“Live” Exercise Report for Baby Abduction

Date: Monday 11th March 2024

Location: Labour Ward, Salisbury Hospital

OUTLINE

This report is produced by the Head of Emergency Planning, Resilience & Response (EPRR) for Salisbury Hospital NHS Foundation Trust to detail the response provided by the ward and Trust to a baby abduction from the maternity unit and to identify any best practice and any learning. This report is required to support the assurance processes as laid down in the Civil Contingencies Act 2004 where all NHS Funded organisations must plan and practice responses to incidents that affect a service and is also designed to support present plans and identify any recommendations to ensure the Trust is able to respond effectively to such incidents.

METHOD

On Monday 11th March 2024 a “live” exercise was organised by the Emergency Planning team to run through how the maternity unit manage a baby abduction and what actions specific staff should do to support the baby’s family as well as making sure other patients are kept safe and feel secure. The exercise was formatted by the Head of EPRR with support from the ward matron, to ensure the procedures are in pace. This exercise was not designed to test individuals, it is to examine if the process is correct.

The Head of EPRR gave a brief outline to those who would be contacted if this type of incident was to happen e.g., Clinical Site Team, COO/Deputy COO, Security team and Switchboard, as this exercise was to test the ward response and its escalation process. It was not required to advise anyone outside of the organisation as this wasn’t part of the exercise objectives.

To keep the exercise as real as possible, a doll was used to simulate a baby, the person taking the “baby” had a large handbag to put it into and the ward matron acted as the family member (mother). The EPRR team followed those in-charge and took notes of their actions and timings. The person taking the baby is a Trust staff member but isn’t known to the ward and isn’t carrying their Trust ID.

The exercise group consisted of the EPRR Team, Security Manager, a person to take the baby and the ward matron.

Scenario – A baby is taken from room 4 in labour ward whilst its mother was in the toilet.

The exercise started when the person entered maternity and entered room 4 to take the baby. The timeline is as follows:

12:57 Person who is taking the baby tries to gain entry by tail gating a staff member but is stopped by the Registrar and asked to use the buzzer.

12:58 Person rings the buzzer a couple of times, but it doesn't work.

12:58 Staff member who is turning up for work asks the person "what they want" and the person says they are here to collect something, so they are allowed into the unit.

12:58 Person is not challenged and goes into room 4.

12:59 Person takes the baby, puts it into their handbag and walks out of the room.

12:59 Person is let out of the unit by a staff member coming out of theatres. There is a comment by the staff member "You aren't taking a baby are you" in a joking way.

13:04 The mother presses to emergency button in room 4.

13:04 two members of staff come into the room and are asked by the mother "where is my baby", to which they ask "why?". The mother advises she was in the toilet and came out to find the baby had disappeared.

13:05 Both members of staff go out of the room to advise the team and then one returns and stays with the mother.

13:05 The unit is locked down by staff member.

13:05 Labour ward call 2222 and request assistance from switchboard.

13:06 The Nurse In-Charge tells the mother that security has been called and the ward has been locked down, and that the room is to be sealed off until the Police arrive.

13:07 The Nurse In-Charge requests the wards are advised via a nurse to the nurse's station.

13:10 Security arrive and advise that they have started to look at the CCTV and have requested Police attend. They are available to assist where possible and will wait to be tasked.

13:12 Child Safeguarding lead arrives in the ward and requests information on what has happened.

13.13 Director of Midwifery arrives at the ward and requests information on what has happened.

13:15 Nurse In-Charge asks as it is an exercise, if they should escalate the response and the EPRR Team advises they can.

13:20 Clinical Site Team arrive in the unit after initially being stopped from entering.

13:21 Exercise is stood down.

13:25 Hot debrief held in room 4 facilitated by the Head of EPRR.

A hot debrief was carried out with those involved and the following was identified:

Best Practice

1. The unit was locked down very quickly.
2. Staff seemed to be calm.
3. Process was followed by the Nurse In-Charge (on a phone).
4. Room was made secure relatively quickly.

Learning

1. In room 4 the window was open so anyone could have passed a baby through to someone outside.
2. The person taking the baby was let in by a staff member who didn't request ID.
3. The person taking the baby was not challenged when they were in the unit.
4. The were let out of the unit without being challenge.
5. One staff member should have always stayed with the mother to reassure them.
6. The Action Card with the response on, was not located behind the door where it normally sits.
7. The Nurse In-Charge felt like a "rabbit caught in headlights" as never done this type of incident before.
8. Did not see the ward being searched by staff (checking cupboards, storerooms, etc.
9. No Trust senior team contacted e.g., Deputy COO/Site team, Senior Divisional Team. (Don't know if anyone from the Senior Divisional Team were onsite).

Recommendations

1. Ensure windows are closed in rooms.
2. Ensure action cards are available and located at the same place on each ward.
3. Advise staff that tailgating and checking ID is a priority and if someone does come onto the unit, they are always with a member of staff.
4. Check action cards to ensure they are robust and up to date.
5. Exercise the plans regularly so it becomes the norm – gives staff confidence if a real incident was to occur.

CONCLUSION

The session was to test the response to a baby abduction and to identify any leaning which can be used to make the process more robust. It was not designed to fingerprint at any staff member but to look at the plans.

From the exercise there have been some key learning which requires immediate review, and the highest priority is to advise staff of their requirements to check anyone who comes onto the unit and to stop anyone who may be tailgating, and not to let anyone out of the unit without checking them.

The Head EPRR would like to thank those who supported the ex4rcsie and those who were tested, from the hot debrief, all thought it was worthwhile and more of these exercises should be held.

List of Attendees (hot debrief)

Steve Court	Head of EPRR
Sameer Anthony	EPRR Officer
Becky Roberts	Matron
Andy Hyatt	Security & Car Parking Manager
Vicki Marston	Director of Midwifery
Chris Butt	Midwife-in-charge
Michelle Read	Baby Abductor
Emily Goodge	Midwife
Etolie Gulliver	Midwife