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# Striving for a Secure Environment: A Closer Look at Hospital Security Issues Following the Infant Abduction at Loyola University Medical Center

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## INTRODUCTION

Lifting the baby boy out of the nursery bassinet and placing a coat over him, Vanecha Cooper smuggled the four-pound infant, undetected, past a nurses' station where they were buzzed out of the ward and past a security guard, as she left the Loyola University Medical Center in Maywood, Illinois.[1] Wearing a sensor bracelet around his ankle, 13-day-old Zquan Wakefield was whisked into the night with an alarm sounding behind him. A security door that should have closed and locked, preventing the abductor's escape with the child, malfunctioned.[2]

Despite the numerous measures to protect against infant abductions, Loyola's security system failed, tragically. By 7 a.m. the next day, Zquan was found dead at the abductor's home in a make-shift laundry hamper, where he had asphyxiated as a result of having clothing placed over him, apparently to prevent him from being detected.[3] The events surrounding the Wakefield abduction and subsequent death reveal the fallibility of humans and technology in protecting against the will of individuals intent upon their actions. This incident also serves as a wake-up call to hospitals regarding the importance of diligent

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1. Editorial, *Anatomy of a Tragedy*, CHI. SUN TIMES, May 4, 2000, at 35 (Late Edition) [hereinafter *Anatomy of a Tragedy*]; Jeremy Manier & Vanessa Gezari, *Baby Dies in Hospital Kidnap; Loyola's Security System and Police Actions Raise Questions*, CHI. TRIB., May 3, 2000, § 1, at 1; Jeremy Manier, Janan Hanna & Vanessa Gezari, *Baby Alive When Hidden from Police; Cops 'Followed Book' Probing Abduction, Official Says; Hospital Explains Security Failure*, CHI. TRIB., May 4, 2000, § 1, at 1.

2. Manier, Hanna & Gezari, *Baby Alive When Hidden from Police, supra* note 1, § 1, at 1.

3. *Abducted Baby May Have Died in Hamper*, CHI. SUN-TIMES, May 4, 2000, at 3.

oversight of security systems and procedures, as well as the costs associated with protecting even their smallest patients.

This article will discuss the events leading up to and following the Wakefield baby abduction,[4] as well as the more general security issues that affect the hospital environment.[5] It will then address the legal requirements that are in place to help prevent abductions and other acts of violence from occurring in facilities.[6] Next, this article will discuss other sources that help facilities to develop security policies and procedures.[7] Then, it will look at several cases where victims of crime or their families have sued hospitals for failure to provide a secure environment.[8] Finally, this article will focus on the consequences that hospitals and communities must face when facilities do not adequately ensure that patients, visitors and staff are safe from the violent actions of others.[9]

## I. Infant Abductions as a Hospital Security Concern

### *A. The Wakefield Abduction at Loyola University Medical Center*

Upon hearing the alarms in the nursery, Loyola University Medical Center ("Loyola" or "LUMC") nurses performed a head-count of the infants in the nursery and detected that a baby was missing.[10] Security personnel from the hospital arrived soon after the alarm was triggered and searched the building for an hour before calling the police.[11] When the police arrived, they reviewed the hospital security tapes and the list of approved visitors, and they interviewed hospital personnel.[12] This investigation led police to Vanecha Cooper, who had been captured on videotape leaving the nursery with a coat over her arm.[13] Police went to her home to question her, and she agreed to go to the police station to be interviewed further. Throughout the questioning, Cooper was helpful, according to police, and

4. *Infra* Part I.
5. *Infra* Part II.
6. *Infra* Part III.
7. *Infra* Part IV.
8. *Infra* Part V.
9. *Infra* Part VI.
10. Manier & Gezari, *Baby Dies in Hospital Kidnap, supra* note 1, § 1, at 1. *But see* Manier, Hanna & Gezari, *Baby Alive When Hidden from Police, supra* note 1, § 2, at 1 (disputing whether the initial head count detected a missing baby).
11. Manier & Gezari, *Baby Dies in Kidnap, supra* note 1, at 1.
12. *Anatomy of a Tragedy, supra* note 1, at 35.
13. Manier & Gezari, *Baby Dies in Hospital Kidnap, supra* note 1, at 1.

she denied knowing anything about the kidnapped infant.[14] It was not until 7 a.m. the next morning that officers searched her residence and found the baby dead in a large trashcan that was being used as a laundry hamper.[15]

The security system and the actions of Loyola staff and police garnered criticism from government officials and from the public.[16] The failure of a key technological element of Loyola's security system, a device that would close and lock the ward's security doors if a sensor passed a certain detector location, failed when it was most needed.[17] This alarm system had been broken several months before and had been falsely sounding, possibly leading staff to ignore it.[18] The public also criticized Loyola staff and security personnel for waiting an hour to contact police after they detected that Zquan Wakefield was missing.[19] This delay possibly allowed Ms. Cooper to escape more easily and take the child to her home.[20]

The failure of the police to perform a search of Vanecha Cooper's home when they went to question her also resulted in criticism.[21] Police stated that they did not have a search warrant to look for the baby, had no reason to believe that the child was in Cooper's house, and found her to be cooperative.[22] Newspaper stories conflict regarding whether during the first visit the officers asked to look around Cooper's home. Patrick Murphy, the Cook County public guardian, stated that police should have searched the home immediately, despite not having a warrant,

14. *Id.*

15. Janan Hanna, *Kidnapping Suspect's Bond Set at $2.5 Million*, CHI. TRIB., May 3, 2000, § 1, at 1 (Evening Update Edition).

16. *Anatomy of a Tragedy*, *supra* note 1, at 35.

17. In the first part of 2000, renovations to the LUMC nursery damaged the security system, which resulted in numerous false alarms, as many as five in a single morning, according to hospital officials. The problems were fixed in February 2000, and LUMC did not believe that the problems were related to the May 2000 failure. Manier & Gezari, *Baby Dies in Hospital Kidnap*, *supra* note 1, §1, at 1.

18. *Id.*

19. *Id.* Delays in reporting may be a "function of rejecting the thought that someone has actually stolen a baby," and can be a normal reaction in these situations. JOHN B. RABUN, JR., ANN W. BURGESS, & ELIZABETH B. DOWDELL, *Infant Abduction in the Hospital*, CREATING A SECURE WORKPLACE, EFFECTIVE POLICIES AND PRACTICES IN HEALTHCARE 277, 279 (1996).

20. Because law enforcement is "the key link between the primary incident (the abduction) and the outcome," their involvement is critical and necessary to recovering an abducted infant. *Id.*

21. Manier & Gezari, *Baby Dies in Hospital Kidnap, supra* note 1, §1, at 1.

22. *Id.*

even if it risked losing the criminal case against the defendant.[23] "At this point, you're interested in saving a baby's life, not in a conviction," Murphy said.[24]

Vanecha Cooper was charged with murder and aggravated kidnapping and held under a $2.5 million bond.[25] In a videotaped confession, Ms. Cooper stated that the baby was still alive when police arrived and she had placed him in the hamper.[26]

With just one technological glitch, Loyola faced being sued by the baby's family, losing Medicare and Medicaid funding, and causing the public's confidence in the security of the hospital to wane.

### *B. Related Abduction Statistics*

Infant abductions from hospital maternity wards, although not common, have occurred with increasing frequency over the past few years. According to a study of cases between 1983 and 1999, the number of infant abductions from various locations by nonfamily members ranges from zero to eighteen per year.[27] Of

23. *Id.* Although the seriousness of an offense cannot itself create an emergency situation that would justify a warrantless search, "kidnapping investigations present unusually compelling circumstances for emergency analysis" because the "life, freedom and future of a human being is at stake." Oliver v. United States, 656 A.2d 1159, 1167 (D.C. Cir. 1995). In that case, a woman posing as a nursing volunteer kidnapped a "boarder baby," an infant staying in the hospital after having been abandoned, from the maternity ward. *Id.* at 1160. The child was recovered when the alibis that the woman provided police were found to be untrue. *Id.* The police removed the baby without a warrant in order to test his identity and determined that the baby was indeed the abducted child. *Id.* at 1163. The court held that the entry and seizure of the baby were justified by exigent circumstances. *Id.* at 1171.

24. Manier & Gezari, *Baby Dies in Hospital Kidnap*, *supra* note 1, § 1, at 1.

25. Hanna, *Kidnapping Suspect's Bond Set at $2.5 Million*, *supra* note 15, at 1.

26. Vanessa Gezari, *Settlement in Hospital Kidnapping; Loyola Keeping Details a Secret*, CHI. TRIB., Aug. 18, 2000, § 2, at 1.

27. NATIONAL CENTER FOR MISSING AND EXPLOITED CHILDREN ("NCMEC"), FOR HEALTHCARE PROFESSIONALS: GUIDELINES ON PREVENTION OF AND RESPONSE TO INFANT ABDUCTIONS 1 (6th ed. Mar. 2000), *available at* http://www.ncmec.org [hereinafter NCMEC GUIDELINES]. The National Center for Missing and Exploited Children is an organization that provides assistance to parents, law enforcement, schools and the community in recovering missing children and raising public awareness about ways to help prevent child abduction, molestation, and sexual exploitation. The NCMEC has helped recover more than 48,000 children with a current recovery rate of 91 percent. For a more complete discussion of NCMEC guidance in preventing infant abductions, see *infra* notes 191-237 and accompanying text. According to a NCMEC press release, in 1999 there were no reported infant abductions from health care facilities. NCMEC, *Coordinated Response to Infant Abductions from Healthcare Facilities Pays Off, 1999 Marks Significant Milestone as Baby Kidnappings from Hospitals Decrease to Zero*, Jan. 6, 2000, *available at* http://www.ncmec.org/html/news_1999milestone.html.

the 187 infants abducted during that time period, 104 were kidnapped from hospital facilities.[28] Including the Wakefield kidnapping and an infant abduction from a Joliet hospital on August 14, 2000,[29] there have been eleven abductions from hospitals in Illinois since 1983.[30] Two of those kidnappings took place at Cook County Hospital.[31]

In the Joliet incident, a 19-year-old woman named Tessa Mitchell abducted an 8-day-old baby girl from the pediatric unit of Silver Cross Hospital and carried the infant in a duffel bag past staff and into the parking lot, where hospital employees stopped her.[32] A nurse on duty saw the woman in the pediatric unit with the duffel bag and a baby carrier.[33] When asked, Mitchell told the nurse that she was delivering some things to the baby's family. When the nurse saw her getting on the elevator a few minutes later, the nurse alerted security.[34] Employees were able to recover the infant, who suffered no harm. In a videotaped statement, Mitchell revealed that she had suffered a miscarriage early in the year and wanted a baby to replace that child.[35] A jury found Mitchell guilty of kidnapping, and on February 7, 2001, she was sentenced to thirteen years in prison.[36] While this case had a less tragic ending than the Wakefield abduction, it is nonetheless unsettling to potential patients and the community generally, that someone can successfully remove a child from a hospital maternity ward without attracting much attention. Clearly, incidents of this nature have a damaging effect on the public's confidence in hospital security.

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28. *Id.*

29. Nancy Munson, *Kidnap Try at Hospital Leaves Fear; Suspect's Bond Set at $200,000*, CHI. TRIB., Aug. 16, 2000, § 2, at 1 (Southwest Edition).

30. *Id.*

31. Jeremy Manier, *Abducted Baby Found Dead; Police Arrest Suspect after Boy Was Stolen from Hospital Ward*, CHI. TRIB., May 2, 2000, § 1, at 1.

32. David Heinzmann, *Hospital Averts Abduction of Infant; Joliet Nurse's Instincts Save 8-day-old Girl*, CHI. TRIB., Aug. 15, 2000, § 1, at 1.

33. *Id.* at 1.

34. *Id.*

35. David Heinzmann, *Suspect Seen on Videotape Telling Why She Took Baby; Jurors Hear Her Say She Had a Miscarriage*, CHI. TRIB., Dec. 9, 2000, § 1, at 5 (Southwest Edition). Apparently, Mitchell had originally claimed that she and the mother of the infant, Erica Knight, had staged the kidnapping so that the mother could sue the hospital for negligence. Both women lived in the same apartment complex and worked at Harrah's Casino. *Id.*

36. Nancy Munson, *Woman Gets 13 Years in Hospital Abduction*, CHI. TRIB., Feb. 8, 2001, § 1, at 6. Prosecutors also asked the judge to consider having Mitchell register as a sex offender after completing her prison term. *Id.*

As is the case with many crimes, experts have been able to develop a specific profile of the type of person who might kidnap an infant. According to the National Center for Missing and Exploited Children ("NCMEC"),[37] an organization that helps to recover abducted children, there are several factors common to individuals who abduct. Generally, this person:

1. is female and of childbearing age and is often overweight.
2. is likely compulsive and relies often on manipulation, lying and deception.
3. frequently indicates that she has lost a baby or is incapable of having one.[38]
4. is often married or cohabitating. The companion's desire for a child may be the motivation for the abduction.
5. lives in the community where the abduction takes place.
6. initially visits the nursery and maternity units at more than one health care 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 move to the home setting.
7. usually plans the abduction but does not necessarily target a specific infant. She frequently seizes on any opportunity present.
8. impersonates a nurse or other allied healthcare personnel.
9. often becomes familiar with healthcare personnel and with the victim's parents.
10. demonstrates a capability to provide "good" care to the baby once the abduction occurs.[39]

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37. *Supra* note 27 (providing an overview of the NCMEC).

38. Generally, persons who kidnap babies express a desire to "have a baby of their own." Manier, *Abducted Baby Found Dead, supra* note 31, at 1. However, a survey of 119 abductions from 1983 to 1992 revealed that about 12% of those babies were abandoned shortly after the abduction. Some of these infants were found in a hospital laundry bin, outside in the bushes, in a paper bag in an alley, in a gas station rest room, and in a church pew. The subsequent abandonment would seem to "suggest a general indifference to the welfare of the infant." RABUN, BURGESS & DOWDELL, *supra* note 19, at 279. Two of the babies were dropped by their abductors when security officers confronted the abductors on the hospital premises. *Id.*

39. *The Typical Infant Abductor*, NCMEC GUIDELINES, *supra* note 27. The third element, that the woman has lost a baby or is incapable of having one, was also the motivation for a woman to kidnap an infant in Detroit, Michigan on November 21, 2000. *Kidnapped Newborn Found Unharmed*, WASH. POST, Nov. 24, 2000, § 1, at 16. In that incident, a woman who falsely claimed to have been pregnant, and even had a baby shower thrown in her honor, kidnapped a two-day-old infant from his mother's room. Previously, the woman was seen loitering in the maternity ward and began talking to the infant's mother. *Id.* After spending a few hours together, the mother allowed the kidnapper to hold the baby while she went into the bathroom. *Id.* That was when the woman escaped with the child. *Newborn is Taken from Hospital Room*,

Interestingly, 24-year-old Vanecha Cooper nearly matched the typical profile of an infant abductor.[40] Police determined that she had suffered two miscarriages previously and told friends that she was pregnant and planned to have labor induced during the first week of May.[41] Prior to the abduction, Ms. Cooper had visited the Loyola maternity ward on several occasions because her name was on a list of family-approved visitors to the maternity ward by another family with a baby in the unit.[42] The staff had become accustomed to Ms. Cooper's presence in the ward and failed to see any warning signs. The tragic consequences, however, were unusual. The Loyola abduction is the only incident in Illinois that has resulted in the death of the infant,[43] and only the second such death in the country.

## II. Security Issues and the Hospital Environment Generally

While hospital incidents involving infant abductions receive considerable public attention,[44] other criminal acts within and around the hospital do not always create the same amount of publicity. By looking at the hospital environment, one can understand how, even with appropriate security measures, the likelihood of violent behavior is greater in these facilities than in other settings.

Citing Bureau of Labor Statistics data for 1993, the Occupational Safety and Health Administration ("OSHA") indicates that health care and social service workers had the highest incidence of assault injuries.[45] Furthermore, "almost two-thirds of

N. Y. Times, Nov. 23, 2000, § 1, at 27. The baby was recovered unharmed the following day, and during questioning, the kidnapper admitted to taking the child because relatives believed that she was due to deliver a baby. *Newborn Kidnapped at Hospital Found Alive*, Charleston Gazette, Nov. 23, 2000, News, at 12C.

40. *Anatomy of a Tragedy*, *supra* note 1, at 35.

41. Manier & Gezari, *Baby Dies in Hospital Kidnap*, *supra* note 1, at 1.

42. News Conference with Trisha Cassidy, Senior Vice President for System Development and Strategy, Loyola University Health System, *available at* http://www.luhs.org/feature/media.htm (last visited Mar. 1, 2001).

43. Jeremy Manier, *Abducted Baby Found Dead, supra* note 31, at 1.

44. More than eighteen articles were written in the Chicago area about the Wakefield abduction.

45. United States Department of Labor, Occupational Safety and Health Administration ("OHSA"), Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers [hereinafter OSHA Workplace Violence], *available at* http://www.osha-slc.gov/SLTC/workplaceviolence/ guideline.html (last visited Mar. 1, 2001). For an in-depth discussion of the OHSA Guidelines, see *infra* notes 165-190 and accompanying text.

nonfatal assaults occurred in nursing homes, hospitals and [facilities] providing residential care and other social services."[46] While people might ordinarily view the hospital as a refuge from violence[47] and a place for healing, numerous factors make the hospital a susceptible place for a variety of criminal acts, including violent behavior. OSHA states that health care workers face an increased risk of work-related assaults mainly because of unrestricted movement of the public in hospitals.[48]

As a result, problems from the outside world are taken into the hospital. Facilities have recognized the increasing prevalence of handguns and other weapons being brought into hospitals by patients or their families or friends.[49] Potentially 25% of patients who are treated in the emergency room are carrying weapons.[50] A survey of teaching hospitals revealed that, out of 128 hospitals, 46% confiscated weapons at least once a month.[51] One hospital reported that with the use of a metal detector, it confiscated more than 300 weapons in one month.[52]

Clearly, the emergency room presents the greatest opportunity for violence, as the department is easily accessible and at any time can be occupied by gang members, people addicted to drugs or alcohol, trauma patients and distraught family members.[53] Several factors in addition to weapons possession increase the potential for emergency department violence.[54] These

46. OSHA WORKPLACE VIOLENCE, *supra* note 45, at 5.

47. Susan Bruser, *Workplace Violence: Getting Hospitals Focused on Prevention*, AM. NURSE, May/June 1998, *available at* http://www.ana.org/rnnoharm/tan0205.htm (last visited Mar. 1, 2001).

48. OSHA WORKPLACE VIOLENCE, *supra* note 45.

49. *Id.*; STEPHEN B. GOLDBERG, MD & JOHN R. LION, MD, *Violence in the Emergency Department*, CREATING A SECURE WORKPLACE, EFFECTIVE POLICIES AND PRACTICES IN HEALTH CARE, 265, 268. A patient in a San Fernando Valley emergency room became violent after refusing treatment. Massie Ritsch, *Police Shoot Patient Who Had a Knife at Hospital; Violence: Man is in Guarded Condition at the Panorama City Facility*, L.A. TIMES, Jan. 16, 2001, § 2, at 2. While attempting to leave the hospital, he wielded a knife in the waiting area and threatened guards, doctors and nurses. *Id.* When police officers arrived, the man was shot multiple times with a stun gun and with lead pellets. The man responded with a "karate fly kick." *Id.* After subsequent attempts to pacify him failed, one officer fired his 9-millimeter pistol, hitting the man in the torso and the man fled. *Id.* The police were only able to apprehend the man after they slammed a door on his arm to force him to drop the knife. *Id.*

50. OSHA WORKPLACE VIOLENCE, *supra* note 45.

51. GOLDBERG & LION, *supra* note 49, at 268.

52. *Id.*

53. OSHA WORKPLACE VIOLENCE, *supra* note 45.

54. GOLDBERG & LION, *supra* note 49, at 267.

factors include: the emergency patient's emotional state,[55] the high rate of substance abuse by patients using the emergency room,[56] mental illness, medical illness, and lack of aggression management training of staff.[57] The lack of training can cause hospital staff to not be able to recognize when behavior of a patient or visitor is escalating and could lead to violence.[58] Also, long waits in emergency departments can increase frustration and impatience over the inability to receive care in a prompt manner.[59]

Other factors that may lead to violence in the hospital include: the availability of drugs and money at facilities such as hospitals, clinics or pharmacies, making them targets for drug addicts or robbers;[60] low staffing levels during times of increased activity in a facility, such as during visiting hours or meal times;[61] poorly lighted areas, such as parking areas or secluded corridors that could present criminals with the opportunity to harm someone when they are isolated from other people;[62] and the unrestricted movement of the public in these facilities.[63]

Nurses often become targets of violence in the hospital setting, as they have the most direct contact with patients and family or other visitors.[64] Frequently acts or threats of violence against nurses are considered to be "part of the job,"[65] but some

55. *Id.* Often patients go to the emergency department without prior warning and often are in emotional and physical distress.

56. *Id.* at 267 (indicating that since the mid-1970s, intoxication by alcohol or drug consumption has shifted from being the responsibility of the criminal justice system to that of the health care system).

57. *Id.*

58. *Id.* at 269 (stating that violence might be predictable based on behavioral cues, such as posture, speech and motor activity).

59. OSHA WORKPLACE VIOLENCE, *supra* note 45.

60. *Id.*

61. *Id.*

62. *Id.*

63. *Id.*

64. Bruser, *supra* note 47, at 1. The United American Nurses, a national labor union, adopted a resolution in June 2000 on preventing violence in the healthcare workplace. American Nurses Association & United American Nurses, June 2000 Resolution, *available at* http://www.ana.org/uan/2000res/unanviol.htm (last visited Mar. 1, 2001). Based upon findings that nurses suffer the largest number and highest rate of non-fatal workplace violence, the union resolved to advocate for stronger measures to prevent violence in the healthcare workplace, including: calling for an OSHA standard on violence; developing/sharing contract language to address violence; developing/sharing best practices for addressing and preventing violence; developing/sharing model legislative language for proposal at the state level. *Id.*

65. Bruser, *supra* note 47, at 1. More than 30% of nurses surveyed in 1998 from seven states reported having been the victims of workplace violence during the previ-

argue that changing that philosophy is critical to creating a safer environment.[66] Aside from physical and emotional injuries, violence can take a toll on productivity and well-being.[67] By recognizing and appreciating the dangers that exist on the hospital premises, facilities can establish ways to prevent violence from occurring against patients, staff and visitors.

## III. Security Measures Mandated by Federal and State Law

Part of the role of federal and state governments is to ensure that hospitals maintain appropriate security measures through licensure and Medicare certification. These standards do not present simply a one-time challenge that facilities must meet; rather, hospitals and other entities must continue to fulfill all of the established requirements in order to maintain licensure and accreditation.[68] As will be seen from the language of these laws, however, health care providers may find it difficult to glean sufficient guidance from the laws in working to develop adequate security procedures. Nevertheless, these laws provide a framework for creating and implementing a security plan that helps to ensure that facility patients and staff are protected from acts of violence.

### *A. Federal Law*

In its role as administrator of the Medicare and Medicaid programs, the Health Care Financing Administration ("HCFA") requires that hospitals meet certain standards in order to participate in these programs.[69] Section 1861(e)(9) of the Social Security Act specifically allows HCFA to promulgate regulations that address health and safety issues. As a result, HCFA has developed more than twenty "Conditions of Participation"

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ous year. Furthermore, more than 90% of the nurses surveyed defined "workplace violence" to include physical violence, such as kicking, pushing, slapping, physical violence with a weapon, sexual assault and verbal abuse. Victoria Carroll & Karen H. Morin, *Workplace Violence Affects One-Third of Nurses, Survey of Nurses in Seven SNAs Reveals Staff Nurses Most at Risk*, *available at* http://www.ana.org/tan/98sepoct.violence.htm (last visited Mar. 1, 2001).

66. Bruser, *supra* note 47, at 1

67. American Nurses Association, *Workplace Violence: Can You Close the Door on It?*, *available at* http://www.nursingworld.org/ dlwa/osh/wp5.htm (last visited Mar. 1, 2001).

68. 42 C.F.R. § 482.11 (2000).

69. *Id.* § 482.1.

that control various aspects of hospital operations.[70] Of particular relevance are the conditions that apply to licensing and safety issues.

Under 42 C.F.R. § 482.11, a hospital must comply with federal, state, and local laws. This includes any federal laws involving the health and safety of patients, state licensing issues, and relevant local ordinances.[71] This requirement necessarily involves HCFA's use of state surveyors in helping to determine whether facilities meet state requirements as well as Medicare regulations.[72]

Section 482.41 of the regulations establishes a condition of participation relating to the physical environment of the hospital. This condition requires that hospital be "constructed, arranged and maintained" to assure patient safety.[73] Accordingly, hospitals must be equipped with emergency mechanisms and procedures for fires or power outages, as well as the proper kinds of ventilation, light and temperature controls.[74]

The most relevant condition of participation that directly addresses patient safety was implemented in 1999 after the Clinton Administration began an initiative called "Reinventing Government."[75] The Administration's program included making changes to the health care industry as a result of concerns by the public, media and Congress, who identified a need to ensure basic protections for patient heath and safety in hospitals.[76] HCFA became involved in these initiatives in their efforts to revise some of the conditions of participation in order to focus more on outcomes of care.[77] In August 1999, a new condition of participation regarding patients' rights became effective, and requiring that hospitals create an environment for patients that affords them privacy and safety.[78] Accordingly, 42 C.F.R. § 482.13(c)(2) provides that "the patient has the right to receive care in a safe setting."

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70. 42 C.F.R. § 482.11 *et seq.* (2000)

71. *Id.* § 482.11 (2000).

72. 42 U.S.C. § 1395aa (1992); *infra* note 137 (discussing the role of the Illinois Department of Public Health).

73. 42 C.F.R. § 482.41.

74. *Id.*

75. Medicare and Medicaid Hospital Conditions of Participation, 62 Fed. Reg. 66,726, 66,726 (Dec. 19, 1997) (to be codified at 42 C.F.R. pt 482).

76. Medicare and Medicaid Hospital Conditions of Participation, 64 Fed. Reg. 36,070, 36,070 (July 2, 1999) (to be codified at 42 C.F.R. pt 482).

77. 62 Fed. Reg., at 66,726.

78. 42 C.F.R. § 482.13(c) (1999).

In the Federal Register notes, HCFA offered little additional information that might explain what this "safe setting" condition entails. In order to clarify this requirement for survey purposes, HCFA developed Interpretive Guidelines,[79] offering some additional insight into what constitutes a "safe setting." The Guidelines indicate that "the intention of this [safety] requirement is to specify that each patient receive care in an environment that a reasonable person would consider to be safe. For example, hospital staff should follow current standards of practice for patient environmental safety, infection control, and security. Additionally, this standard is intended to provide protection for the patient's emotional health and safety as well as his or her physical safety."[80] This guidance is important because it expands the requirements beyond previous standards, requiring only an appropriately maintained building or sprinkler system. Instead, this condition establishes a more general security requirement, which may include protection from criminal acts of violence, including infant abductions.

The HCFA Regional Office in the region in which a facility is located has the authority to terminate Medicare providers and suppliers from the Medicare program for failing to comply with the conditions of participation.[81] Where such deficiencies pose an "immediate or serious threat to patient health or safety," the state agency will begin monitoring the facility.[82] An "immediate and serious threat" is generally considered a crisis situation, where the health and/or safety of patients is at risk.[83] When such a threat is determined and is documented, the state agency and the Regional Office will complete termination procedures

79. UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, HEALTH CARE FINANCING ADMINISTRATION, QUALITY OF CARE STANDARDS, HOSPITAL CONDITIONS OF PARTICIPATION FOR PATIENTS' RIGHTS, INTERPRETIVE GUIDELINES, *available at* http://www.hcfa.gov/quality/4b2.htm (last visited Mar. 1, 2001).

80. *Id.* As part of these guidelines, HCFA also developed some procedures for surveyors to follow when evaluating hospitals pursuant to 42 C.F.R. § 482.13(c)(2). These include: 1) reviewing and analyzing patient and staff incident and accident reports prior to the survey to identify problems or patterns of incidents that would require investigation in a survey; 2) reviewing quality assurance, safety, infection control and security committee minutes and reports to determine if the hospital is identifying problems, evaluating those problems and taking steps to ensure a safe patient environment; 3) observing the environment where care and treatment are provided; and reviewing policy and procedures on what the facility does to curtail unwanted visitors or contraband materials. *Id.*

81. 42 C.F.R. § 489.53 (1997); STATE OPERATIONS MANUAL, HCFA Pub. 7 § SOM 3000.

82. STATE OPERATIONS MANUAL, HCFA Pub. 7 § SOM 3274.

83. STATE OPERATIONS MANUAL, HCFA Pub. 7 § SOM 3010.

within twenty-three calendar days.[84] Such a determination will result in an end to valuable Medicare and Medicaid funding. If a subsequent survey is conducted, and the deficiency no longer exists, the State Agency may certify that the immediate and serious threat has been removed and recommend that the termination action be rescinded, which the Regional Office has the authority to approve.[85]

### *B. The Role of the Joint Commission on Accreditation of Healthcare Organizations*

In addition to receiving help from state agencies, HCFA also recognizes accreditation by the Joint Commission on Accreditation of Healthcare Organizations ("Joint Commission") as automatic certification into the Medicare program.[86] The Joint Commission is a non-profit organization that evaluates and accredits hospitals, home care, long-term care and other kinds of providers across the country.[87] To earn and maintain accreditation, a hospital must undergo an on-site survey by a Joint Commission survey team at least every three years.[88]

As part of this accreditation process, the Joint Commission has established an entire program around patient safety, including creating guidelines for what are called "sentinel events." Such an event is an unexpected occurrence that involves death or serious physical or psychological injury or a risk of such an occurrence.[89] These events are called "sentinel" because they signal the need for immediate investigation and response.[90]

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84. *Id.*

85. *Id.*

86. 42 U.S.C. § 1395bb (1994); HCFA PROGRAM MANUALS, HCFA Pub. 10 § HO 147. When notified that a participating hospital has been accredited, the State Agency verifies the accreditation, removes the hospital from future resurvey schedules and discontinues any follow-up on deficiencies. STATE OPERATIONS MANUAL HCFA PUB. 7 § 605-74.

87. From the Joint Commission for Accreditation of Healthcare Organizations ("Joint Commission") website, *at* http://www.jcaho.org/aboutjc/facts.html (last visited Mar. 1, 2001) [hereinafter "Joint Commission website"]. The mission of the Joint Commission "is to continuously improve the safety and quality of care provided to the public through the provision of health care accreditation and related services that support performance in the improvement of health care organizations." *Id.*

88. *Id.*

89. JOINT COMMISSION, SENTINEL EVENT POLICY AND PROCEDURES 1 (June 2, 2000), *available at* http://www.jcaho.org/ sentinel/se_pp.html [hereinafter SENTINEL EVENT POLICY] (citing COMPREHENSIVE ACCREDITATION MANUALS FOR HOSPITALS: THE OFFICIAL HANDBOOK [hereinafter HANDBOOK]).

90. SENTINEL EVENT POLICY, *supra* note 89, at 1.

The goal of the Joint Commission's Sentinel Event Policy is to help improve patient care.[91] By motivating facilities that have experienced a sentinel event to consider the possible causes of the incident and make appropriate changes to prevent recurrence, the Joint Commission hopes "to increase the general knowledge about sentinel events and their causes, and to devise helpful strategies for prevention."[92] Accordingly, when the Joint Commission learns about an event either through facility self-reporting or other means, the information is stored in a database that analysts can review to determine methods to avoid these events from happening in the future.[93] The final goal of the sentinel event policy is to maintain the confidence of the public in the accreditation process.[94]

### 1. Sentinel Event Standards

The Joint Commission's *Comprehensive Accreditation Manual for Hospitals* outlines a number of standards that hospitals must fulfill in order to appropriately manage sentinel events in their facilities.[95] Most relevant are the following standards:

(a) Leaders must ensure that the processes for identifying and managing sentinel events are defined and implemented;[96]
(b) New or modified processes are well designed;[97]
(c) The organization collects data to monitor the performance of processes that involve risks or may result in sentinel events;[98]
(d) Undesirable patterns or trends in performance and sentinel events are intensively analyzed;[99] and
(e) The organization identifies changes that will lead to improved performance and reduce the risk of sentinel events.[100]

Pursuant to these standards, each facility must define "sentinel event" for its own purposes and communicate that definition

91. *Id.*
92. *Id.* at 2.
93. JOINT COMMISSION, *Facts about Patient Safety*, at 2, *available at* http://www.jcaho.org/sentinel/safety.html (last visited Mar. 1, 2001) [hereinafter *Facts about Patient Safety*].
94. SENTINEL EVENT POLICY, *supra* note 89, at 2.
95. *Id.*
96. *Id.* (referring to HANDBOOK, at STANDARD LD.4.3.4).
97. *Id.* (referring to HANDBOOK, at STANDARD PI.2).
98. *Id.* at 3 (referring to HANDBOOK, at STANDARD PI.3.3.1).
99. *Id.* (referring to HANDBOOK, at STANDARD PI.4.3).
100. *Id.* (referring to HANDBOOK, at STANDARD PI.4.4).

to the entire organization.[101] Then, the facility must create a process to identify, report and manage these events.[102] This includes developing a process for conducting a "root cause analysis" if a sentinel event does occur.[103] A "root cause analysis" is a process for "identifying the basic or causal factors that underlie variation in performance."[104] It focuses not on individual performance, but on systems and processes. A "root cause analysis" also helps to identify potential improvements to decrease the likelihood of such events occurring in the future.[105] After conducting a "root cause analysis," the facility will essentially have an action plan to help in these improvements.[106] The Joint Commission suggests that the action plan should designate someone who will be responsible for implementation, oversight, pilot testing, time lines and strategies for measuring the effectiveness of the procedures.[107]

While reporting of sentinel events is required of accredited facilities, a subset of events is subject to review by the Joint Commission and may be reported to the Joint Commission on a voluntary basis.[108] Only those sentinel events that affect recipients of care, such as patients, clients, residents, and meet certain criteria are part of this category. Reporting is voluntary if the event resulted in an unanticipated death or major permanent loss of function, not related to the natural course of the patient's illness or underlying condition.[109] Also, a facility may self-report if the event is one of the following: suicide of a patient in a setting where the patient receives around-the clock care; infant abduction or discharge to the wrong family; rape; hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities; or surgery on the wrong patient or the wrong part.[110]

If the Joint Commission learns about a sentinel event through self-reporting or otherwise, such as from a patient or through the media, and that event is reviewable, the organization must prepare an analysis and action plan within forty-five days of the

101. *Id.* at 2 (discussing the intent of HANDBOOK STANDARD LD.4.3.4).
102. SENTINEL EVENT POLICY, *supra* note 89, at 4.
103. *Id.* at 2. (discussing the intent of HANDBOOK STANDARD LD.4.3.4).
104. *Id.* at 4.
105. *Id.*
106. *Id.*
107. *Id.*
108. *Id.* at 5.
109. *Id.*
110. *Id.*

event or becoming aware of the event.[111] Then, the organization must submit these documents to the Joint Commission or otherwise provide the Joint Commission with an evaluation of its response to the sentinel event under an approved protocol within forty-five days of the known occurrence of the event.[112]

### 2. Infant Abductions as a Sentinel Event

The Joint Commission considers infant abductions to be a sentinel event, involving all of the necessary review that should take place for such events. On April 9, 1999, the Joint Commission released a Sentinel Event Alert discussing the eight cases of infant abduction that it had reviewed for the three previous years, as well as identifying the root causes for these incidents.[113] In those cases, all of the abductions took place in hospitals that had more than 400 beds, and five of the infants were taken from their mothers' rooms.[114] All of the abductors were female, and in three cases, the women impersonated a nurse or aide.[115] In the other cases, the abductor pretended to be a volunteer, physician or the infant's mother.[116] Generally, the babies were abducted "when they were taken for testing, during return to the nursery, when left unattended in the nursery or while a mother was napping or showering."[117] Four cases occurred during the day shift, two occurred during the evening shift and two occurred during the night shift.[118]

In evaluating the root causes for these incidents, the Joint Commission determined that all of the hospitals indicated that unmonitored elevator or stairwell access to the postpartum and nursery areas was a root cause of the abduction.[119] The Sentinel Event Alert identified six other areas that contributed to the incidents occurring:

(a) Security equipment factors, because equipment was not available, not operational or not used as intended.

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111. SENTINEL EVENT POLICY, *supra* note 89, at 7.

112. *Id.*

113. SENTINEL EVENT ALERT, *Infant Abductions: Preventing Future Occurrences*, at 1, Apr. 9, 1999, *available at* http://www.jcaho.org/edu%5Fpub/sealert/sea9.html [hereinafter SENTINEL EVENT ALERT].

114. *Id.*

115. *Id.*

116. *Id.*

117. *Id.*

118. *Id.*

119. *Id.*

(b) Physical environment factors, such as no line of sight to entry points, or elevator or stairwell access was unmonitored.
(c) Inadequate patient education.
(d) Staff-related factors, such as insufficient orientation or training, competency or credentialing issues and insufficient staffing levels.
(e) Information-related factors, such as birth information published in local newspapers, delays in notifying security when an abduction was suspected, improper communication of relevant information among caregivers, and improper communication between hospital units.
(f) Organization cultural factors, such as reluctance to confront unidentified visitors or providers.[120]

The Sentinel Event Alert also listed a number of strategies to reduce the risk of infant abductions from hospital facilities. These strategies complement guidelines developed by the National Center for Missing and Exploited Children ("NCMEC"), which will be discussed in more detail below.[121]

### 3. Security Standards

The Joint Commission also has developed security guidelines as part of their "Environment of Care" standards[122] that hospitals must fulfill in order to be accredited by the organization. Joint Commission Standard EC.1.2 requires facilities to identify how they establish and maintain security procedures to protect patients, visitors and staff from harm.[123] The standard requires that facilities: develop a security plan to address issues relating to patients, visitors, personnel and property;[124] develop processes for reporting and investigating all security incidents;[125] require proper identification of patients, visitors and staff;[126] and maintain controlled access and egress from sensitive areas, as determined by the facility.[127] The security plan should also es-

120. SENTINEL EVENT ALERT, *supra* note 113, at 1-2.
121. *See infra* notes 191-237 and accompanying text (reviewing the guidelines developed by the NCMEC).
122. Generally, the Environment of Care Standards are: general safety, security, hazardous materials and wastes (including infectious waste), emergency management, fire safety, medical equipment and building utilities.
123. HANDBOOK, *supra* note 89, at STANDARD EC 1.2.
124. *Id.* at STANDARD EC.1.2(a).
125. *Id.* at STANDARD EC.1.2(b).
126. *Id.* at STANDARD EC.1.2(c).
127. *Id.* at STANDARD EC.1.2(d).

tablish orientation and education programs on security issues.[128] Facility procedures should be developed to monitor staff performance relating to their knowledge of and skills and participation in security procedures, including: adequate monitoring and inspection methods, emergency and incident reporting, and preventive maintenance and testing of equipment.[129]

The plan should also create a process for an annual evaluation that will review the security-management plan's objectives, scope, performance and effectiveness.[130] A process should also be created to designate facility leaders to develop, implement and monitor the security management plans;[131] and to provide vehicular access to the urgent care area. Finally, the plan should create emergency security measures, that will address: actions taken in the event of a security incident or failure, the handling of civil disturbances and situations involving VIPs or the media, and the provision of additional staff to control human and vehicle traffic in and around the environment during disasters.[132]To evaluate whether a facility has met these guidelines, the Joint Commission, as part of a survey, might interview staff members and review management plans and emergency procedures.[133]

### 4. Office of Quality Monitoring

The Joint Commission also maintains an Office of Quality Monitoring that receives complaints from patients, facility staff and government agencies about patient safety.[134] This information is either: incorporated into the quality monitoring database that is used to track health care organizations over time to identify trends or patterns in their performance; reviewed before the health care facility is asked to provide a written response to the complaint; reviewed for compliance with related standards at the time of the organization's next accreditation survey, if it is scheduled in the near future; or used as a basis for conducting an unannounced on-site evaluation of the organization, if the com-

128. *Id.* at STANDARD EC.1.2(i).
129. *Id.* at STANDARD EC.1.2(j).
130. *Id.* at STANDARD EC.1.2(f).
131. *Id.* at STANDARD EC.1.2(e).
132. *Id.* at STANDARD EC.1.2(g).
133. HANDBOOK, *supra* note 89, at STANDARD EC.1.2 (providing examples of evidence of performance).
134. JOINT COMMISSION, *Office of Quality Monitoring*, *at* http://www.jcaho.org/govt/pubaccount.html (last visited Mar. 1, 2001).

plaint raises serious concerns about a continuing threat to patient safety or continuing failure to comply with standards.[135]

### C. *Illinois Law*[136]

The laws and regulations enacted by the Illinois General Assembly and the Illinois Department of Public Health[137] ("Department") also establish requirements that hospitals must meet in order to be licensed by the State of Illinois. These laws provide some additional insight into developing security plans that will help prevent criminal acts harmful to hospital patients, including infant abductions.

The Illinois Hospital Licensing Act[138] was drafted to "provide for better protection of the public health through the development, establishment and enforcement of standards."[139] The law states that these standards are intended "for the care of individuals in hospitals; and for the construction, maintenance and operation of hospitals, which will promote safe and adequate treatment of patients."[140] The Act also sets standards to help determine that a person establishing a hospital has the qualifications, background, character and financial resources to adequately provide an appropriate level of hospital service for the community.[141] To determine that facilities meet all of the licensure requirements, the Department may conduct investigations and inspections as it deems necessary.[142]

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135. *Id.*

136. This article will discuss security requirements under Illinois law, as it is most relevant to the abduction at Loyola University Medical Center.

137. The mission of the Illinois Department of Public Health ("IDPH") is to promote health through the prevention and control of disease and injury. IDPH, *About the Department, An Overview, at* http://www.idph.state.il.us/about/overview.htm (last visited April 24, 2001). Depending on the health care provider, the IDPH, through its Office of Health Care Regulation, may license, inspect or certify those providers that must comply with state and federal regulations. IDPH, *About the Department, Office of Health Care Regulation, at* http://www.idph.state.il.us/about/ohcr.htm (last visited April 24, 2001). Some of the entities subject to review under the IDPH include: ambulances, breath test monitors, certified nurse aids, health maintenance organizations, home health agencies, hospices, hospitals, laboratories, nursing homes, poison control centers and trauma centers. *Id.*

138. 210 ILL. COM. STAT. 85/1 et seq. (West 2000).

139. 210 ILL. COM. STAT. 85/2(a) (West 2000).

140. *Id.*

141. *Id.*

142. 210 ILL. COM. STAT. 85/9 (West 2000).

### 1. Facility Design and Maintenance

As part of the licensing requirements established in the Illinois Administrative Code, like the HCFA conditions of participation, Illinois law requires that hospitals meet certain design and construction requirements that afford adequate security to facility occupants. Such requirements include that doors to patient rooms not be lockable from the inside[143] and that electronic locking devices on doors "may be installed at specific locations to restrict egress or ingress for patient/staff safety or security" upon approval by the Illinois Department of Public Health.[144] To receive the Department's approval:

(a) The facility must submit a narrative to the Department providing a rationale for having a locked door in a required means of egress. The rationale must relate to *security issues.*
(b) The building must be protected by a sprinkler or fire detection system approved by the Department.
(c) All locking system components must be U.L. listed.
(d) Cross corridor, smoke or control doors that are located in a required means of egress may only be secured with electronic locks and automatic release devices. The use of manual keys or tools only to unlock the door is not permitted.
(e) Locked doors must have continuous staff supervision (direct or electronic remote).
(f) No other type of locking arrangement may be used in a required means of egress.
(g) All locked doors must release automatically with actuation of the fire alarm system.
(h) All doors must release automatically with loss of electrical power to the locking device.
(i) All locks must initiate an irreversible process that will release the lock within fifteen seconds whenever a force of not more than fifteen pounds is continuously applied to the release device for a period of not more than three seconds.
(j) Permanent signs must be posted on locked doors that state: "Push until alarm sounds. Door will be opened in fifteen seconds." Signs may be omitted for security reasons based on review of the hospital's written rationale.
(k) Emergency lighting must be provided at all locked door locations.

143. 77 Ill. Adm. Code § 250.2450(c)(1) (1995).
144. 77 Ill. Adm. Code § 250.2450 (1995).

(l) The local fire department must be fully apprised of locked doors or units and all related details of the system.
(m) Any discharge exit door may be locked against entry.
(n) No additional electronic release of locked doors initiated from a staff duty station is to be provided.
(o) No more than one device may be installed in any path of travel to exit discharge.[145]

### 2. Staff and Hiring Procedures[146]

Visitors are not the only persons who commit crimes in the hospital setting. Hospital staff can also be the perpetrators of violent or criminal acts in this environment. As part of the hospital licensing requirements in Illinois, the regulations indicate that hospitals must perform background checks of all health care workers before hiring them.[147] If a hospital subsequently learns that a health care worker has violated one of the twenty-seven offenses listed in the regulation, the hospital may not retain that person as an employee.[148] Some examples of such offenses include murder, manslaughter, concealment of a homicidal death, kidnapping or child abduction, unlawful restraining or forcible detention, sexual exploitation of a child, assault, battery, aggravated stalking, home invasion, sexual assault or abuse, or armed violence.[149]

Hospital personnel, like visitors and patients, also need protection from individuals who commit violent crime in the hospital and possibly harm or abduct someone. Any security plan developed by a facility must take into consideration possible violent behavior from distraught family members, frightened patients or disgruntled ex-employees.

### 3. Illinois Requirements for Infant Abductions

The Hospital Licensing Act specifically requires that hospitals create procedures addressing infant abductions. Specifically, 210 ILCS 85/6.15 requires that every hospital demonstrate to the Department that the hospital has adopted procedures:

145. 77 Ill. Adm. Code § 250.2450(c)(2).
146. The Department has also implemented licensing regulations requiring facilities to draft nursing policies and procedures that include policies on patient safety. 77 Ill. Adm. Code. § 250.1030(c)(7) (1980).
147. 77 Ill. Adm. Code § 250.435(a) (2000).
148. 77 Ill. Adm. Code § 250.435(b).
149. For the entire listing of offenses, see 77 Ill. Adm. Code § 250.435(a)(1)-(27).

1) designed to reduce the likelihood that an infant patient will be abducted from the hospital. These procedures may include but need not be limited to, architectural plans to control access to infant care areas, video camera observation of infant care areas, and procedures for identifying hospital staff and visitors.
2) designed to aid in identifying allegedly abducted infants who are recovered. The procedures may include, but need not be limited to footprinting infants by staffs that have been trained in that procedure, photographing infants, and obtaining and retaining blood samples for genetic testing.[150]

Accordingly, the Department promulgated regulations that address staffing and visiting procedures in the nursery or maternity ward. Section 250.1830 requires that one nursing staff person be available for every six to eight normal infants in the nursery,[151] and that infants never be left unattended.[152] Visitors must be limited to two per patient at any one time.[153] Any contact with the infants also limited to the father or one other adult selected by the mother.[154] Siblings and grandparents may have contact with the infant only if the hospital has established specific policies and procedures for such a program that require: approval of the program by the hospital's Infection Control Committee and Governing Board; requirement for written consent of the mother for visitation by siblings or grandparents; a procedure for visitor hand washing prior to having contact with the infant; and a policy about where visitation will occur.[155]

The Department has also prescribed standards to assure proper identification of infants,[156] which can be helpful in the event that a baby is kidnapped. Accordingly, the regulations require that facilities place identical bands on the mother and on the infant while both are still in the delivery room.[157] The nurse in charge of the delivery room is responsible for preparing and securely fastening the identification bands to the infant's wrist

150. 210 ILL. COMP. STAT. 85/6.15 (West 1996).
151. 77 Ill. Adm. Code § 250.1830 (1996).
152. *Id.*
153. 77 Ill. Adm. Code § 250.1830(k)(2) (amended by 20 Ill. Reg. 3234, *eff.* Feb. 15, 1996).
154. *Id.*
155. 77 Ill. Adm. Code § 250.1830(k)(4) (1996).
156. 77 Ill. Adm. Code § 250.1830(g)(6)(A) (1996). The Illinois Department of Public Health has adopted guidelines recommended by the American Academy of Pediatrics.
157. *Id.*

or ankle.[158] These bands should state the gender of the infant and the date and time of birth.[159] Then, the birth records and identification bands should be checked by both the nurse and the responsible physician before the baby leaves the resuscitation area of the delivery room.[160] When the baby is admitted to the nursery, both the delivery room nurse and admitting nurse should check the identification bands and birth records, and verify the gender of the baby and sign the baby's record.[161] The admitting nurse should fill out the bassinet card and attach it to the bassinet.[162] Visits to the mother should include her verification of information on the identification bands. Generally, maternity staff should "be meticulous in preparation and placement" of identification bands and records.[163]

The regulations also suggest additional identification measures, such as footprinting, fingerprinting or sophisticated blood typing.[164]

Clearly, identification and visitation rules will help to prevent abductions from occurring in facilities. However, it should be noted that Loyola University Medical Center had such procedures in place when the Wakefield baby was abducted from the neonatal ward. Increased supervision may be the only way to ensure that infants are protected from individuals who seek to abduct them.

## IV. Other Resources Providing Guidance in Developing Security Procedures

While the federal and state law set out requirements that hospitals must fulfill, the language of the laws is general enough so that each facility can develop a tailored security plan that will apply specifically to the resources of that facility, including building layout and type of health services that it provides. Different security measures may be necessary for a hospital located in an area with a high crime rate as opposed to one located in a safer neighborhood. Sometimes facilities find it difficult to divine the government's expectations, which can lead to the loss of licensure or Medicare funding. Fortunately, other sources offer

158. 77 Ill. Adm. Code § 250.1830(g)(6)(A).
159. *Id.*
160. *Id.*
161. *Id.*
162. *Id.*
163. *Id.*
164. *Id.*

helpful information that facilities can use to devise security procedures that meet the government's expectations. This information is generally offered only as guidance to facilities and is not mandated by law.

### *A. Preventing Hospital Violence: OSHA Guidance*

In 1996 the Occupational Safety and Health Administration ("OSHA") developed Workplace Guidelines ("Guidelines") to help prevent workplace violence for health care workers.[165] While these guidelines do not create a new standard that facilities must meet pursuant to the Occupational Safety and Health Act of 1970,[166] OSHA encourages facilities to establish violence prevention programs and evaluate their effectiveness.[167] Interestingly, although these guidelines are not mandated, health care facilities may be cited for failure to meet OSHA's "General Duty Clause," which requires that "each employer furnish to each of his employees' employment and a place of employment which are free from recognized standards that are causing or are likely to cause death or serous physical harm to his employees."[168] However, OSHA will not cite employers who have effectively implemented the workplace guidelines."[169]

Pursuant to this guidance, OSHA identifies four components to an effective program to help prevent violence in facilities: management commitment and employee involvement, worksite analysis, hazard prevention and control, and health and safety training.[170]

#### 1. Management Commitment and Employee Involvement

OSHA emphasizes that the commitment of management and employees to a security plan is critical, because the entire organization is needed to work together develop a safe environment for the entire staff.[171] Such a plan should include a demonstrated organizational concern for employees' emotional and physical safety, as well as assignment of responsibility to various individuals to ensure that everyone understands his or her obligations

165. OSHA WORKPLACE VIOLENCE, *supra* note 45.
166. Occupational Safety and Health Act of 1970, Pub. L. No. 91-596 § 2, 84 Stat. 1590 (1970) (codified as amended at 29 U.S.C. § 654(a)(1)).
167. OSHA WORKPLACE VIOLENCE, *supra* note 45.
168. Occupational Safety and Health Act of 1970, § 2.
169. OSHA WORKPLACE VIOLENCE, *supra* note 45.
170. *Id.* at 7.
171. *Id.*

under the plan.[172] OSHA also suggests a system of accountability for managers, supervisors and employees.[173] Comprehensive medical and psychological counseling should also be available to employees who experience or witness assaults and other violent incidents.[174]

Employees should also become involved in the violence prevention program by reporting violent incidents and participating on committees or teams that receive reports violent incidents and make recommendations for corrective strategies.[175] Education programs will ensure that employees understand and comply with security measures and use techniques to identify a person's escalating agitation or assaultive behavior and the appropriate responses to such behavior.[176]

Through a written program for safety and security, facilities should implement a clear zero-tolerance policy against violence, verbal and nonverbal threats and other similar behavior.[177] Having such a policy requires that all staff, patients and visitors must be notified of the policy when they arrive at the facility. Health care facilities should also ensure that employees are not retaliated against for reporting incidents.[178]

### 2. Worksite Analysis

A worksite analysis, according to OSHA, is "step-by-step, commonsense look at the workplace to find existing or potential hazards for workplace violence."[179] Such a process entails conducting a detailed analysis of past incidents of violence, jobs or locations in the facility that are under the greatest risk of violence, types of clients or patients that pose the greatest risk, and the effectiveness of existing security measures.[180] This analysis will help the facility appreciate all of the current problems that need to be addressed in a comprehensive security plan.

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172. *Id.* at 8.
173. *Id.*
174. *Id.*
175. *Id.*
176. *Id.*
177. *Id.*
178. *Id.*
179. *Id.* at 9.
180. OSHA WORKPLACE VIOLENCE, *supra* note 45, at 11.

### 3. Hazard Prevention and Control

The next step, hazard prevention and control, requires using the worksite analysis to devise a plan to make any necessary changes to prevent harm in the future.[181] From the standpoint of the physical environment, changes might include: installing alarm systems, panic buttons and metal detectors; using closed-circuit video recording in high risk areas; placing curved mirrors at hallway intersections or concealed areas; and creating waiting rooms designed to maximize comfort and minimize stress. Facilities might also install bright, effective lighting indoors and outdoors; place nursing stations behind bullet-proof glass; and provide employee "safe rooms" in cases of emergency.[182]

Appropriate procedures should then be implemented to ensure that administrative and work practices help create a safe environment.[183] These include: notifying staff, patients and visitors that violence is not tolerated; instituting sign-in procedures with passes for visitors particularly in newborn nurseries or pediatric units; prohibiting employees from working alone in the emergency room or secluded areas; ensuring adequate and qualified staff coverage at all times; providing timely information to those persons waiting in waiting rooms; adopting measures to decrease waiting times; providing staff with identification badges showing that they are employees; and discouraging staff from wearing jewelry that could possibly be used to harm them.[184]

Procedures should also be developed to handle problems that occur as a result of the violent incident.[185] This includes setting up post-incident planning that entails obtaining medical treatment and trauma-crisis counseling for victims and witnesses.[186]

### 4. Training and Education

Finally, facilities should provide training and education to employees so that they can appreciate security hazards and learn how to protect themselves and others.[187] Accordingly, "every employee should understand the concept of 'Universal Precau-

181. *Id.*
182. *Id.* at 12.
183. *Id.*
184. *Id.* at 14.
185. *Id.* at 14-15.
186. *Id.*
187. *Id.* at 15.

tions for Violence,' that violence should be expected but can be avoided or mitigated through preparation."[188] Such training should be provided as part of orientation to new employees and then annually for the entire staff.[189]

The topics that OSHA suggest should be addressed in training include: the violence prevention policy, risk factors and warning signs that a person might act with violence, ways of diffusing volatile situations, response plans for violent situations, location of safety devices and alarms, "buddy systems," and policies and procedures for recordkeeping, and post-incident services.[190]

While most of these guidelines are directed specifically at facilities and their employees, many of the suggestions would also benefit patients and visitors and prevent them from being harmed by a violent person.

### *B. Preventing Infant Abductions: Guidance from the Joint Commission on Accreditation of Healthcare Organizations and the National Center for Missing and Exploited Children*

The Joint Commission, as discussed previously, considers infant abductions from hospitals to be sentinel events.[191] Through analysis of these incidents, the Joint Commission has developed strategies to help prevent infant abductions from the hospital environment. These strategies are enhanced by the protocols and guidelines developed by the National Center for Missing and Exploited Children ("NCMEC"),[192] a non-profit organization that helps recover missing children and raises public awareness about ways to prevent child abduction, molestation and sexual exploitation.[193] The guidance of both organizations provides a valuable resource to hospitals in developing a security plan that strives to prevent opportunities from arising for a potential infant abductor.

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188. *Id.* at 16.

189. *Id.*

190. *Id.* at 16-17.

191. SENTINEL EVENT POLICY, *supra* note 89; *see also* notes 95-121 and accompanying text (defining "sentinel event" and outlining a number of standards that hospitals must fulfill in order to appropriately manage sentinel events in their facilities).

192. NCMEC GUIDELINES, *supra* note 27. Following the abduction of Adam Walsh in 1981, his parents sought help from a national source that could help them locate their son. Discovering that no such organization existed, Adam's father, John Walsh co-founded the National Center for Missing and Exploited Children in 1984.

193. NCMEC, *About NCMEC*, *at* http://www.ncmec.org/html/history.html (last visited Mar. 1, 2001).

### 1. Prevention Guidelines

As part of its efforts, NCMEC has established its *Guidelines on Prevention of and Response to Infant Abductions*[194] to help health care professionals address this issue and respond appropriately if such incidents occur in their facilities.[195] The focus of an appropriate and useful plan includes developing a comprehensive program of policy, procedures and processes; offering education for and encouraging teamwork among nursing staff, parents, physicians, security and risk management personnel; and coordinating various elements of physical and electronic security.[196] Planning and coordinating efforts to this degree will help to create a secure environment and to deter abduction incidents. In addition to identifying the "typical abductor,"[197] the guidelines discuss various real-life scenarios that led to infants being abducted. As a result, the suggested procedures are placed in context, which aids in developing a more realistic security plan.

As part of its multidisciplinary approach, NCMEC views nurses as the main focus of these security programs because they have direct contact with the infants and are charged with watching over them.[198] The guidelines emphasize that nurses are "'surrogate parents' and the front line of defense" in preventing individuals from abducting them from the facility.[199] Staying alert and watching over the babies are the most important ways for nurses in the maternity ward to prevent abductions from happening. Electronic security methods should be viewed as "simply modern tools used to back up hospital policies and practices."[200] NCMEC suggests that these devices should not be relied upon as the sole method of creating a secure nursery or pediatric ward, but that these systems, when properly installed, can help deter an abduction.[201]

194. NCMEC GUIDELINES, *supra* note 27.
195. *Id.* at 9.
196. *Id.*
197. *See supra* notes 37-39 and accompanying text (outlining characteristics of the "typical abductor").
198. NCMEC GUIDELINES, *supra* note 27, at 9.
199. *Id.*
200. NCMEC GUIDELINES, *supra* note 27, at 9.
201. *Id.* Following the Wakefield abduction an editorial criticized Loyola University Medical Center for putting too much weight in the technological security systems. "No electronic gizmo can substitute for an alert staff who know their charges by name and know who should, and shouldn't be hovering over each bassinet." Editorial, *Loyola's Painful Lesson on Safety*, CHI. TRIB., May 11, 2000, § 1 at 30.

Both the Joint Commission and NCMEC suggest that facilities develop a written proactive prevention plan addressing the abduction issue.[202] Such a plan includes identification of the infant and of hospital staff, a process to transport the infant, education of staff and parents, confidentiality of the mother and the infant, and additional security devices to control access into the nursery area.

### 2. Identification

#### *Infant Identification*

NCMEC and the Joint Commission suggest that immediately after a baby is born, identical identification bands should be attached to the infant on the wrist or ankle, and to the mother and the father or significant other.[203] The baby's band should be verified with the mother when taking the infant for care and when the infant is returned to the mother after care has been given.[204] Before removing the baby from the birthing room, hospital staff should take additional steps to ensure that they have adequate identification records of the infant in the event that the baby is kidnapped, by either footprinting, taking a clear high-quality color photograph or performing and recording a physical assessment of the baby.[205] Facilities may also store a sample of the infant's blood until at least the day after the infant's discharge.[206] All of this information should be noted in the baby's medical chart.[207]

#### *Staff Identification*

Staff identification is also an important aspect of an effective security plan. Often, abductors pose as a nurse or aide, and if staff and parents are educated to understand that persons handling the baby should have the proper identification, abductions may be prevented. Therefore, hospital staff should have up-to-date, color photo identification badges that are worn conspicu-

202. SENTINEL EVENT ALERT, *supra* note 113, at 2; NCMEC GUIDELINES, *supra* note 27, at 12.

203. NCMEC GUIDELINES, *supra* note 27, at 12-13; SENTINEL EVENT ALERT, *supra* note 113, at 2.

204. NCMEC GUIDELINES, *supra* note 27, at 13.

205. *Id.* at 13-14.

206. *Id.* at 13.

207. *Id.*

ously.[208] NCMEC also suggests that personnel, including physicians, who are in direct contact with the infants should wear a form of unique identification used only by them and known to the parents.[209] Ideally, this will let parents know whom they can trust with the baby.[210]

### 3. Transporting the Infant

Hospitals should also develop procedures to protect infants when they are being transported within the facility. NCMEC suggests that only authorized staff or persons with an authorized identification band should be allowed to transport the baby while in the hospital.[211] Babies should always be pushed in a bassinet during transportation and should never be left in a hallway unsupervised. Nursing staff should transport babies to their mothers one at a time, never in groups.[212] Infants should also always be in direct line-of-sight supervision of a responsible staff member or a parent or close friend designated by the mother.[213] Having guidelines on the transportation of infants within health care facilities will help to alert staff when someone is acting contrary to procedure, making it easier to detect an abduction attempt.

### 4. Education of Hospital Staff and Parents

As part of the Joint Commission suggestions and the NCMEC guidelines, facilities are urged to educate staff about the identification requirements for parents, staff and also for visitors to the nursery.[214] Hospital personnel should also be aware of the potential for abductions from the facility.[215] Education programs for staff should include information on the offender profile, unusual behavior, prevention procedures and the critical incident

208. SENTINEL EVENT ALERT, *supra* note 113, at 2; NCMEC GUIDELINES, *supra* note 27, at 14.

209. NCMEC GUIDELINES, *supra* note 27, at 14.

210. In Oregon, a new mother who had been educated about the hospital's security procedures prevented her 3-day-old baby from being abducted by a woman who posed as a hospital staff member. Ryan Frank, *Possible Baby Snatching Averted at St. Vincent*, THE OREGONIAN, Jan. 27, 2001, § 2, at 1. At 6:30 a.m., the woman entered the mother's room and requested that the mother give her the baby for a "routine medical procedure." *Id.* Because the woman did not have proper hospital identification, the mother refused to give her the baby. *Id.*

211. NCMEC GUIDELINES, *supra* note 27, at 15.

212. *Id.*

213. *Id.*

214. SENTINEL EVENT ALERT, *supra* note 113, at 2.

215. *Id.*; NCMEC GUIDELINES, *supra* note 27, at 15.

response plan.[216] Examples of unusual behavior that might indicate a person's intent to kidnap include: repeated visits to the nursery "just to see" or hold the babies, asking in-depth questions about the time for feedings, where emergency exits lead, how late are visitors are allowed in the ward, and if babies stay with their mothers at all times.[217] Other suspect behavior involves taking uniforms or other hospital identification, carrying large packages, such as duffel bags, out of the maternity unit.[218] Parents also should receive informational materials that describe the hospital's security procedures and that discuss abduction risks and the role that they, the parents, have in preventing abductions.[219]

### 5. Confidentiality of Parents and Infants

Because of confidentiality concerns, hospitals should not post the mother's or infant's name where it is visible to visitors.[220]This includes refraining from listing full names on bassinet cards, by rooms or on status boards.[221] Listing personal information such as a last name and address in newspaper announcements can also put the family at risk when they return home.[222] Accordingly, the Joint Commission and NCMEC have suggested that facilities discontinue publishing birth notices in the newspapers,[223] because these announcements and other "good marketing" tools, such as giving away yard signs or listing

216. NCMEC GUIDELINES, *supra* note 27, at 15.
217. *Id.* at 11.
218. *Id.*
219. *Id.* at 15; SENTINEL EVENT ALERT, *supra* note 113, at 2.
220. NCMEC GUIDELINES, *supra* note 27, at 16.
221. *Id.*
222. *Id.* In early 2001, eight Iowa hospitals decided to stop sending birth notices to the Des Moines Register for publication, citing security concerns and recommendations by the Joint Commission and the NCMEC that suggest that the information in announcements can lead to abductions. Tony Leys & Bert Dalmer, *Bradlawns Stops Birth Notices, Critics of the Notices Say Abductors Can Use Names to Pose as Visiting Relatives*, DES MOINES REGISTER, Feb. 3, 2001, Metro, at 2; *Seven Hospitals Cite Security Reasons for Halting Birth Announcements; Dubuque Not Included: Local Hospitals Leave the Decision Up to New Parents*, TELEGRAPH-HERALD, Jan. 18, 2001, § 1, at 13; *Hospitals Stop Birth Releases; Abductions: Some Fear for Safety of Infants and Families*, TELEGRAPH-HERALD, Mar. 3, 2001, at C6. In a subsequent editorial by the Des Moines Register, the newspaper accused the local hospitals of allowing fear to cause them to change their birth announcement policy, and that such a decision is an "absurd" solution to reducing the risk of infant abductions because "baby-snatching is extremely rare." Editorial, *We're Letting Fear Change Us, Iowa Diary*, DES MOINES REGISTER, Jan. 21, 2001, § 1, at 12.
223. SENTINEL EVENT ALERT, *supra* note 113, at 2; NCMEC GUIDELINES, *supra* note 27, at 16.

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births online, can provide potential infant abductors with the information to locate a baby.[224]

### 6. Security Safeguards

Facilities should consider implementing additional security devices to help deter and also physically prevent abductors from leaving the facility with a baby. Alarms, self-closing hardware on doors, electronic surveillance systems and security video cameras can help to create a safer environment in the nursery by adding another layer of security to the watchful eyes of the staff.[225] Such devices also include infant security tags, locking systems on all stairwell and exit doors leading to and from, or in proximity to, maternity, nursery, neonatal and natal intensive care and pediatrics units.[226] Particular attention should be paid to the positioning of cameras to ensure that they capture the faces of everyone using any entrance into the maternity ward or nursery,[227] which will help law enforcement discover the identity of potential abductors, as was the case in the Wakefield abduction.

### 7. Critical-Incident-Response-Plan or "Code Pink"

According to NCMEC, hospitals should also develop a critical-incident-response plan to outline the procedures that staff should undertake in the event that an abduction occurs.[228] Drafters of this plan should take into consideration factors that are specific to the hospital, such as facility layout, traffic patterns, entrance and exit doors, alarm systems and staffing patterns.[229] Facilities should also evaluate the proximity of the maternity unit to exits to parking areas, city streets and other locations where vehicles can be located for escape.[230]

As part of this process, hospitals might want to develop a code word, such as "Code Pink" that alerts the entire hospital staff that an infant is missing.[231] As part of this alert process, an action plan should be created that identifies each step that staff should take in attempting to recover the child. This plan should

224. NCMEC GUIDELINES, *supra* note 27, at 17.
225. *Id.* at 19; SENTINEL EVENT ALERT, *supra* note 113, at 2.
226. NCMEC GUIDELINES, *supra* note 27, at 19.
227. *Id.* at 20.
228. *Id.* at 21.
229. *Id.*
230. *Id.*
231. *Id.*

designate someone to act as the liaison with law enforcement.[232] An alert of this kind should also trigger other departments, such as security, communications, environmental services, accounting and public relations to commence following their own departmental action plan for such incidents.[233] Once established, hospitals should conduct infant-abduction drills to practice the required steps and to determine if the procedures are in fact appropriate and useful.[234]

### 8. Nursing Guidelines for "Code Pinks"

The NCMEC also suggests actions for nursing staff when a "code pink" alert is triggered. Nurses should perform an immediate search of the unit, including a head count of all infants.[235] At the same time, nursing staff should call hospital security or other designated authorities as identified in the critical-incident-response plan.[236] Then, they should protect the crime scene in order to preserve any forensic evidence that might be helpful to law enforcement officials.[237]

As can be seen from the OSHA, Joint Commission and NCMEC guidelines, creating a comprehensive security plan is a very detailed process that requires an in-depth analysis of the facility in order to develop a plan tailored to the needs of the hospital. In order to create a safe environment for patients, visitors and employees, hospitals must coordinate the efforts of facility personnel staff to meet that goal.

## V. Lawsuits Against Hospitals

When crimes are committed in the hospital maternity ward, the emergency room or the parking lot, victims often seek some financial recovery for their losses. Frequently, persons committing these crimes are unable to pay restitution or are "judgment proof,"[238] so hospitals become the likely defendants, as they have more financial resources. While settlement agreements are

232. *Id.* at 22.
233. *Id.* at 21.
234. *Id.*
235. *Id.* at 23.
236. *Id.* at 23.
237. *Id.* at 24.
238. According to Black's Law Dictionary (7th ed., 1999), "judgment proof" means "unable to satisfy a judgment for money damages because the person has no property, does not own enough property within the court's jurisdiction to satisfy the judgment or claims the benefit of statutorily exempt property."

often reached between hospitals and crime victims, the cases that have been litigated present a number of legal theories that have been asserted to attempt to redress the harm sustained by victims, as well as the parents of abducted infants.[239]

### *A. Premises Liability*[240]

In recent years, courts have expanded landowner liability to include persons injured by third parties who commit crimes on the premises.[241] Applying the theory of premises liability to the health care context, crime victims assert that the hospital or facility has a duty to protect its patients or employees and is negligent because it allowed a criminal the opportunity to harm someone.[242]

#### 1. Reasonable Care

Such liability might arise out of a duty to provide a standard of reasonable care, because a special relationship exists,[243] or because the criminal act is foreseeable.[244] Courts in various jurisdictions have approached premises liability from these

239. This discussion will address primarily causes of action by third persons against persons against patients and the parents of abducted infants, as well as some cases brought by employees of hospitals. Criminal acts committed by employees of health care facilities are beyond the scope of this article, but for a discussion of liability associated with employees in the health care environment, see Adam A. Milani, *Patient Assaults: Health Care Providers Owe a Non-Delegable Duty to their Patients and Should be Held Strictly Liable for Employee Assaults Whether or Not Within the Scope of Employment*, 21 OHIO N.U.L. REV. 1147 (1995).

240. For a more in-depth discussion of premises liability issues and health care patients, see N. Jean Schendel, *Note: Patients as Victims—Hospital Liability for Third-Party Crimes*, 28 VAL. U.L. REV. 419, 428 (1993).

241. *Id.* at 439; Robert J. Homant & Daniel B. Kennedy, *Landholder Responsibility for Third Party Crimes in Michigan: An Analysis of Underlying Legal Values*, 27 U. TOL. L. REV. 115, 115 (1995) (stating that traditionally, a criminal act committed by a third party on the premises would be viewed as an unforeseeable intervening act, and thus not the responsibility of the landowner).

242. RESTATEMENT (SECOND) OF TORTS, § 448 (1965). The RESTATEMENT (SECOND) OF TORTS § 448 addresses criminal acts under opportunity afforded by actor's negligence stating:

> The act of a third person in committing an intentional tort or crime is a superseding cause of harm to another resulting therefrom, although the actor's negligent conduct created a situation which afforded an opportunity to the third person to commit such a tort or crime, unless the actor at the time of his negligent conduct realized or should have realized the likelihood that such a situation might be created, and that a third person might avail himself of the opportunity to commit such a tort or crime.

243. RESTATEMENT (SECOND) OF TORTS § 315 (1965).

244. Schendel, *supra* note 240, at 423.

perspectives, which have led them in some cases to extend victims an opportunity to obtain financial recovery.

The Minnesota Supreme Court, in *Sylvester v. Northwestern Hospital of Minneapolis*,[245] an early case contemplating hospital liability for harm committed by a third person, allowed a patient to recover damages from the hospital for injuries he sustained when another patient, who was intoxicated, attacked him.[246] The court recognized that although hospitals are not insurers of patient safety, they "must exercise reasonable care for the protection and well being of a patient as his known physical and mental conditions requires, or as is required by his condition as it ought to be known to the hospital in the exercise of ordinary care."[247] This level of care should be proportional to the patient's inability to maintain his own safety.[248]

The Minnesota court in *Sylvester* further noted that when hospitals accept patients who have tendencies toward violence, and through reasonable care those tendencies should have been known, the hospital becomes liable to other patients for injuries sustained by the violent actions of such patients.[249] The court determined that it was immaterial that the hospital "could not have anticipated the particular injury" that the plaintiff sustained, and held for the plaintiff patient.[250]

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245. Ernest Sylvester v. Northwestern Hosp. of Minneapolis, 53 N.W.2d 17 (Minn. 1952).

246. *Id.* In *Sylvester,* a patient who had undergone an appendectomy and was recovering in the hospital when an intoxicated patient jumped on his bed and subsequently hit him, causing him injuries. *Id.*

247. *Id.* at 19.

248. *Id.*

249. *Id.* According to the RESTATEMENT (SECOND) OF TORTS § 320 (1966):

> One who is required by law to take or who voluntarily takes the custody of another under circumstances such as to deprive the other of his normal power of self-protection or to subject him to association with persons likely to harm him, is under a duty of exercising reasonable care so to control the conduct of third persons as to prevent them from intentionally harming the other or so conducting themselves as to create an unreasonable risk of harm to him, if the actor
>
> (a) knows or has reason to know that he has the ability to control the conduct of the third persons , and
>
> (b) knows or should know of the necessity and opportunity for exercising such control.

250. *Id.* For more discussion about cases addressing the "reasonable care under the circumstances" standard, see Schendel, *supra* note 240, at 448-449.

### 2. *Special Relationship*

Focusing on the relationship between hospitals and patients, the Alabama Supreme Court in *Young v. Huntsville Hospital*[251] considered whether a hospital owed a duty to protect a patient who was sedated or anesthetized from the criminal act of sexual assault by a third person.[252] The court looked to the Restatement (Second) of Torts § 315, which states that:

> There is no duty so to control the conduct of a third person as to prevent him from causing harm to another unless
> (a) a special relationship exists between the actor and the third person which imposes a duty upon the actor to control the third person's conduct, or
> (b) a special relationship exists between the actor and the other which gives to the other a right to protection.[253]

Because the patient in *Young* was under sedation or anesthetic, she was "unable or less able to protect herself from an assault such as the one that occurred."[254] The plaintiff also proved that the attacker was a trespasser in the hospital, and the hospital had decided to not enforce its visiting hours, even though those hours were posted.[255] After indicating a hesitance to impose liability on a person for the intentional acts of another,[256] the court determined that there was sufficient evidence to conclude that the relationship between the hospital and the patient was a "special relationship or circumstance."[257] The court reversed and remanded to consider the negligence claim but affirmed the lower court decision that the plaintiff failed to prove that the defendant acted with wantonness.[258]

### 3. Foreseeability

Other courts have evaluated whether hospitals are liable based upon the foreseeability of the criminal act by the third person. Some courts have determined foreseeability by using ei-

251. Young v. Huntsville Hosp. and Battle Services, Inc., 595 So.2d 1386 (Ala. 1992)
252. *Id.*
253. RESTATEMENT (SECOND) OF TORTS § 315 (1965).
254. *Young*, 595 So.2d at 1388.
255. *Id.* at 1389.
256. *Id.* at 1388.
257. *Id.* at 1389. While courts may not be willing to grant this special relationship for all hospital patients, it seems clear that infants are unable to protect themselves from abduction, and may more easily be deemed to be in a special relationship with the hospital.
258. *Id.* at 1386.

ther a "totality of circumstances" test,[259] or a "prior similar incidents" test, which, to varying degrees, focus on the number and frequency of prior criminal acts at the place where the act occurred.[260]

In 1985, the California Supreme Court in *Isaacs v. Huntington Memorial Hospital*[261] considered whether the hospital was liable for harm sustained by an anesthesiologist who was shot in the chest in the hospital parking lot.[262] In examining whether it was foreseeable that such an incident might occur on the hospital premises, the court posited that the "prior similar incidents" rule that the California courts had been applying "improperly remove[d] too many cases from the jury's consideration,"[263] as well as allowed a landowner to "get one free assault" before being held liable for criminal acts on the property.[264] Instead, the court adopted the "totality of the circumstances" test which looks to the "general character of the event or harm and not its precise nature or manner of occurrence,"[265] and takes into account the facts of the case, prior incidents, whether similar or not, the nature, condition and location of the premises.[266] The court reversed and remanded the trial court judgment of nonsuit, indicating that numerous factors, such as the number of threats of assault in the emergency room, thefts in the area, and the lack of security in the parking lot, supported that the assault was foreseeable.[267]

259. The totality of circumstances test was adopted by the California Supreme Court in *Isaacs v. Huntington Memorial Hospital*, 695 P.2d 653 (Cal. 1985), but the Court later retreated from that test following criticism from lower courts who had supported the previous test used to determine foreseeability, which was to review "prior similar incidents." Ann M. v. Pacific Plaza Shopping Ctr., 863 P.2d 207 (Cal. 1993); *see infra* notes 268-269 and accompanying text (elaborating on the "totality of circumstances" test).

260. Baptist Mem'l Hosp. v. Gosa; Baptist Mem'l Hosp. v. Wright, 686 So.2d 1147, 1152 (Ala. 1996).

261. Isaacs v. Huntington Mem'l Hosp., 695 P.2d 653 (Cal. 1985).

262. *Id.*

263. *Id.* at 659.

264. *Id.* at 658.

265. *Id.* at 659.

266. *Id.* at 661.

267. *Id.* at 662. The court also looked at the facts that the hospital was located in a high crime area; that the hospital security guard testified that harassing incidents were "very common;" that one expert testified that emergency room facilities and surrounding areas are "inherently dangerous;" that parking lots, by their very nature create temptation and opportunity for criminal acts; that there was poor lighting in the parking lot; and that the parking area had no security at the time of Dr. Isaacs shooting. *Id.*

Since the *Isaacs* decision, the California Supreme Court has retreated from the "totality of circumstances test" following criticism from lower courts questioning the "wisdom of [the court's] apparent abandonment of the 'prior similar incidents' rule."[268] Instead, the court concluded that determining foreseeability necessarily requires review of prior similar incidents of violent crime on the landowner's premises. "To hold otherwise would be to impose an unfair burden upon landlords and, in effect, would force landlords to become the insurers of public safety, contrary to well-established policy in this state."[269]

Following the reasoning in the *Isaacs* case, the South Dakota Supreme Court in *Small v. McKennan Hospital*,[270] adopted the "totality of circumstances test" in determining foreseeability. In that case, an employee of the hospital was abducted from the hospital's parking ramp and was raped and murdered.[271] Although there were no prior similar incidents on the ramp, vandalism and theft had occurred,[272] the lighting was inadequate, and people often loitered in the area to drink or smoke marijuana.[273] The court reasoned that even though crimes of this nature are not in themselves violent, concern about being caught in the act of doing such activities could lead to violence.[274] Based upon all of the facts, the Supreme Court affirmed the lower court's determination that the attack on the hospital employee was foreseeable.[275] The court indicated that the prior similar acts rule is "unduly restrictive and places too great a burden on the plaintiff."[276] With this decision, South Dakota agreed, and continues to agree, with a minority of courts who have disfavored the prior similar acts rule because it unfairly prevents the first victim of crime on the premises from recovering for their harm, while subsequent victims may prevail.[277]

268. Ann M. v. Pacific Plaza Shopping Ctr., 863 P.2d 207, 214 (Cal. 1993).
269. *Id.* at 215-16.
270. Small v. McKennan Hosp., 403 N.W.2d 410 (S.D. 1987) (hereinafter "*Small I*"), *appeal after remand*, 437 N.W.2d 194 (S.D. 1989) (hereinafter "*Small II*").
271. *Small II,* 437 N.W.2d at 197.
272. *Id.* at 198.
273. *Id.* at 197.
274. *Id.* at 198.
275. *Id.* at 202.
276. *Small I*, 403 N.W.2d at 413.
277. D. Mark Collins, *Comment: The Business Inviter's Duty to Protect Invitees from Third-Party Criminal Attacks on the Premises: An Overview and the Law in South Dakota after Small v. McKennan Hospital*, 33 S.D. L. REV. 90 (1988)(discussing the Supreme Court's first review of the case in *Small I*).

While some litigants have been able to meet a less stringent foreseeability test, many plaintiffs have failed, particularly when the facts to support foreseeability must be specific.[278] In *Arnett v. Straith Memorial Hospital*, a Sixth Circuit case applying Michigan law, the court held that even if a special relationship exists between a hospital and a patient, the duty of the hospital is not absolute.[279] Rather, a hospital is "obligated to take reasonable steps to protect its patients from foreseeable risks of harm."[280] Because the plaintiff failed to show that the criminal act of sexual assault was foreseeable to the hospital or that acts or omissions by the hospital "regarding security were unreasonable to deal with any foreseeable risk," the appellate court affirmed summary judgment for the hospital.[281]

In a 1996 case, the Alabama Supreme Court determined that past criminal activity on the hospital premises must also be similar to the act that caused the plaintiff's harm in order to meet the foreseeability requirement.[282] The court in *Baptist Memorial Hospital v. Gosa* held that a hospital employee did not prove that the attack she sustained in the parking lot by third person was foreseeable, even though she presented evidence of fifty-seven incidents, including the case before the court, in the area during a five-year period.[283] Forty-eight of those incidents involved thefts of vehicles or thefts from vehicles; and because only six involved physical touching, and only the instant case involved a gun, the court determined that foreseeability test was not met because the "number and frequency of crimes were not sufficient to give [the hospital] actual constructive notice that a third party would assault" the plaintiff.[284]

### *B. Harm to Parents of Abducted Infants*

Parents of abducted infants have similarly tried to recover for their emotional harm resulting from incident, with no avail. Generally, the prevailing view is that one is not liable for mental distress caused by his or her injuring of a third person through

278. Arnett v. Straith Mem'l Hosp., 886 F.2d 1315 (6th Cir. 1989).
279. *Id.* at 1315.
280. *Id.* (citing Samson v. Saginaw Prof'l Bldg., Inc., 224 N.W.2d 843, 848 (Mich. 1975)).
281. *Id.*
282. Baptist Mem'l Hosp. v. Gosa; Baptist Mem'l Hosp. v. Wright, 686 So.2d 1147, 1152-53 (Ala. 1996).
283. *Id.* at 1152.
284. *Id.* at 1153.

an act of negligence.[285] The most relevant and notable case is *Johnson v. Jamaica*,[286] where the parents of a newborn asserted a case of emotional distress against a New York hospital after their infant was abducted from the nursery. The parents argued, and the lower courts agreed, that the complaint stated a cause of action because the hospital owed them, as parents, a duty to "care properly for their child, and that it was or should have been foreseeable to the defendant that any injury to [the baby], such as an abduction, would cause them mental distress."[287] The highest state court disagreed with this determination, because the parents did not allege that they were within the "zone of danger" or that their injuries resulted from "contemporaneous observation of serious physical injury or death caused by the defendant's negligence."[288] The court stated that there was no direct duty on the part of a hospital to the parents of hospitalized children.[289] Instead, the "direct injury caused by the defendant's negligence, the abduction, was sustained by the infant."[290] The parents also tried to assert that the emotional distress theory arose under a contractual duty or because the hospital was acting *in loco parentis*.[291] The court also disagreed with both of these theories, stating that "absent a duty upon which liability can be based, there is no right of recovery for mental distress resulting from the breach of a contract-related duty."[292] As to the argument that the hospital stood *in loco parentis*, the court indicated that there was no basis for finding that the hospital held this status because the hospital's care was only temporary, and such a designation, if applicable, creates a duty to the child, not the child's parents.[293] The court reversed the lower court decision, holding that the plaintiffs failed to state a cause of action.[294]

285. Bruce I. McDaniel, *Recovery for Mental or Emotional Distress Resulting from Injury to, or Death of, Member of Plaintiff's Family arising from Physician's or Hospital's Wrongful Conduct*, 77 A.L.R. 3d 447.

286. Johnson v. Jamaica, 467 N.E.2d 502 (N.Y. 1984).

287. *Id.* at 526.

288. *Id.* at 527.

289. *Id.* at 526-27.

290. *Id.* at 528.

291. *Id.* According to BLACK'S LAW DICTIONARY, (7th ed., 1999), "in loco parentis" means acting as a temporary guardian of a child.

292. *Johnson*, 467 N.E.2d at 528.

293. *Id.* at 529.

294. *Id.* at 525.

While some victims have been able to recover from hospitals for the harm that they received at the hand of a third person, the parents of abducted infants have failed in the courts to recover for their own harm. The number of cases that have settled out of court is not known. The dearth of infant abduction cases might indicate that hospitals have sought an expeditious resolution to these cases, in light of the publicity that the incidents attract, as well as possible government sanctions for the failure to provide a secure environment. Interviews of families who did not sue the hospital indicated that they did not file suit because the hospital took a personal interest in them and their child, while those who felt like they were treated poorly were more likely to sue.[295]

## VI. The Consequences of Violence in Healthcare Facilities

### *A. Loyola University Medical Center, May 2, 2000*

When the Illinois Department of Public Health, on behalf of HCFA,[296] began its investigation of the security system at Loyola University Medical Center on May 2, 2000, the day following the abduction,[297] surveyors determined that there was an "immediate threat to the health and safety of patients."[298] Such a determination sets in motion procedures for the termination of a hospital from the Medicare/Medicaid programs within twenty-three days.[299] Accordingly, following the inspection, HCFA told Loyola that they had until May 26th to correct the deficiencies.[300] Hospitals are motivated to respond to the government and make the necessary changes, because termination results in the loss of a vital source of income for the hospital.[301] Loyola was no exception; the hospital faced losing approximately $109

295. Rabun, Burgess, & Dowdell, *supra* note 19, at 286.

296. *See supra* notes 72, 81-85 and accompanying text (discussing the HCFA's use of state agencies in evaluating hospitals' compliance with medicare laws and regulations). Pursuant to 42 U.S.C. § 1395aa, HCFA contracts with state agencies to conduct hospital surveys.

297. Frank Main, *Feds Rip Security at Loyola, Hospital Where Baby was Stolen Could Lose Medicare*, Chi. Sun-Times, May 10, 2000, at 1.

298. *Id.*; *see infra* notes 81-85 and accompanying text (defining "serious and immediate threat").

299. Main, *supra* note 297, at 1.

300. *Id.*

301. *Id.*

million a year in Medicare reimbursements and millions of dollars in Medicaid reimbursement.[302]

HCFA approved Loyola's plan of correction, which created more stringent requirements for visitors to the nursery, more oversight of the babies by the nursing staff, and frequent testing of the security system.[303] Loyola also increased the number of security officers in the nursery and maternity ward units, so that it provided around-the-clock coverage.[304] Hospital staff are also required to notify the police immediately if an abduction is suspected.[305] As a result of determining that security lapses were fixed, federal regulators rescinded the Medicare/Medicaid termination process.[306]

The parents of the Wakefield baby subsequently filed lawsuits against the hospital for negligence and later settled for an undisclosed amount of money.[307] The result of the tragic incident has been an increased awareness of the infant abduction issue, which has possibly motivated other facilities to reassess their procedures and safety mechanisms.

### *B. Costs and Loss of Confidence*

The consequences of infant abductions, as in the Wakefield case, and other acts of violence in hospitals are many and are far-reaching. Hospitals must bear the costs associated with developing security policies and procedures and training staff members to implement and follow these policies.[308] Furthermore, expensive electronic security devices, such as surveillance

302. Jeremy Manier, *Loyola Hospital on Notice; Kidnapping Puts U.S. Funds in Peril*, CHI. TRIB., May 10, 2000, § 1, at 1; Jeremy Manier, *Loyola No Longer Faces Loss of Medicare Funds; Baby's Kidnapping Led to Warning*, CHI. TRIB., May 26, 2000, § 1, at 10; Frank Main, *Loyola to Call Cops Quicker in Baby Cases*, CHI. SUN-TIMES, May 17, 2000, at 14.

303. Jeremy Manier, *Loyola No Longer Faces Loss of Medicare Funds, supra* note 302, at 10.

304. Loyola University Health System Media Statement, May 25, 2000, *available at* http://www.luhs.org/feature/ media.htm (last visited March 25, 2001).

305. Jeremy Manier, *Loyola No Longer Faces Loss of Medicare Funds, supra* note 302, at 10.

306. *Id.*

307. *Kidnapped Baby's Family Sues Hospital*, CHI. TRIB., May 13, 2000, § 1, at 5; *Loyola Settles Lawsuits in Infant's Abduction*, CHI. SUN-TIMES, Aug. 18, 2000, at 20. The baby's mother, Zandra Wakefield, accused the hospital of not properly maintaining the nursery's alarm system, not providing sufficient staffing and training, and not notifying police promptly. *Id.* Craig Singleton, the baby's father, filed a separate suit that "included a statement from former New England hospital executive William Nellis, who said faulty security systems led to the baby's death. *Id.*

308. Schendel, *supra* note 240, at 423.

cameras, alarms and automatic locking doors, must be installed and maintained. Following an incident of violence, hospitals could lose valuable Medicare and Medicaid funding and owe damages and fees resulting from lawsuits by patients, family members or employees.

Widely publicized violent incidents also cause the community to lose confidence in hospital security and the accreditation process. When facilities have to resort to arming their doors with metal detectors, security guards and bullet-proof glass, the facility atmosphere becomes less like a place of healing and more like a lockup.

Access to hospitals may also become restricted in response to hospital violence. In order for security policies and procedures to be effectuated, facilities must limit the access and egress of the public into various parts of the hospital. Hospital departments, such as maternity wards, must prevent unauthorized people from entering certain areas to prevent harm to patients and staff despite the fact that these barriers may also obstruct patients from receiving timely care.

## VII. Conclusion

Crime in whatever form has a destructive effect on society. People who use violence to get what they want may find a hospital or other facility easily accessible for their purposes. Often there is no limit on ingress and egress into various hospital buildings and departments. This creates a dangerous mix for patients, who are often in their most vulnerable state when receiving treatment from health care facilities. Staff who are charged with the duty to protect these individuals are also very busy working to treat them. This dual role is undoubtedly very difficult to balance, but the reality is that violence will continue unless watchful eyes ensure that patients are secure from violent third persons. Mechanical devices cannot detect odd behavior or distinguish whether an authorized person is suddenly acting in an unauthorized manner. While implementing a security plan might be costly for facilities and might limit to some degree patients' access to care, such an undertaking is worthwhile if it prevents violence or another abduction from happening again.