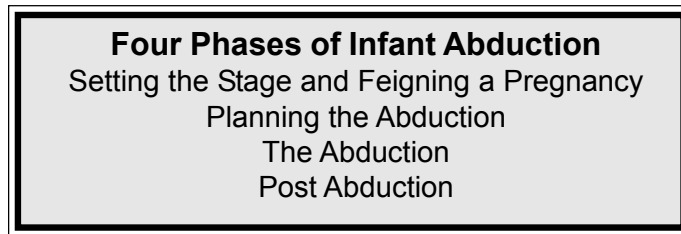


Figure 5-1

Setting the Stage and Feigning a Pregnancy

The motivation to give birth to an infant is not unusual, but the act of planning and stealing a newborn is. What prompts a person to behave in such a way? Asking abductors the “why” of their act produced two broad categories of explanation. First the women talked of internal pressures pertinent to having an infant that are specific to the psychodynamics of the individual. These women said that they had recently lost an infant and were unable to tell people that truth. In essence a pregnancy fantasy is continued and acted out. A second reason the women gave was for external or social pressures to have an infant usually coming from a partner. Women said that they wanted to restore a failing partner relationship. In the sample, 16 abductors, 40 percent of the cases with data, said that they felt pressured by a partner to have an infant. The stolen infant is seen as saving a relationship. Consciously this individual wants an infant to keep a relationship. The infant is instrumental in maintaining the relationship, and there is no truly empathetic burning desire to have another child. She imagines the infant is getting reflected attention from the male and that this status and attention will reflect on her.

In this first phase of an abduction we find that abductors start to plant the idea in peoples’ minds that they are going to be involved in some legitimate way with an infant in their life. Because most of the abductors are women, one of the most common methods of this involvement is feigning a pregnancy. Likewise the few men in the study indicated to a partner that someone’s infant needed to be cared for.

After the stage is set abductors begin to carry out their plan. In a feigned pregnancy the woman must change her body size to indicate a developing pregnancy, make and keep doctor’s appointments for the pregnancy, tell people about the pregnancy, and prepare for maternity leave. People believe the woman and may have baby showers and give her presents.

The women may have some history regarding an actual pregnancy. In 30 of 62 cases, 48.4 percent, the women allege a miscarriage prior to abduction. Eight of 62 cases, 12.9 percent, report being diagnosed with pseudocyesis. Older women in their 30s and 40s who may have already had children were more likely than younger women to have been diagnosed with pseudocyesis. Pseudocyesis is an incorrect belief that one is pregnant marked by some of the physical symptoms of pregnancy even when conception has **not** occurred. Only 10 of 62 abductors said that they never faked a pregnancy. Twenty-six or 41.9 percent reported gaining weight coincidental with the feigned pregnancy. Twenty-eight or 45.2 percent said that they purchased “baby goods,” and of those 18 reported keeping medical appointments. One abductor took urine from a pregnant woman and used it as her sample. Another abductor stole a sonogram to convince a partner of the impending birth of their infant.

In this first phase abductors lie about being pregnant and considerable deception is used. Some of the abductors had a history of prior efforts to deceive as through impersonation such as check forgery and prior feigned pregnancy. In almost one quarter, 24.2 percent, of 38 cases with data, abductors had deceived others and been arrested for crimes such as forgery of checks and credit cards. Several older women who had a hysterectomy were in a new partner relationship and had not told the partner of their surgery.

Planning the Abduction

As the ninth month approaches the individual’s anxiety increases over her need to produce an infant. In this phase abductors plan where they are going to get an infant. They begin to target and search out infants. Continuing the deceptive ploy, they devise some kind of legitimate reason for being in a setting using a false identity such as a nurse or social worker in a healthcare facility or a visiting nurse or babysitter in the home.

The abduction is not an impulsive act. They have a plan for getting away and changing the identity of the infant. This is an emotionally consuming phase. In this phase cleverness is often used in conjunction with a disguise.

Impersonation, lying, and deceit are characteristic of the abductor. Abductors impersonate nurses, lab technicians, photographers, and members of the family. They may befriend a parent to get access to the infant or ask for assistance such as use of a telephone or glass of water.

The Abduction

This third phase includes the abductor entering the healthcare facility, home, or other location for the abduction. The abductor either enters unnoticed or wears a disguise to deceive people. She takes the infant and escapes to a predesignated place. She must also explain the presence of the infant to others.

The age range in this study was 14-46. The case of the youngest abductor illustrates not only planning but persistence in waiting for the opportunity to act. When

apprehended the abductor characteristically minimizes and denies the planning and makes it appear as an impulsive act.

Case 5-1

A 14-year-old abductor took a 2-month-old infant from a hospital emergency waiting room. Both the victim mother and adolescent abductor were at the hospital waiting to be seen for nonacute services. The adolescent struck up a conversation with the victim mother and repeatedly asked to hold the infant. The victim mother refused each time. When considerable time elapsed, the victim mother said that she needed to telephone her family and the adolescent volunteered to watch the infant. When the mother went to make the telephone call, the abductor immediately took the infant and left the emergency room. She was seen by witnesses getting on a bus with the infant.

A telephone tip led law enforcement to the location of the abductor. When interviewed, the adolescent said she had been told that, due to an infection she had several years earlier, she was sterile and unable to have children. She wondered what it would be like to have a child, claimed that she saw the opportunity to get one, and took it.

There is deliberate planning and a consuming desire to have a child regardless of consequences. Prior failed abduction attempts may increase the agitation of the abductor. In one case a 2-month-old hospitalized boy was abducted from a pediatric unit where he was receiving intravenous fluids and antibiotics for a high fever. The abductor entered the room, bit the IV tubing, placed the infant in a gym bag, and left the hospital via a bus.

In this third phase, the abductor is very intent on getting the infant. The extensive planning of the “baby stealing” confirms the presence of an abduction scenario. Approximately half of the abductors admit to deliberate planning of the abduction from as long as nine months to as short as a few hours. Approximately half of the abductors make prior visits to the abduction site before committing the act and 87 percent impersonate a healthcare worker — usually a nurse. This suggests a rehearsed script to the scenario.

Abductors rehearse and become obsessed with their plan. Those who go to the home to abduct an infant reduce the risk of chance occurrence for other people to protect the infant and mother. Thus perpetrators have some sense of their capacity to confront and overpower the parent or caretaker. Murders usually occur when the infant is being taken from someone. Home abductors were more likely to be found to carry a weapon, suggesting that murder may be a more integral part of their abduction scenario.

Violence may be part of the abductor’s plan. The fact that more than one third of home abductions had violence associated with the act emphasizes the potential dangerousness of home abductions. Seven parents, six mothers and one father,

were killed and three mothers, one father, and one grandmother were injured. One abductor performed a Cesarean section on a pregnant woman outdoors in a secluded field using a car key. That mother died from blood loss and exposure.

Post Abduction

Getting away with the crime is the goal after the abduction. This phase pertains to how well the person planned to escape the abduction scene with the infant and reenter her own social circle without having anyone challenge the legitimacy of the relationship to the infant.

The abduction act is ego-syntonic in that it is consonant with the immediate conscious wish of the individual. Immediately following the act there may or may not be genuine regret, self-reproach, or guilt. There was only a small number of cases where the abductor expressed such feelings. Generally the infant was recovered because someone identified the abductor. When confronted by authorities, with the infant in their possession, 53 percent of the abductors explain that the infant is their own child.

In those situations where the infant was recovered, the abductor did not demonstrate that she planned this phase well. In addition it is usually someone within the abductor's own social network who turns her in.

This phase requires skill in keeping the infant without discovery, maintaining the story regarding the infant, and handling the suspicions of others. The gratification of taking the infant is noted in their open display of the child that happened 62.3 percent of the time with these abductors. For example the abductor walked in public with the infant or showed the infant off at a neighborhood bar.

The case summarized below, whereby the infant had been missing for more than 2 1/2 months, illustrates how long the characteristics of the abductor's lying persists.

Case 5-2

An investigating officer went to a residence and said to the African-American woman answering the door that he had a report she had an infant and he wanted to see if it was the missing Caucasian infant that he was looking for. When the woman first said, "On no, I do not have a baby," the officer thought, "Another lead failed." As he went to leave, he heard an infant cry and asked, "What's that?" She said, "Oh, I am babysitting for a friend." He asked to see the infant. She brought the infant out, and the officer began to ask her questions about the infant's parents that she could not answer. She then said that the infant's name was Susan and that Susan was her daughter's infant. She explained that the infant, "Is an albino and that is why she is so light." He asked to see the infant's birth certificate and was told, "There is none." The woman insisted that the child was a girl despite the fact that he looked like a boy. Thus the officer asked to check the sex of the child and observed that the infant was in fact a boy. After sensitive questioning she admitted that she had taken the infant.

Abductor Profiles

The case summarized below reflects a 42-year-old woman who believed that she needed to have an infant to both maintain a relationship and compensate for a loss. Such a “loss” can come from a miscarriage, a stillbirth, or an inability to reproduce an infant in a woman who feels incomplete without an infant. When those feelings are coupled with her need to maintain a relationship, a scenario can arise where the woman will falsify a pregnancy and plan to abduct an infant. Such a woman may believe very strongly that the infant is hers. Below is another aspect of Case 1-6 as first reported on page 6. This account highlights the abductor’s life and events leading up to the abduction.

Case 5-3

Ten days after Marie was born her mother went off to college and left her in the care of her paternal grandfather. Marie lived with her father and his parents, but her father was a workaholic and did not spend much time with the family. Her mother returned home only on the weekends, but the first time she had an extended stay with her daughter was nine months later during her summer break. Growing up Marie came to feel like an orphan in her own home. She received positive parenting from her grandfather, but she felt unwanted because she was regularly shuffled around.

When Marie was a young girl her parents built a home together, and Marie lived with them. Her mother was the dominant figure in this home, and she emotionally abused Marie. After her mother gave birth to her sister, Marie perceived that her parents treated her sister better than she was treated. Her father laughed and played with her sister while he remained cool towards her. Through the age of 11 she experienced night terrors, headaches, dizzy spells, blackouts, and claustrophobia. From the ages of 12 to 17 only the claustrophobia continued.

By the time Marie was 18 she had her first child, a girl. In addition Marie was diagnosed as a manic-depressive and suffered from bouts with bulimia. An educated woman with a Masters equivalency, she appeared to have a stable work history. She was a mid-wife for 14 years and later an entrepreneur/designer, preferring this type of work because she could control her own hours.

Marie was high functioning despite her psychiatric illness. She worked a steady job, held a volunteer job, and was a licensed foster parent for 17 years. Unfortunately she could not gain control over her illness. In her manic phases she would spend her money extravagantly on frivolous items and was caught writing bad checks, but she was never charged or prosecuted. Chronic lying became a way of life for her as she thought it was easier than telling the truth. During a depressive phase she often became withdrawn, isolated, and extremely shy. She was hospitalized on three separate occasions for her manic-depressive illness. Her posthospitalization

treatment consisted of medication, but no therapy. As a result Marie was very angry at the medical community for how her illness was being treated. She claimed that it took several years for the doctors to tell her what was wrong with her and how her illness could be properly treated. In addition she had difficulty receiving consistent medical treatment as she frequently moved around with her second husband.

The infant abduction occurred during her third marriage that was to a man 20 years her junior. In the eighth month of her alleged fifth pregnancy, after one child, two miscarriages, and one stillbirth, she gave birth to another stillborn infant. At the time of the alleged miscarriage, her husband was away on a Navy ship. It was also at this time that her husband relocated to a base, and she was left with the sole responsibility of moving their possessions to the new base. She packed up all of the infant's equipment and began the trip to her new home. For several weeks of this trip she "drifted" from place to place before finally arriving at her new residence. She became paranoid at this point and even called the Governor to report that people were after her. Suffering from apparent post-partum depression she began searching for her infant.

Several weeks prior to the abduction Marie was observed posing as a social worker and offered her services to mothers of infants. A 16-year-old mother, Ann, was fooled by this con and agreed to have Marie help her, but only after she introduced Marie to her mother for approval.

On the night of the abduction Marie met with Ann and her mother. After the meeting Marie told Ann that she would take her and her 3-month-old son, Josh, out to visit potential babysitters. They did not actually meet any babysitters as Marie simply drove by homes and stated that a babysitter lived there. Marie then pulled into a fast-food restaurant, gave Ann a \$20 bill, and said that she would wait in the car with the infant while Ann got them some food. When Ann returned from the restaurant, Marie and the infant were gone.

Marie drove to her home where she cared for the infant, claiming that she even breast fed him several times a day. She claimed that she believed this infant was her lost child. After nine days law enforcement received a tip from one of the other mothers approached by Marie before the abduction. Marie was arrested and received 105 months in prison.

Discussion

Abductors carry out a planned abduction scenario that usually includes a successfully feigned pregnancy. They search out sites for the abduction including nurseries and clinics. The abduction scenario includes details of how to steal the

infant and a clothing disguise to impersonate a healthcare staff member. Abductors are mission-oriented, and the desire to steal an infant is intense during the actual abduction. Those who are victims of home abductions are at high risk for lethal injury when resisting to release their infant. The post-abduction phase indicates the breakdown of the plan, specifically when the social network has not been prepared for the arrival of an infant.

Force during an abduction ranges from none to lethal. It seems important to distinguish between those who are willing to and do commit murder and those who use elaborate plans to steal a child without violence. There is some indication that violence may occur when the abductor is thwarted in the process of carrying out his or her act. This latter phenomenon may suggest that once the abductor makes up his or her mind to get an infant, any interference with this scenario can be dangerous because the narcissistic investment is so great that aggression could ensue.

In summary it is important to look at the structure of the crime. The woman may present a scenario indicating that her actions are to fulfill an emotional need to ward off abandonment from the male, but when details are obtained it is learned that the plan was to get the infant regardless of any consequences. Investigators and mental-health experts should ask questions regarding the crime such as

- How well planned was the abduction?
- What risks were taken?
- What was the level of impulsivity?
- What was the amount of aggression and violence?

Infant Abductors

In response to the growing trend of infant abductions, security in healthcare facilities began receiving requests for assistance and training in the area of infant abduction. To better understand the dynamics of this problem and assist security in implementing solid policies to help thwart these crimes, this study also reviewed the various “criminal” aspects of this crime.

Crime Classification: Infant Abduction

Law enforcement uses the crime-classification process as a way to analyze crime in an organized manner. The procedure for classifying crimes begins with identifying the defining characteristics of the crime. Those characteristics of the crime are victimology, crime-scene indicators, and forensic findings. Through an evaluation of these three factors, investigative considerations and search warrant suggestions are developed.

Defining Characteristics

Victimology

The characteristics noted below are observed in these abductions.

- Infant age ranges from birth to 6 months.
- Gender of infant is not usually a significant factor.
- Race of the child usually matches the race of the offender or the offender’s partner.
- Risk of physical injury for the victim infant is low. No significant physical injury has been noted in the infants recovered to date. Many parents, however, report observing things such as fears, flashbacks, and nightmares in their recovered children that they attribute to the abduction.
- Risk to the victim parents is high for injury or death if the abduction location is a residence.
- The physical health of the infant appears to be a significant factor. Most abducted infants are healthy; however, infants have been taken from pediatric units. To date no infants have been abducted from neonatal-intensive-care units.

Crime-Scene Indicators frequently noted include

- Infant abduction is generally a daytime crime with 72 percent of the infants stolen between 9 A.M. and 6 P.M.
- High risk for offender identification when an infant is abducted from a healthcare facility.
- At a residence the absence of forced entry is often noted.
- Evidence of panic or hurried retreat.
- The observation that a single offender generally perpetrates abductions from healthcare facilities while possible co-offenders are involved when infants are abducted from residences or other locations.
- In abductions from healthcare facilities the setting is usually the nursery, mother’s room, pediatric unit, or pediatric clinic.

- The presence of unexplained items such as discarded clothing typically worn by healthcare personnel and wigs.

Forensic Findings indicate that

- The forensics necessary to identify an infant when found include footprints, blood type, color photograph, description, and unusual physical characteristics. See Figure 6-1 for a listing of methods used to identify infants.
- Identification of any weapon used or present during the abduction is important for investigative purposes.

Methods Used to Identify Infants Abducted from Healthcare Facilities Upon Recovery*			
1983 - 2002			
Single Method of Identification Used: 56 Cases			
Footprints (plus 11 cases in multiple methods)	15	Abductor Identified by Witnesses	1
Blood Test	8	Birthmark	1
Visual Identification (ID)	18	Facility Wristband	6
Confession of Abductor	4	Deoxyribonucleic Acid (DNA)	2
Photographs	1		
Multiple Methods of Identification Used: 39 Cases			
Visual ID, Confession of Suspect	7	Photographs, Way in Which Umbilical Cord was Tied, Confession of Abductor	1
Footprints, Blood Tests	3		
Visual ID, Facility ID Bracelet	9		
Footprints, Visual ID	4	Description of Suspect, Witness Testimony	1
Footprints, Blood Tests, Visual ID	1		
Footprints, Photographs	1	Visual ID, Facility ID Bracelet, Clothes from Facility	2
Footprints, Medical Charts	1		
Footprints, Birthmark	1	Visual ID, Photographs, Birthmark	1
Footprints, Cord Clamp, Description of Child	1	Visual ID, Birthmark, Facility ID Bracelet Found at Site of Recovery	1
Blood Tests, Birthmark	1	Visual ID, Photographs	1
Blood Tests, Cord Clamp	1	Visual ID, DNA	1
Antibody Profiling, Criminal Investigation, Confession of Suspect	1		
Pending Cases: 18			
Child Still Missing	5		
Unable to Obtain Information	13		
Total Cases: 113			
*NCMEC tabulated this data based on a study of 113 infants abducted from healthcare facilities between 1983 and 2002.			

Figure 6-1

Investigative Considerations: The Offender Profile indicates that the abductor

- Female of “childbearing” age (range now 12 to 50), often overweight.
- Most likely compulsive; most often relies on manipulation, lying, and deception.
- Frequently indicates that she has lost a baby or is incapable of having one.
- Often married or cohabitating; companion’s desire for a child or the abductor’s desire to provide her companion with “his” child may be the motivation for the abduction.
- Usually lives in the community where the abduction takes place.
- Frequently initially visits nursery and maternity units at more than one healthcare facility prior to the abduction, asks detailed questions about procedures and the maternity floor layout, frequently uses a fire exit stairwell for her escape, and may also try to abduct from the home setting.
- Usually plans the abduction, but does not necessarily target a specific infant; frequently seizes any opportunity present.
- Frequently impersonates a nurse or other allied healthcare personnel.
- Often becomes familiar with healthcare staff, staff work routines, and victim parents.
- Demonstrates a capability to provide “good” care to the baby once the abduction occurs.

Search-Warrant Suggestions

Upon identification of a potential suspect, obtain a warrant to search for infant items including evidence of planning for the “arrival” of a child such as credit-card purchases of infant supplies or feigning pregnancy. Also consider searching the abductor’s car, telephone records, and home especially looking for newspaper clippings that appear to “follow” media coverage of the abduction and/or birth announcements used by abductors to target the victim family.

Abduction Scenarios Highlighting the Law-Enforcement/Security Response

Below are various abduction scenarios that illustrate the abduction situation and steps taken by the law-enforcement/security personnel involved.

Case 6-1

Victimology: A 2-day-old girl was stolen from a hospital nursery at 11:15 P.M.

Crime-Scene

Indicators: The abductor, dressed in a stolen nurse’s uniform and white shoes, took the infant from a nurse saying that she was taking the infant to her mother for feeding. The infant taken was the nearest infant to the viewing window. The “nurse’s” uniform and shoes were later found in a bathroom wastebasket.

Forensic

Findings: The infant was recovered 11 days after the abduction and identified by her footprints and full medical charts.

Investigative

Results: An interview with the abductor, Candice, revealed that she had lived with her mother and her abusive stepfather for the first 8 years of her life. His physical abuse appeared to be random acts of violence that occasionally involved the use of large objects like pieces of wood. When Candice was 8 years old she and her older brother were sent to live with her grandparents. Her mother was in and out of psychiatric hospitals for depressive illness. At the age of 10 Candice left her grandparents home and went to live with her father and stepmother again. She became withdrawn and unhappy in this environment and, as a result, she began running away. The last time Candice ran away she was returned to a detention center where she remained for a short period of time before being sent to a psychiatric hospital for evaluation. Her evaluation determined that she suffered from an adjustment disorder. In addition she had also suffered from headaches and claustrophobia since early childhood. Candice remained in that hospital for several weeks while receiving therapy.

At the age of 12, after only two years with her father and stepmother, she returned to live with her grandparents. Living with her grandparents through high-school graduation she felt as if they had the greatest influence on her life. A year after moving in with her grandparents, she got a job that lasted throughout her high-school years. An honors student she enjoyed drama class and acting out scenes. Her drama coach characterized her as being able to manipulate people with great ease. She went easily from role-to-role during the classes. After she was denied a lead role in a play, students went to the coach and said Candice was spreading rumors that she was pregnant by him. He called her in and demanded that she stop spreading the rumors.

Shortly after that episode, Candice began to abuse alcohol and nonprescription medication. Her headaches and claustrophobia remained throughout adolescence, and she also developed "terrorizing" but unspecified nightmares.

Upon graduation Candice went out on her own to pursue a college education. During her first semester she stated that she became pregnant. Approximately two months into that pregnancy, she claimed to have miscarried the infant. This apparently was not her first miscarriage as she claimed to have miscarried at age 13 and again at the age of 17. At the time of the third miscarriage she was fighting with her live-in boyfriend so she decided not to tell him that she had lost the infant. Choos-

ing not to receive medical treatment for the miscarriage Candice decided to pretend that she was still pregnant. As time progressed she continued to fake the signs of pregnancy thus fooling everyone into believing that the infant was soon to be born.

Approximately six months after her miscarriage Candice spent a difficult weekend with her mother. Her mother had been fighting with her stepfather and needed to get away from him. After her mother's visit she decided to steal an infant. Candice alleges that she had no real abduction plan, but she did obtain an infant car seat, diapers, and bottles. Telling friends at her part-time job that she was going on vacation, she left town. Driving 350 miles from her home she ended up in an area that she had lived in when she was living with her father and stepmother.

Upon arriving in that city Candice began investigating hospitals. Her criteria for the right hospital included easy access to the nursery and minimal security. She determined that the infants were too sick at the first hospital she visited, and she did not feel comfortable at the second hospital. There were not enough infants at the third hospital; however, she felt very comfortable at the fourth hospital. She selected the County Hospital because it did not have the constraints of the first three hospitals that she had visited, nurses did not wear identification tags, and there was minimal staffing during shift changes. This posed an opportunity for her to pretend to be a nurse who was arriving on the next shift. During her first visit she entered the nurse's locker room and stole nursing scrubs. Noticing that the front hospital door was locked by midnight, she planned to return the next evening to abduct the infant just before midnight during the 11:00 P.M. shift change.

The morning of the abduction she purchased nurses' shoes and spent the rest of the day relaxing. At 11:00 P.M. she returned to the hospital and slipped into her scrubs in a bathroom. Since access to the nursery was through the nurses' station, she approached the nursery nurse; leaned on the counter as she had seen other nurses do; and told her that the infant's mother, "Mrs. B," wanted to see her child. Candice chose that infant because her name was the easiest to read through the nursery window. The nurse told her it was OK, and when Candice tried to wheel the infant out in her crib the nurse told her to simply carry the child to keep the noise level down. Taking the infant to the first floor bathroom Candice removed her scrubs and walked out the front door of the hospital. She took care of the infant in the motel room until driving back to her hometown.

When she arrived home her boyfriend was overjoyed to see what he believed to be “his new baby girl.” Over the next 11 days she took good care of the infant. She did not follow the media reports of the abduction, openly displayed the infant as hers, and forged a birth certificate for the infant.

Her ex-boss became suspicious when he heard the media report of the abduction and saw Candice when she brought the infant to the workplace. He tipped off law enforcement. Even after Candice was arrested she claimed that the infant was hers. When informed that painful genetics tests were necessary to prove that the infant was hers, she confessed. She stated that her reason for abducting the infant arose out of her need for stability in her life. She had been “dumped by her parents” and was going to find something to love that also loved her back. She was convicted for this crime and received a five-year prison term.

Case 6-2

Victimology: A 1-day-old boy was stolen from his mother’s room in a suburban hospital.

Crime-Scene

Indicators: On the Friday morning that the child was circumcised his mother had her catheter removed, and the pastor from their church visited around 1:00 P.M. that afternoon. The mother’s room was the last one in the hallway, right across from the fire exit. Around 1:25 P.M. a 44-year-old woman wearing a lab coat entered the room. Upon seeing the pastor, infant, and the infant’s mother she left. Ten minutes later she returned with a urine cup and asked the mother for a sample that needed to be taken to the doctor. She then asked for the infant. The mother asked why and was told that lab tests had been ordered. When the mother asked why the tests were not conducted during the circumcision, she was told “they forgot.” At this time the mother looked at the urine cup and thought that it was very different from the ones used at the hospital. She thought of saying something but didn’t. The mother gave the infant to the woman who then left. The mother knew something was wrong because the woman carried him out in her arms and no person was allowed to transport infants unless they were in their bassinet. The mother told the pastor to stop the woman, but she had already gone out the fire exit. Then he ran to the nurses’ station and alerted the nurses.

Interviews with staff members revealed that the woman had been seen earlier that day. During nonvisiting hours she had been in other rooms but had been chased away. The media was alerted, and news of the abduction was carried in the local and national press.

A tip was received from the abductor’s daughter who lived 2,000 miles away after she saw the newscast and became suspicious since

she had just heard that her mother had a new infant. The daughter had tried to help her mother with an unsuccessful adoption and remembered her mother commenting that she would “go to a hospital and get a baby that way.”

Forensic

Findings: The infant was identified through medical records.

Investigative

Interview: An interview of the abductor, Susan, revealed that she was born into an unstable home. She was the second oldest child with an older brother and a younger half sister and brother. When she was 4 months old, and her older brother was 2 years old, they were sent to live with their maternal grandparents due to the pending separation and divorce of their parents. The parents divorced on three separate occasions. Whenever her parents would get back together, she and her older brother would be taken back to live with their parents. Susan believed that her father’s infidelity and gambling was a strong factor in her parents’ marital discord. When she was 5 years old, her older brother was beaten to death by a playmate. She was present when the authorities arrived to help her brother.

At the age of 7 Susan reported that her father began to sexually abuse her. She claimed that the abuse continued until she was 9 years old when her father abandoned the family, and she never saw him again. Shortly after his departure her mother moved the family in with her parents so that she could pursue a nursing career. For the next several years Susan was primarily taken care of by her grandparents. Her mother appeared sporadically to care for her, but never tried to regain full parenting responsibilities. As a young child Susan suffered from nightmares, chronic bedwetting, fear of the dark, and extreme shyness. These problems continued with her until she was 18 years old.

Susan felt that she was largely influenced by her grandmother who she perceived to be a kind and nonjudgmental woman; however, she reported having been physically abused by her “binge” alcoholic grandfather. A pivotal point in her adolescent life was the hospitalization of her grandmother. The absence of her grandmother was so difficult that she decided to find a way to get out of her abusive home. At the age of 15 she married a 20-year-old man who she had only known a short period of time. Eventually she became pregnant, but her husband’s drug problem led her to divorce him shortly after her infant daughter was born. Feeling depressed during her pregnancy she attempted suicide by slitting her wrists. Two years later she entered into the second of her three marriages.

Susan's second marriage was to a law-enforcement detective who adopted her daughter and together they had two sons. This marriage lasted for 14 years but was fraught with problems that led to several separations. It was also during this marriage that she developed a criminal record. Her first offense was for writing bogus checks for which she received probation. The next offense was embezzlement of funds that occurred while she was working as a bank teller. She was sentenced to 2 years in prison, but served 19 days. She believed that she committed these crimes due to financial stress and marital difficulties. During her last separation, she became pregnant by another man. Although her husband eventually took her back, the marriage did not last and he finally left her.

A year later Susan found herself married to a plumber who had a serious drinking problem. As his business ran into financial trouble his drinking increased along with his physical abuse of her. He allegedly beat her so severely that she had multiple broken bones. After filing for divorce from this man she met another man whom she believed could solve all of her problems. Susan's newest partner was a man named Fred Johnson. He quickly became the center of her life. Having only two daughters from a previous marriage, Fred wanted a son. Although Susan previously had a hysterectomy, she led Fred to believe that she would try to bear a son for him. Her plan was to adopt a son and, at the same time, pretend that she was pregnant. Unfortunately the adoption fell through. When she admitted that she wasn't pregnant, Fred became enraged and allegedly threatened the life of her youngest son. Later Susan faked another pregnancy.

Approximately eight months later Susan informed her work supervisor that she was taking maternity leave. She told Fred that she was going away for a few days for a work-related training program. She spent three days in a hotel trying to figure out a way to abduct an infant now that she had faked a full nine months of pregnancy. When she returned to her boyfriend, he told her that he was going to leave her for another woman after she gave birth to his infant.

A few days later Susan met Fred and his girlfriend at a bar. At the bar a fight ensued, and Susan rushed out. She then went to a motel and called Fred to let him know that she had gone into labor. Checking on her story, he called the local hospital and was not successful in finding her. At 7:00 A.M. the next morning, Susan called Fred with the news that she had delivered a 7-pound, 14-ounce boy.

The next evening Fred appeared at her doorstep wanting to see his son. She fabricated a story that the infant was being placed for adoption and he was visiting with his prospective, adoptive parents. Fred continued to push for her to give him the opportunity to see the child, even agreeing to move back in with her if she showed him the infant.

Later Susan and Fred drove to the area where the abduction ended up taking place. Susan dropped Fred off at a hotel bar and stated that she was going to the adoptive parents' home to retrieve the infant. She changed into a wig and nurse's uniform. When she arrived at the hospital, she went directly to the maternity ward. As she was walking down the hallway she overheard a new mother talking about her infant. Susan walked into the mother's room saying that she had to give the infant a check up. The mother handed her son over to Susan who concealed the infant under her clothing as she walked out of the hospital. She promptly removed his ID and clothing along with her disguise and returned to the hotel.

After abducting the infant, Susan stated that she had a change of heart and wanted to return him to his mother. She met with a priest to try to give him the infant, but Fred would not leave them alone long enough for her to explain the situation to him. Seven days later Susan and Fred were captured in a restaurant by the FBI.

Case 6-3

Victimology: An 8-day-old girl was abducted from her mother's room in an urban hospital at 5:15 A.M.

Crime-Scene

Indicators: A 34-year-old female wearing hospital scrubs and two forms of hospital identification walked into the mother's room while the infant was nursing. The woman said that she was taking the infant to the nursery. The mother went into the bathroom and when she came out she noticed the bassinet had been left behind.

The mother called the nursery, staff members notified security, and all exit doors were secured. The abductor used the stairwell next to the mother's room alongside the elevator. She went down one level below the floor where the security station was located, walked to a point beyond the security station, and came up another stairwell to exit directly in line with where she parked her car. The abductor saw the security officers and started running. A hospital security officer took possession of the infant while another stopped the abductor.

Forensic

Findings: The infant was identified through medical records and by her mother.

Investigative

Interview: The abductor, Terese, was 35 years of age at the time of her interview. She was interviewed in a correctional facility where she is serving a 10-year sentence for the offense of Stealing of an Infant. The interview took place 1 year and 2 months after her arrest and 10 months after she had pleaded guilty to that

charge and an additional 5 counts of forging prescriptions to fraudulently obtain narcotics for which she was sentenced to 5 years in prison. She was sentenced to a total of 10 and 5 years to run consecutively.

Terese was the product of a union between her mother and her mother's second husband. Her mother's previous marriage produced three sons who were 2, 5, and 10 years older than her. Terese reports memories of verbal and physical conflict between her mother and father, who was an alcoholic. They divorced when Terese was 5 years old. Her father continued to live in the neighborhood and continues to maintain contact with his daughter.

Terese's mother went on to remarry, divorce, and remarry again. Terese did not like her first stepfather and spent considerable time during that period with her paternal grandmother who lived nearby. Terese had very strong feelings for this grandmother and openly wept while discussing her.

Terese denied suffering any physical or sexual abuse at the hands of any family members. To the contrary, she described her mother as permissive and did not recall being punished as a child. Her first stepfather was verbally abusive and told her that she was worthless. It was this behavior that led her to move in with her grandmother. Terese described an average childhood up to her entry into the eighth grade. Her mother was steadily employed as a secretary and provided all the family's needs. She classified their economic status as being lower-middle class. A close-knit extended family network consisting of grandparents, aunts, and uncles lived in close proximity and provided the support that might have been lacking from her mother, who worked long hours to provide material support for the family.

Terese's life reached a turning point upon her entry into the eighth grade. To accomplish desegregation of the school system she attended a policy of busing was implemented that year, and Terese was transferred to a different school. In addition to the anxiety created by being moved from her familiar school setting she reported not being academically challenged which led to boredom. She quickly went from being an above-average student to barely passing.

It was in the eighth grade that she first started smoking marijuana and running with what she described as the "wrong crowd." The eighth grade is also the time she met the young man who would become first her close friend; then, three years later, her lover; the father of her child; and her common-law husband.

Throughout high school Terese worked several part-time jobs that supported her increasing use of marijuana. With the exception of her verbally abusive stepfather, Terese reported that she and her family lived a “normal” and happy life, although she did admit that all of her brothers were heavily involved in drugs. She also admitted to experimenting with numerous illegal drugs including hallucinogens.

Immediately after graduating from high school Terese moved in with her paternal grandmother. Her aunt got her a job in a factory, and she was able to purchase her first car. She continued using drugs and started buying and selling kilo amounts of marijuana. During this period of time she began using more alcohol and was arrested for Driving Under the Influence and being Drunk in Public, her only two arrests prior to this offense.

At age 20 or 21 Terese reported realizing that she was “getting out of control” and sought the assistance of a psychiatrist who diagnosed her as suffering from “major depression.” She was immediately, and voluntarily, hospitalized for a period of two months.

Her treatment was of no benefit. She and her youngest brother rented an apartment together, and she worked at numerous menial jobs. She continued using marijuana and began injecting Demerol. Her brother had suffered an injury and was prescribed the drug that she, her brother, and their friends used. She engaged in heavy drug use for about one year before tiring of the lifestyle, and, at that point, made a decision to better herself.

At about age 22 Terese moved back to her paternal grandmother’s home and entered training to become a licensed practical nurse (LPN). Her choice of a profession was not the result of lofty ideals but based on the assumption that it offered job security and a decent income.

After completing a year’s training Terese became an LPN and obtained employment at a local hospital, where she would later be arrested for this offense. Her mother had remarried, and she and her new husband purchased a recreational motor home that they parked on their property. Terese moved into that motor home.

Terese’s first assignment was in the newborn nursery where she worked for six years. She reported that this was a wonderful period of her life when she felt “close to God.” It was a happy place filled with happy people. She took great comfort in holding and rocking an infant for long periods of time.

During her fifth year on the job, at age 27, Terese gave birth to her first and only child, a daughter. The father was the friend who she met in the eighth grade. She described their relationship as that of being "on-again, off-again." She described him as chronically unemployed and an alcoholic and claimed to have provided the stability in their relationship although she too continued regular marijuana use.

Her pregnancy was a surprise since she and her partner practiced birth control. Terese was less than thrilled with the idea of being a mother while her partner was ecstatic. Terese considered an abortion and even made and kept an initial doctor's appointment to that end; however, she did not go through with the abortion because she felt that it was morally wrong.

Terese's daughter was delivered by Cesarean. Terese stated that she abstained from marijuana and alcohol use during her pregnancy. She returned to work and her partner took care of their daughter. She characterized him as an enthusiastic, loving father who did a good job of caring for the child. At the same time she described him as unreliable and constantly under the influence of alcohol.

After the birth of her child Terese resumed the regular use of marijuana. In her sixth year as an LPN she was transferred to the adolescent psychiatric unit at the hospital. She found this assignment depressing and sought another transfer. She was eventually transferred to the physical rehabilitation unit that she enjoyed. This assignment also gave her access to the drug Placidyl which she began stealing.

In an incident in which the narcotics count in the unit came up short, all employees in the unit were ordered to submit to a urine test that Terese refused to take. She was fired but told her supervisor about her marijuana use. She was promised reemployment if she would undergo drug treatment. She attended a one-month, in-patient treatment program that she reported "getting little from." She returned to work and remained drug free for 9 or 10 months. She then began stealing prescription pads and used the narcotic identification number, as assigned by the Drug Enforcement Agency, of one of the doctors working in the unit to forge prescriptions for Demerol. During the next two years her habit got worse, and her addiction began to affect her work attendance. Her partner became the sole caretaker of their daughter. During this period drugs dominated her life, though she was able to maintain her employment.

She was transferred back to the newborn nursery but was soon fired for absenteeism. She described herself as being totally out of control. In the approximately two-month period between being fired

and her arrest Terese reports that her intravenous drug use became extremely heavy. Daily she would forge a prescription for Demerol and inject a solution made from 21 to 24 tablets. During that time she would return to the hospital to steal needles from the storage area in the nursery.

On the morning of her arrest she left her home about 5:00 A.M. to go to the hospital for a supply of needles. She claimed not to recall driving to the hospital, a distance of less than two miles, or taking the infant. Her first recollection was of standing in the stairwell holding the infant. She heard approaching hospital security officers and fled down the stairs. She claimed to have been searching for a place where she could sit down and figure out what to do when apprehended.

Terese denied wanting to steal the infant and had no explanation for her actions other than that she was under the heavy influence of drugs and may have been seeking the comfort that she got when she worked in the nursery. She denied wanting another child and reminded interviewers that she did not want her first child. She characterized herself as not being a bad mother but certainly not being a great mother. She claimed that she did always provide for her daughter but that the child's father did most of the parenting.

Analysis: It is also noted that several facts support Terese's claim of not planning this crime. She did not immediately leave the area of the nursery after taking the infant. She entered the stairwell she normally used when in the hospital stealing needles and only fled when she heard security officers approaching. There was no preparation for a new infant evident at her residence. The amount of narcotics used by Terese leading up to this crime and her state of mind argued against her being able to make a conscious decision regarding anything other than where she would obtain her next fix.

Could Terese's crime be classified as an atypical nontraditional infant abduction? What would have happened had she not been immediately arrested is unknown. When asked, she was unable to state what she would have done with the child; however, it can be speculated that, in a panic, she might have disposed of the child. She may have disposed of the child in such a way as to ensure a healthy and safe return of the child, or she may have disposed of the child in any way that would have ensured her own safety.

Turning to the hospital security and investigative review, several facts were learned. Having been an LPN who was employed at the hospital for 10 years, she had an ID and uniform and knew security controls including where cameras were located as well as exits and

entrances to the nursery. She did have a substance-abuse problem and was treated by the hospital intervention/treatment program. She completed the first phase of the program but not the second and was subsequently terminated from her job.

She went into the mother's room around 5:00 A.M. and told the mother that she was a nurse and needed to take the infant to the nursery. She took the infant and left the unit via the stairwell. She heard someone coming and continued to the basement level where she tried to leave by an exit. While she was in the office area of the radiology and medical-records department two staff members who were coming on duty noted the "nurse in uniform holding a baby." They realized that something was wrong and tried to approach her. She turned and ran in the opposite direction. The employees then called security. Security already had a report from the nursery and had activated their security plan that was to lock all exits. The abductor was apprehended in the basement while trying to exit the building.

Four days after she was apprehended and the abduction had been on the news, a law-enforcement officer called the hospital's security director and brought over a composite and a car make from an attempted abduction two weeks earlier at a nearby daycare center. In that situation the suspect tried to get a little girl to enter her car. Two weeks prior to that attempt, the little girl had been hospitalized at the healthcare facility where Terese had worked. The composite and car make matched the hospital abductor and her car; however, the abductor would not admit that she had either met the child during her hospitalization nor that she had tried to abduct her.

This added information suggested a higher level of suspicion about Terese's ability or willingness to tell the truth. More interviews were needed to uncover additional details to confirm her motivation and explain the high risk of trying to steal an older child.

National Center for Missing & Exploited Children

The National Center for Missing & Exploited Children (NCMEC), established in 1984 as a private, nonprofit organization, serves as a clearinghouse of information about missing and exploited children; provides technical assistance to the public and law-enforcement agencies; offers training programs to law-enforcement and social-service professionals; distributes photographs and descriptions of missing children worldwide; coordinates child-protection efforts with the private sector; networks with nonprofit service providers and state clearinghouses regarding missing-person cases; and provides information about effective legislation to help ensure the protection of children per 42 USC § 5771, 42 USC 5773(b)(1)(H), and 42 USC § 5780.

A 24-hour, toll-free telephone line, **1-800-THE-LOST (1-800-843-5678)**, is available in Canada, Mexico, and the United States for those who have information regarding missing and exploited children. The “phone free” number when dialing internationally is 00-800-0843-5678. The CyberTipline® is available worldwide for online reporting of these crimes at www.cybertipline.com. The TTY line is 1-800-826-7653. The NCMEC business number is 703-274-3900 within the United States. The business number when dialing from other countries is 001-703-522-9320. The NCMEC facsimile number is 703-274-2200. The NCMEC web-site address is www.missingkids.com.

For information regarding the services offered by our NCMEC branches, please call them directly in California at 714-508-0150, Florida at 561-848-1900, Kansas City at 816-756-5422, New York at 585-242-0900, and South Carolina at 803-254-2326.

Of special interest to readers looking for additional information about this topic is *For Healthcare Professionals: Guidelines on Prevention of and Response to Infant Abductions*. This guidebook and a number of publications, addressing various aspects of the missing- and exploited-child issue, are available free-of-charge in single copies by contacting the National Center for Missing & Exploited Children’s Publications Department at



Charles B. Wang International Children’s Building
699 Prince Street
Alexandria, Virginia 22314-3175
U.S.A.



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The Federal Bureau of Investigation's National Center for the Analysis of Violent Crime

The National Center for the Analysis of Violent Crime (NCAVC) is part of the FBI's Critical Incident Response Group. NCAVC combines investigative/operational support functions, research, and training in order to provide assistance, without charge, to federal, state, local, and foreign law-enforcement agencies investigating unusual, bizarre, or repetitive violent crimes. This effort is augmented in the field by more than 150 NCAVC Coordinators who provide a necessary and effective link between NCAVC and FBI field offices and local law enforcement.

NCAVC supports major violent criminal cases for all levels of law enforcement by providing the services noted below.

- Profiles of unknown offenders
- Crime analysis
- Personality assessments
- Threat assessments
- Investigative strategies
- Interview strategies
- Trial preparation and prosecutive strategies
- Support for search-warrant affidavits
- Expert testimony
- Coordination of other resources including the use of FBI Evidence Response Teams and FBI laboratory services

NCAVC staff members deploy, as necessary, to provide on-site assistance. Other assistance is provided through telephone communication or consultations where investigators travel to Quantico, Virginia.

NCAVC also serves the law-enforcement community by producing such resources as the Child Abduction Response Plan. This guide was developed to assist investigators in the very time-sensitive, life-threatening investigations involving child kidnapping.

The changing trends in violent criminal behavior necessitate continuous staff member training and research, which directly impacts on NCAVC's ability to provide useful crime analyses. NCAVC staff members conduct behaviorally based research in such areas as serial murder, weapons of mass destruction, sexual homicide, child abduction or sexual exploitation, threat assessment, serial rape, and school violence. Results of the research are incorporated into training and operational functions and shared with the law-enforcement community through presentations and publications in professional journals.

H.R. 3494, legislation passed in 1998, created the Morgan P. Hardiman Child Abduction and Serial Murder Investigative Resources Center (CASMIRC). CASMIRC is to provide investigative support through the coordination and provision of federal law-enforcement resources, training, and application of other multidisciplinary expertise to assist federal, state, and local authorities in matters involving child abductions, mysterious disappearance of children, child homicide, and serial murder across the country.

NCAVC works in close coordination with other federal agencies and organizations. In child exploitation or abduction matters, NCAVC maintains a strong liaison with the National Center for Missing & Exploited Children and the Office of Juvenile Justice and Delinquency Prevention within the U.S. Department of Justice.

Requests for services should be directed to the nearest FBI field office or

The National Center for the Analysis of Violent Crime

FBI Academy

Route 1

Quantico, Virginia 22135-0002

U.S.A.

703-632-4400

An Analysis of Infant Abductions

Introduction

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Recovery of Abducted Infants

Infant Abductions: Facility and Nursing Staff Response

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