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Serial Murder in Institutional Settings

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SERIAL MURDER IN INSTITUTIONAL SETTINGS

by

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ABSTRACT

This research explored the topic of professional caregivers who commit serial murder in institutional settings. In-depth case studies were created for individuals convicted of serial murder in institutional settings in the United States. The purpose of this research was to identify the characteristics of this group of institutional serialists and compare the current data to existing data on serial killers. A technique of secondary data analysis was utilized to gather information on the sample of 17 individuals. Only public information was reviewed. Results of the data comparison between the current sample and existing information on serial killers indicated that institutional serialists share many similarities with previously identified serialists, but differences between the groups were identified as well. The characteristics of this current sample that were similar to those identified in previous research include sex of offender, race of offender, the offender's age at first murder, marital status of offender, number of victims, and victim characteristics. The characteristics that differed from those identified in previous research include sex of offender, the offender's childhood family situation, the offender's birth order, method of murder, number of victims, and victim characteristics.

Serial Murder in Institutional Settings

Serial murder is a familiar topic in academic research as well as in popular culture. While the majority of the literature on this phenomenon is published for entertainment purposes, recent years have seen the emergence of academic literature on the topic of serial murder (e.g., Egger, 2002; Holmes & Deburger, 1988; Holmes & Holmes, 1998; Hickey, 2002; Jenkins, 1994; Ressler, Burgess, & Douglas, 1988). One aspect of this literature that has made its way into the popular culture media is a highly specific profile of the typical serial killer. The essence of this profile describes a serial killer as a White male sexual predator, age 25 to 35 years of age, of average to above average intelligence, who stalks his victims before he kills them by an overt method (Ressler, Burgess, & Douglas, 1988).

Recently, it has been suggested that this existing profile does not provide accurate information on all serial killers (Hickey, 2002; Holmes & Holmes, 1998; Keeney, 1992; Kelleher & Kelleher, 1998; Kirby, 1998). In particular, the component of gender in the existing profile has been challenged. Hickey (2002), for instance, stressed that not all serial killers are male, noting that approximately 17% of serial killers who operated in the United States during the past two centuries were female.

With research on the topic broadening, the need for a more comprehensive definition of serial murder became apparent. At the time, existing definitions were very limiting due to their specificity. For example, many definitions specified the gender of

the offender as male (Egger, 1990; Ressler, Burgess, & Douglas, 1988). Keeney (1992) responded by developing an inclusive definition of serial murder that has been used in subsequent research: "Serial murder is the premeditated murder of three or more victims committed over time, in separate incidents, in a civilian context, with the murder activity being chosen by the offender" (p. 7).

An important component of Keeney's (1992) definition is that it allows for the identification of an additional type of serial killer: professional caregivers who kill in institutional settings. This new type of serialist provides a unique perspective on the study of serial murder because it does not fit the established profile of a serial killer. Consequently, to date, little academic research has been performed on this type of serial killer.

Given the paucity of research on the topic, this thesis explores the topic of professional caregivers who kill in institutional settings. Although a few high profile cases have attracted national attention, academic research has largely ignored this topic. Therefore, a review of serial murder cases that fit into the institutional category, as well as a comparison to other identified serialists who fit the more typical profile, adds to the existing literature.

Definition of Concepts

Serial Murder.

As mentioned earlier, Keeney (1992) developed an inclusive definition of serial murder that has since been used in research on this subject. To reiterate Keeney's definition, "serial murder is the premeditated murder of three or more victims committed over time, in separate incidents, in a civilian context, with the murder activity being

chosen by the offender" (1992, p. 7). This definition presents a more inclusive approach by excluding a number of drawbacks in previous definitions, including the notion that serial murder is a uniquely male crime and the necessary inclusion of a sexual element in serial murder.

Keeney's (1992) definition is used in the present research, but because of the small sample size and the difficult process of convicting an individual of murder, five individuals were included in this current study who were convicted of lesser charges, but were strongly suspected of many other murders. Four of these individuals were convicted of only one murder and one individual was convicted only of aggravated assault. Two other individuals were included in the sample who had been charged with serial murder, but whose cases have not yet gone to trial.

Professional Caregiver.

A professional caregiver is defined as an individual who is formally employed to provide some defined caregiving service. Individuals who have committed serial murder as part of informal employment arrangements, most notably baby-sitters, were excluded from this study.

Institutional Setting.

The term "institutional setting" is used in this study to include hospitals, nursing homes, assisted living facilities, and clinics. An institution is an established licensed facility that exists for the purpose of providing care to individuals.

Review of the Literature

Although ample literature exists on the topic of serial murder, little academic focus has been given to institutional serial murder. In fact, while an abundance of popular culture information is available on individual institutional serial killers, the academic literature on the phenomenon of institutional serial murder is notably lacking.

Recently, however, a few researchers have approached the topic of institutional serial murder. One problem with these investigations is the lack of connection between the research studies. Seldom mentioned in research on this subject are suggestions and conclusions of other researchers. Of course, this problem could be the result of the paucity of information on the subject. Information on this subject is difficult to locate because, to date, no empirical research solely devoted to this topic exists. The discussion that follows is a review of the scant literature that is available.

Hickey

Eric Hickey compiled a database of 399 serial killers from 1800 to 1995 in his book, *Serial Murderers and Their Victims* (2002). Included in this book are two sections that are relevant to the topic of serial murder in institutional settings. First, he discusses males who kill elderly victims. Secondly, he addresses caregivers who commit serial murder. Although these sections are very brief, Hickey, by far, devotes the most attention to this topic than any other source.

In the succinct section on males who kill elderly victims, Hickey states that in the majority of these cases, the victims were elderly females who were sexually assaulted

before they were killed. Many of the victims lived alone or in institutions at the time of their deaths.

In his review of caregiving serialists, Hickey identified several variables which assist offenders in committing murder. The first is the accessibility and vulnerability of the victims. Research has found that serialists, no matter what type, generally seek out vulnerable victims because they increase the offenders' probability of successful completion of the crime (see also, Holmes & Holmes, 1998; Kelleher & Kelleher, 1998).

The second condition mentioned is the fact that it is very unexpected for murder to occur in an institutional setting. Institutional settings, such as hospitals and nursing homes, are places of care where individuals place their health and well being in the hands of others. Professional caregivers assume responsibility for providing care to those in need and therefore occupy positions of ultimate trust and respect.

Hickey also commented on the variety of murder weapons available to professional caregivers in institutional settings, as well as the ease of disposal of the weapons. There are numerous instruments that, although intended to save lives, can also be misused to end lives. Disposing of murder devices, such as medication, is not difficult in a setting where these means are used every day for life saving and healing purposes and are often readily available to the staff.

Because death is somewhat routine in many institutional settings, autopsies are rarely performed. Also, because physicians are often present when a death occurs and, no explicit signs of foul play are evident, there is no apparent basis to raise suspicion as to the cause of death. Covert methods of murder such as lethal injection, poison, and

smothering typically resemble natural causes of death and can therefore inhibit detection of the offenders' activities.

Another factor noted by Hickey (2002) is that administrators, or other individuals in positions of authority, may "…minimize reports that somebody is acting suspiciously or could be harming patients" (p. 319). For an institution to employ a suspected serialist can potentially cause devastating effects to that institution's reputation. Until an employee is charged with murder, administrators may be reluctant to publicize the suspicion of a serial murderer working in their institution. In addition to political issues, legal issues are present as well. If an institution makes unfounded accusations against an individual, the potential of a lawsuit is very high.

Hickey (2002) also noted that "…prosecuting those who are believed to be involved in the deaths of patients can be very difficult as a result of lost evidence, sensationalism, and legal procedures" (p. 319). Oftentimes, a professional caregiver who kills in institutional settings goes undetected for a long period of time. When the offender is accused, bodies are often exhumed for examination of evidence of foul play. However, two problems with exhuming bodies have been documented. First, there may not be a body available to examine if cremation was chosen. Secondly, some drugs used to kill victims have a very fast elimination time. That is, the drug stays detectable in the body for only a brief amount of time. If the body of an individual who suffered a lethal overdose of this type of drug is exhumed, the probability of finding trace elements of the drug is very low.

According to Hickey (2002), another factor that may assist professional caregivers in their crimes is the pressing need for hospital workers in the United States.

Because of the present scarcity of hospital workers, references and qualifications may not be checked thoroughly. Consequently, unqualified individuals may be able to obtain employment.

Hickey (2002) states that care-providing serial killers do not fit typical profiles that many people hold, nor do they attract the media attention that is usually associated with serial murder cases. These may be among the reasons why this type of serial murder is so underrepresented in research.

Hickey (2002) concludes by stating that more research should be completed on this topic. He adds that future research should focus on these offenders in order to "develop effective tools for profiling and apprehension" (p. 320).

Holmes & Holmes

Ronald Holmes and Stephen Holmes (1998) mention female caregiving serialists under a typology of female serialists entitled "power seeker". They define power as "…the ability to influence the behavior of others in accordance with one's own desires" (p. 152), and suggest that power seeking female serialists desire domination over others. Included in this category are both females who seek ultimate domination by taking other's lives and those who suffer from Munchausen Syndrome by Proxy. Munchausen Syndrome by Proxy is classified in the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1994) under Factitious Disorder by Proxy. Factitious Disorder by Proxy is "…the intentional production or feigning of physical or psychological signs or symptoms in another person who is under the individual's care for the purpose of indirectly assuming the sick role" (p. 725).

Holmes & Holmes do not address males who kill in institutional settings. Instead, they describe a type of male serialist, the power/control serial killer, who shares some similar characteristics with the power seeking female serialist. However, the authors suggest many differences between these two groups as well. For example, the male power/control serial killer is distinguished by an intense fantasy life, an element not mentioned in their work on female power seekers. Also, according to the authors, most male power/control serialists have the desire for a particular type of victim and stalk their victims prior to killing them. There is no mention of either of these two characteristics included in the information for female power seeking serialists.

Finally, one key difference in this research between power/control male serialists and power seeking female serialists is the element of torture. A large proportion of power/control male serialists inflicted some form of torture on their victims, a component not found in power seeking female serialists, nor among the male and female institutional serialists to be discussed in the present study.

Other Literature

Kelleher & Kelleher (1998) discuss a type of serialist that they call the "Angel of Death". The authors define the "Angel of Death" as "a woman who systematically murders individuals who are in her care or rely on her for some form of medical attention or similar support" (p. 15). The description of this type of serialist is very similar to Holmes & Holmes' (1998) power seeking female serialist.

Several characteristics of both the offender and the victim are discussed by Kelleher & Kelleher (1998). As will be demonstrated later, these are also the characteristics of male serialists who kill in institutional settings and their victims. However, because this book specifically focuses on female serialists, males are not explicitly mentioned in the definition of the "Angel of Death".

Kelleher & Kelleher (1998) offer a description of the "Angel of Death". She almost always operates in an institutional setting, such as a hospital or nursing home, and chooses victims based on their vulnerability. The motivation of this type of serialist is the need for domination and control. These two factors are often fueled by a lack of self-esteem or ego maintenance. Also, the authors state:

> In a few cases, this killer may suffer from a significant psychological disorder (such as Munchausen syndrome by proxy) which has remained undetected and unrecognized for some time. If so, she will be compulsively driven to attract the attention of medical personnel in order to gain recognition and self-aggrandizement through her heroic efforts to save the lives of those she has marked for injury of death. (p. 87)

Kelleher & Kelleher's (1998) work supports Hickey's (2002) research by including discussion on victim characteristics of this specific type of serialist. Two elements are provided that make victims attractive to the "Angel of Death." First, the victims are powerless to defend themselves against the offender. Very young, old, and/or frail victims are often chosen due to their increased vulnerability. Secondly, the victim

has no reason to suspect the offender of any ill will because of the nature of the relationship between caretaker and patient.

Keeney & Heide (1994a) suggest a few interesting directions for future research. After mentioning the phenomenon of female serialists, the authors suggest that the next step in serial murder research is the examination of male and female health care workers who murder their patients. They address the fact that some research has focused on female healthcare serialists, but males of this typology are largely ignored in the literature. Because of this, the authors believe that cases of male serialists who kill in institutional settings need to be reviewed and compared with information on their female counterparts. This comparison, they believe, may reveal gender differences in institutional serial killers.

Keeney & Heide (1994a) also suggest that future research should focus on reviewing cases of female institutional serialists for any evidence of fantasies involved with the murders. The importance of fantasies has been emphasized in many cases of male serialists (Hickey, 2002; Ressler, Burgess, & Douglas, 1988), but is rarely noted in cases of female serialists, especially those who kill in institutional settings.

Keeney & Heide (1994b) recognized institutional serialists again in their work on defining serial murder. Their critique of existing definitions presented the problems associated with the many definitions often cited for serial murder. They utilized examples of institutional serialists to illustrate that while these offenders fit every basic element of the definition of a serial killer, they are often not included in research because so many of the definitions for serial murder were too exclusive. This article was very

beneficial to the study of serial murder in general because due to its broader definition, more offenders, such as institutional serialists, can officially be included in research on serial murder.

Kirby (1998) explored the gender identities of female serialists and those male serialists who used covert methods of murder. In this work, the author focused mainly on institutional serialists. She found that males and females who used covert methods of murder (lethal injection, asphyxiation, etc.) were employed in the traditionally female roles/occupations of providing care to others. While the institutional serialists in her sample all used covert methods of murder, the males acted masculine and the females acted feminine. Thus, although a typically feminine method of murder was used by both males and females, the males did not identify with the female gender. The males in the study acted masculine in all aspects of their jobs except for choosing the method of murder.

Therefore, because all of the institutional serialists used similar methods of murder, but identified with different genders, Kirby concluded that one's gender identity does not determine method of murder. Finally, she postulated that occupation, not gender identity, determines the method of murder.

The previous research described above has served as the foundation for the work to be presented in this thesis. Many important questions were raised that, if explored, could facilitate additional constructive research on this topic. This review yielded the need for an accurate, comprehensive sample of institutional serialists, as well as an in-depth exploration into the characteristics of these individuals.

The Present Study

Much of the previous research on serial murder has excluded professional caregivers who kill in institutional settings, therefore possibly limiting the reliability and validity of the research. Thus, the present study was initiated because of the dearth of academic research on institutional serial killers and the phenomenon of institutional serial murder. By utilizing an in-depth case study approach, the intent is to expand the information already presented concerning professional caregivers who commit serial murder in institutional settings. Characteristics of the sample of institutional serial killers generated for this study will be summarized and compared with general characteristics of serial killers reported in previous research (Hickey, 2002; Holmes & Holmes, 1998; Kelleher & Kelleher, 1998; Ressler, Burgess, & Douglas, 1988).

The specific intent of this work is to develop a general profile of professional caregivers who kill in institutional settings by providing an overview of their characteristics. The characteristics investigated include background information such as childhood family situation, socio-demographic information such as sex and race, and other relevant characteristics identified by previous research on the subject. Once established, this profile is compared to the existing general profile of a serialist. In essence, two main research questions are pursued:

1. What are the general characteristics of professional caregivers who kill in institutional settings?
2. How do these characteristics compare to those of previously identified serialists?

Methods

Sample

The intent of this study was to include all known professional caregivers who committed serial murder in institutional settings in the United States through March of 2003. The resulting sample consisted of 17 individuals (7 females, 10 males) who committed serial murder in institutional settings and were employed, at the time of the murders, as professional caregivers in the United States.

Because of the small sample size and the difficult process of convicting an individual of serial murder, five individuals were included in the sample who were convicted of lesser charges but strongly suspected of serial murder. Two other individuals were included in the sample who had been charged with serial murder, but whose cases have not yet gone to trial.

Procedure

The sample for this study was obtained by an exhaustive search of academic journals, books, newspapers, the World Wide Web, and legal documents. All known professional caregivers who committed serial murder in institutional settings in the United States were included in this study. In-depth searches were performed to gather as much data as possible on the sample. Basic information, such as occupation, number of victims, and age at time of the murders, was collected for the entire sample (see Table 1). Case studies were then created for the individuals for whom the most information was available. Eleven case studies were completed.

After compiling this information and forming a general profile of characteristics, this data was then compared to the existing profile of a serial killer. This existing profile states that a serial killer is often a White male sexual predator, 25 to 35 years of age, of average to above average intelligence, who stalks his victims before he kills them by an overt method (Ressler, Burgess, & Douglas, 1988).

Variables

Several variables were analyzed to establish a general profile of professional caregiver serial killers who kill in institutional settings. Most of these variables were identified through previous research (Hickey, 2002; Ressler, Burgess, & Douglas, 1988) and include: the offenders' sex, race, age at first murder, sexual orientation, childhood family situation, birth order, reported childhood abuse, physical characteristics, mental disorders, marital status, occupation, shift worked, method of murder, average number of victims, sexual assault on victims, and victim characteristics.

Results: Case Studies

Joseph Akin

Joseph Akin, a White male, was born in 1956 in the rural south. Both of his parents worked in family businesses. His father owned a service station and his mother worked in her family's restaurant. An only child, Akin claimed to have had a successful academic career as a child. He asserted that he was involved with different clubs and played two instruments.

Akin continued through school and received this Associate's, Bachelor's, and Registered Nurse degrees. He worked in intensive care units in various Georgia hospitals. Co-workers noticed that Akin enjoyed being recognized as a hero and participating in "code blue" incidents. He was also known to often brag about his skills as a nurse.

He was fired from five Georgia hospitals before moving to Alabama. The last Georgia hospital where he was employed experienced an extremely high rate of "code blue" emergencies during the six months in 1990 that Akin was employed. In fact, in those six months, there were 32 "code blue" emergencies. The average for a six-month period at that hospital was 20 "code blue" emergencies before Akin arrived.

Although he experienced problems with employment in Georgia, it was in Alabama where Akin was charged and convicted of murder. He was charged in 1991, and convicted in 1992, of killing one patient by a lethal injection of Lidocaine, a painkiller. He was sentenced to life in prison. However, in 1996, the Alabama Court of Appeals overturned the conviction and ordered a new trial because of the presence and

admission of a juror who stated that she had decided Akin was guilty before the trial began. The Alabama Supreme Court upheld the order for a new trial in 1997.

Akin's next trial, held in 1997, resulted in a deadlocked jury and was ruled a mistrial. His third trial was scheduled to be held in March of 1998. In January of 1998, Akin pled guilty to manslaughter and was sentenced to 15 years in prison. However, two days after this sentence was issued, Akin was released from prison. Under an Alabama "good time" law, Akin was eligible for release after spending approximately six years in prison.

Although Akin is now a free man, he is suspected of 17 other deaths in Georgia and Alabama, though none have been confirmed. Suspicious "code blue" emergencies were also cited in at least three of the hospitals where Akin was employed, but again, these suspicions were never validated (Kirby, 1998; McIntosh, 1992; Pearson, 1996; "South in Brief Trial", 1992).

Richard Angelo

In August of 1962, two teachers gave birth to a son in Lindenhurst, Long Island, New York. Richard Angelo was an only child whom neighbors described as a "normal kid". He was a good student and was very involved in activities as a child. In fact, he was an Eagle Scout, altar boy, and volunteer firefighter. However, despite his active social and academic life, he often felt inadequate in many areas and suffered from low self-esteem. Angelo was overweight and wore eyeglasses as a child and adult, which may have increased his feelings of low self-esteem.

Angelo attended nursing school and began work in a burn unit and later was employed at Brunswick Hospital in Long Island, New York. An investigation into these two institutions uncovered no suspicious deaths while Angelo was employed. It was at his next job at Good Samaritan Hospital in West Islip, New York, where investigators believe Angelo began killing. Angelo worked the night shift at this hospital.

All of the attacks occurred within a one-year period. His victims were elderly patients who died from an overdose of muscle relaxants. Angelo told investigators that he did not mean to kill anyone; he actually wanted to revive them so he would be the hero.

At his trial, Angelo's defense team had two psychologists testify that Angelo suffered from a dissociative disorder, and therefore was unable to understand the repercussions of his actions. However, these testimonies did not seem to sway the jury's decision; Angelo was convicted of criminally negligent homicide, two counts of second degree murder, one count of second degree manslaughter, one count of first degree assault, and three counts of second degree assault. Angelo was sentenced to 61.3 years to life in prison. He will be eligible for parole in January of 2049 (Bowles, 1996; Caher, 1996; Gutis, 1987; Levine, 1996; Linedecker & Burt, 1990; Smith & Sengupta, 1994; Spencer, 1996).

Robert Diaz

Robert Diaz, a White male, was born in 1935 in Gary, Indiana, into a very large and poor family. In fact, he was one of 17 children. Diaz was very ill as a child and only

completed 10 formal years of schooling. As a child, Diaz wanted to be a doctor, but was discouraged due to his family's financial situation.

When Diaz turned 18, he enlisted in the Marine Corp. However, this career ended quickly as Diaz went absent without leave (AWOL). After leaving the Marine's, he returned home to Indiana and worked at an auto-parts factory. He continued in this field until he reached his thirties and began his nursing career.

Diaz was married to a woman who had two children from a previous marriage. The couple had one child of their own. The family moved to southern California where Diaz became a coronary care nurse working the night shift in various hospitals. During the spring of 1981, twelve elderly patients died at two of the hospitals where Diaz worked. All of the deaths occurred on Diaz's shifts. Because the symptoms were similar in all of the deaths: the victims turned red and blue and experienced violent seizures, an investigation was initiated.

Twenty-four bodies were exhumed and tested for the drug Lidocaine. Lidocaine is usually used to control irregular heartbeats, but an overdose of the drug can cause a heart attack. Large amounts of Lidocaine were found in many of the bodies. Diaz was questioned about the deaths, but denied any involvement.

He then filed a $1 million lawsuit against authorities for ruining his career. In May of 1981, Diaz was arrested for illegally possessing drugs, such as Morphine. However, due to a problem with the search warrant, these charges were dropped. In August of that same year, Diaz filed a $4.5 million lawsuit against the police department for defamation of character and libel. Both lawsuits were dismissed.

Investigators then found two syringes with traces of Lidocaine at one of the hospitals where Diaz had worked. The labels on the syringes were written in Diaz's handwriting and signed by him as well. At this point, Diaz was arrested and charged with killing 12 elderly patients by the lethal injection of Lidocaine during the spring of 1981.

During his indictment, Diaz waived his right to a trial by jury. After pleading not guilty to the crimes, he was convicted in March of 1984 of killing all 12 patients and sentenced to death. Although Diaz was charged and convicted of these 12 murders, he is suspected of killing a total of over 60 patients. He is currently incarcerated in California's San Quentin Prison and awaiting execution (Linedecker & Burt, 1990; "Nurse on Coast", 1982; "Trial Begins", 1983) .

Jeffrey Feltner

Jeffrey Lynn Feltner, a White male, was born in 1963. His parents separated three months before Feltner was born and he grew up living with his mother and three older siblings in Miami. Throughout his life, Feltner was small in stature: As a fully-grown adult, he was only 5'3" tall and weighed just over 100 pounds. As a child, he was often teased by other children because of his size. Instead of playing with other children, Feltner preferred to stay indoors and work on domestic activities and chores.

At the age of 16, Feltner moved with his mother, who had remarried, and siblings to Melrose, Florida. Feltner seemed to adjust well and made friends in the new community. He was an average student, making mostly Bs and Cs on his report cards. During this time, Feltner began to secretly visit homosexual locales.

After graduating from high school, Feltner began working the 3 p.m. to 11 p.m. shift at the same nursing home where his mother was employed as a nursing assistant. Here, as a nurse's aide, his performance was so exceptional that he was quickly promoted to aide supervisor.

In July of 1988, an anonymous caller to a crisis line and television station confessed to killing several residents of the nursing home. The caller identified himself as a nurse's aide and confessed to the mercy killings of three females and two males. The caller also warned that he would probably kill again. Investigators questioned Feltner, but, because of the lack of evidence, the investigation was put on hold. At that point, the calls began again. This time the caller confessed to the attempted murder of another patient, but when authorities investigated the claims, there was no evidence to support them, in fact, the evidence seemed to contradict what the caller claimed to have done.

Nevertheless, Feltner was arrested and charged with making harassing phone calls, trespassing, and filing a false report. He was found guilty on all charges and spent four months in jail. After his release, Feltner visited his father in Michigan for a short time and then went back to Florida.

Feltner moved to Daytona Beach and found employment at a temporary agency for healthcare professionals. He was employed by several nursing homes and often worked the evening shift. Around this same time, Feltner was diagnosed with Acquired Immunodeficiency Syndrome (AIDS). He again began making anonymous phone calls to television stations, law enforcement agencies, and mental health agencies. In these calls, he confessed to killing two more patients, bringing the total of alleged murders to

seven. He included his modus operandi of asphyxiation in these conversations. Feltner also discussed these murders with his roommate, who immediately notified law enforcement.

After an investigation, Feltner was arrested in August of 1989 on one charge of first-degree murder. While under arrest, Feltner confessed to the murder. He also confessed to the mercy killing at least one other victim at the nursing home where he was first employed after high school. This victim's body was exhumed, an autopsy was performed, and the remains exhibited evidence of foul play. Investigating the other murders confessed through the anonymous phone calls, proved to be quite difficult because many of the bodies had been cremated. Subsequently, when the investigation was concluded, Feltner was charged with only two murders.

Feltner was held without bail and, while awaiting trial, he recanted his confessions. In a letter to his father, he stated that his confessions were only a ploy to draw attention to the poor conditions and neglect in nursing homes. While in jail, Feltner intentionally cut his wrists and upper arm on separate occasions.

During his first trial, he pled not guilty to the first-degree murder charge. His lawyer attempted to plea bargain with a second-degree murder charge in exchange for a 40-year maximum sentence, but the judge rejected it. Feltner then changed his plea to guilty on one first-degree murder charge. He was sentenced to life in prison, with a mandatory 25-year minimum sentence. A few days after this sentence, he pled guilty in his second trial, to a second-degree murder charge and was sentence to an additional 17

years in prison ("A Nursing Aide", 1990; Lavin, 1990; Lavin & Journey, 1990; Linedecker & Burt, 1990).

Gwendolyn Graham

Born in August of 1963 in California, Gwendolyn Graham was raised in Texas. Graham, a White female, came from a broken home and claimed to have never been happy. As a child, as well as an adult, Graham was overweight and suffered from depression and low self-esteem. She allegedly suffered sexual abuse by her father, but this accusation was never proven. As a teenager, she engaged in acts of self-mutilation, often burning herself with cigarettes.

Graham never graduated from high school and worked in various dead-end jobs in Texas until she began her career as a nurse's aide. She moved to Waler, Michigan, and began working at the Alpine Manor Nursing Home.

At the Alpine Manor Nursing Home, Graham started dating her supervisor, Catherine Wood. The couple moved in together soon after they began their relationship. Their sex life included violent acts, such as asphyxiation, to increase orgasm. They would often have sex at work and, after a period of time, began thinking of new ways to embellish their sex life.

Their solution was a game they called "murder". They would kill patients at the nursing home according to the first letter of their last name to eventually spell the word "murder". Graham would kill the victims, by suffocation or smothering, while Wood acted as a lookout. Afterwards, they would have sex in a closet or vacant room. They commenced with the game but after one patient struggled too much, decided to kill only

the most helpless patients. They also decided to kill only females because they were not as strong as their male counterparts. Most of their victims were Alzheimer patients. Ultimately, they attacked at least 10 victims, but only succeeded in killing five individuals.

During the time of their murderous activities, they told colleagues of their behavior, and even displayed souvenirs of their killings such as handkerchiefs and dentures to other nurse's aides. Remarkably, these confessions were laughed off as jokes. At one point, Graham wanted Wood to take a more active role in the murders, and asked Wood to kill someone herself. Wood refused and requested to be transferred to another shift.

Graham and Wood eventually ended their relationship and Graham moved to Texas with a new lover to work as a nurse's aide in a hospital. Soon after Graham moved in August of 1987, Wood confessed the murders to her ex-husband. She claims she confessed because Graham told her that she was going to kill children at her new workplace. However, in the Texas hospital where she was employed, Graham worked on the neurology-orthopedic floor and did not have access to young children.

Wood's ex-husband waited for over one year before he shared this information with the police. When he finally notified the police, an investigation was launched. In December of 1988, Woods and Graham were both arrested. Wood pled guilty to second-degree murder and was sentenced in October of 1989 to 20-40 years in prison. Graham was charged and convicted of five counts of first-degree murder and one count of conspiracy to commit murder. In September of 1989, she was sentenced to life in prison

without the possibility of parole. She is currently serving her sentence in Western Wayne Correctional Facility in Michigan (Ex-Nursing Home Aide, 1989; Kelleher & Kelleher, 1998; Lane & Gregg, 1995; Linedecker & Burt, 1990).

Donald Harvey

On August 15, 1952, Donald Harvey was born in a small town in Ohio. A White male, he is the oldest of three children and grew up in a very poor family. When he was born, his mother was 17 years old and his father was 32 years old. Harvey's father was rarely at home. He worked various constructions jobs where he traveled an average of three weeks out of the month. Harvey's mother stayed at home with her children. She was very ill and suffered from post-partum depression. Because of his mother's illnesses, Harvey and his siblings were raised by their maternal grandparents.

Harvey's life did not start out well. He claims that he was sexually abused by his uncle and a neighbor for years, starting at the age of five. He was an unhappy child who was not well liked by his peers. He preferred to play with girls and enjoyed doing housework. Harvey was also very close with his mother. Because of these characteristics, Harvey was often teased and called a "sissy" or "mama's boy". Despite the negative attention he received, he performed well in school.

Harvey's family was so financially depressed that Harvey had to quit school and work in a factory to help support the family. During this time, his relationship with his parents was very strained due to the realization that Harvey was homosexual. He did finish high school however, and at age 17, left home to visit his grandfather in Kentucky. During this visit, Harvey met a young hospital orderly who helped get him a job. He

began working in a hospital as a ward clerk. Harvey had dreamed of becoming a doctor as a child, but was unable to fulfill this goal when he was forced to drop out of school to help his family.

In 1971, less than two years after Harvey began his hospital career, he burglarized one of his neighbors and set a fire in another apartment. However, these acts did not compare to the 13 murders he had already committed while working at the hospital. Unfortunately, these murders would go unnoticed until he was arrested many years later for another set of murders. He was arrested for the burglary and arson, and, upon his father's urging, enlisted in the Air Force at the age of 18. He entered as a clerk/typist, but his Air Force career did not last long because he overdosed twice on drugs. In March of 1972, Harvey was discharged due to a character/behavior disorder.

He returned home where he attempted suicide by overdosing on medication because his family was so ashamed of his actions while he was enlisted in the Air Force. After this incident, Harvey entered a hospital inpatient psychiatric ward for four months. He continued with outpatient services for an additional eighteen months.

When his psychiatric treatment ended, Harvey worked in a few different hospitals. In 1975, he began working in a veteran's hospital in Ohio. It is here that he allegedly killed 17 patients over a period of two years.

After working as a ward clerk, he accepted the position of autopsy assistant, a position that he held for eight years. During this time, Harvey is not believed to have committed any murders.

Harvey began dating and living with Carl Hoeweler in 1978, around the time of his fourth year as an autopsy assistant in the morgue. Some time after they started dating, Harvey began poisoning Hoeweler with arsenic. He later confessed that his intention was only to sicken Hoeweler to the point where he would be forced to stay home.

Hoeweler rented apartments in his home. As later confessions would reveal, one of his tenants, Helen Metzger, proved to be Harvey's next victim. After Metzger argued with Hoeweler over bills and repairs to her apartment, Harvey put arsenic into the whipped topping of a piece of pie he gave her. Metzger died from the poison.

Harvey's next victim was Hoeweler's father, an elderly man who was being treated in a hospital. Harvey put a fatal dose of arsenic into a pudding that he served the elder Hoeweler, causing his death. Harvey then moved on to Hoeweler's mother and began putting small doses of arsenic in her food. Mrs. Hoeweler, however, did not succumb to Harvey's attempts at murder.

Harvey became jealous of a female employee of Hoeweler's and, in 1984, stole a sample of Hepatitis from the hospital with which he contaminated the woman's drink. She was hospitalized from the incident, but managed to survive.

Harvey's next victim was another tenant of Hoeweler's. Edgar Wilson was 81 years old, and when he realized that he had been paying the hot water bill for both his apartment and Hoeweler's, he confronted Hoeweler about the issue. This confrontation proved fatal. Within a few days, Harvey offered Wilson an over-the-counter remedy for an upset stomach that was laced with arsenic. Wilson remained ill and Harvey gave him a second bottle of the deadly medicine. Eventually, Wilson was hospitalized and died.

Harvey then poisoned Wilson's dog. Months later, Harvey fatally poisoned another acquaintance by lacing pudding with arsenic and serving it to his victim.

By 1985, Harvey and Hoeweler's relationship was ending. That same year, Harvey lost his job as an autopsy assistant when slides of human tissue, books pertaining to the occult, several syringes, and a gun, among other suspicious items, were found in his possession.

In 1986, Harvey applied for a job as a nurse's aide at another hospital in Cincinnati. With no check of his background, Harvey was hired. This hospital treated mainly terminally ill patients and many were elderly. Within two years, Harvey had killed 21 patients.

Other nurses at the hospital began to get suspicious as the death toll rose. They voiced their suspicions to supervisors, but were ignored. The nurses then decided to present the information they had gathered to a local news channel. After a few months of conducting its own investigation, the news channel aired a story about the suspicious deaths at the hospital. The matter could no longer be ignored. Deaths at the hospital were formally investigated and after finding cyanide in the stomach of one victim, Harvey confessed to the murders.

He confessed to over 60 murders, but after further investigation, the number of victims that he could be charged with killing was between 54 and 58. However, investigators found a list of potential victims whom Harvey was planning on murdering. Most of his victims were elderly males who were killed by injecting poison such as

Cyanide, Arsenic, and cleaning fluids into their intravenous lines. If poison was not readily available, Harvey would suffocate his victims.

Harvey was found sane and competent to stand trial. The psychiatrist who conducted Harvey's evaluation concluded that he was murdering to relieve tension. To avoid the death penalty, Harvey was allowed to plea-bargain and consequently confessed to 37 murders. He was sentenced to four consecutive life sentences and fined $270,000 for his murders in Ohio and Kentucky.

Harvey has been incarcerated in the Warren Correctional Institute in Lebanon, Ohio, since 1987. He is not eligible for parole until May of 2043 (Kirby, 1998; Lane & Gregg, 1995; "Hospital Death Charges", 1988; Linedecker & Burt, 1990; "Mysterious Deaths", 1998).

Genene Jones

Genene Jones is a White female, born in July of 1950 in San Antonio, Texas, where she spent her childhood. Immediately after her birth, she was adopted. Her adoptive parents, Dick and Gladys Jones, had already two adopted children, and would adopt one more child within the next two years.

Jones grew up in a large house with a swimming pool and private tennis courts. Her father provided well for his family and owned several businesses while Jones was growing up, including a nightclub and a restaurant. Jones and her siblings attended Catholic schools and all learned how to play the piano.

Jones, although a bright, child adept at many skilled activities, was homely and overweight. She was often jealous of her brothers and sisters. She craved attention at

school and would often make up stories. After attending a Catholic elementary school, Jones began high school at a public country school. There she was an average student whom teachers recall as not living up to her potential. Other students also remember her as bossy and sometimes obnoxious. All told, Jones was not a popular teenager, especially with the boys in her school.

Her best friend was her younger brother, Travis. When Jones was 16 years old, Travis accidentally killed himself with a homemade pipe bomb. Jones was devastated; however, she returned to school the very afternoon of her brother's funeral. Classmates recall thinking that she relished the attention she was receiving.

After the death of her brother, her family was never quite the same. Jones claimed that she felt unloved. She and her mother argued frequently, but she had a good relationship with her father. As Jones began her senior year of high school, her father became ill and was diagnosed with cancer. He refused all medical treatment and in January of 1968, he died.

Soon after the death of her father, Jones began discussing marriage. She told her mother that she wanted to marry Jimmy DeLany, a boy who had attended the same high school as Jones, but had dropped out during his senior year. Jones' mother refused to sign a consent form allowing her daughter to marry. Her mother did not approve of the relationship and wanted Jones to wait until she had graduated from high school before she married.

In June of 1968, Jones graduated from high school and married DeLany. They were married in a Catholic Church and enjoyed a lavish wedding reception in the party

house on the Jones' estate. After their honeymoon, Jones and DeLany moved into the guest house on her mother's property. Jones stayed at home as a homemaker and DeLany worked as a mechanic for seven months until he enlisted in the Navy. Jones was unfaithful to DeLany while he was away at boot camp. However, when DeLany learned of his wife's infidelities, he chose to ignore the situation. The couple had a son and eventually divorced. By June of 1974, Jones was legally divorced and living with her mother.

Following her divorce, Jones' older brother, Wiley, died of cancer. Jones later allegedly developed a skin allergy to chemicals that she worked with at her job as a beautician. She feared that she had cancer and acquired a phobia of the disease. Consequently, she ended her career as a beautician and began studying to be a nurse.

When she entered the local school of vocational nursing, she was pregnant. The father of the child was a mystery. She told her friends that her ex-husband had fathered the child during a brief period of reconciliation. However, she told her mother that the father of her child was deceased.

Jones excelled in the nursing program. The grades that she received were the best in her life and although she was not very studious, she managed to graduate with honors. She graduated from the nursing program in May of 1977. In July she gave birth to her second child, a daughter.

Her first job after graduation was at a Methodist hospital where she formally worked as a beautician. After only eight months on the job, she was fired because of a

patient's complaints. In a performance review, her supervisors stated that she often made decisions that she was not authorized to make in her position.

After being terminated from her first position, it took Jones only a few weeks to find another job, this time in an obstetrics/gynecology unit of another hospital. She held this position for less time than her last. In October, she chose to have a bilateral tubal ligation so she would not be able to have any more children. As this procedure was not a medically necessity, and Jones had not accrued enough sick time to cover the surgery and post-operative recovery, she had to leave her position.

Jones was then hired by a public hospital to work in the pediatric intensive care unit. For the first three months of her employment in the pediatric intensive care unit, Jones worked the 11 p.m. to 7 a.m. night shift. She was then transferred to the shift of her choice, the 3 p.m. to 11 p.m. shift. Although the head nurse was fond of Jones, many of the other nurses were not. Jones had several incidents in the unit that were eligible for disciplinary action; however, none was taken. Jones would often make decisions that were out of her realm of knowledge and expertise. Several times she ignored doctors' orders because she felt that the doctors were wrong.

After two years in this position, Jones moved out of her mother's house and into her own apartment, although her mother continued to watch her two children. During this time, Jones began admitting herself frequently to the hospital. In the first 27 months of employment at the hospital, she visited the emergency room a total of 30 times.

Jones' unusual behavior at work continued. She began requesting only the most ill patients. When a child would die, she would pick up the body and rock with it while

sobbing. She would volunteer to transport bodies to the morgue. Normal protocol for transporting bodies was to use a cart on wheels. However, Jones would carry the bodies in her arms.

Beginning in May 1981, employees in the pediatric intensive care unit began noticing that an unusually high number of children were dying in their unit. After investigating the situation, it was apparent that the majority of the deaths were occurring on the 3 p.m. to 11 p.m. shift. Although the nurses talked among themselves about the possibility of Jones being connected to the deaths, no one approached the head nurse because of her relationship with Jones.

It was not until October of 1981 that anyone admitted their suspicions to the head nurse. The nurse who came forward had researched the deaths in the unit and found that the number of deaths on the 3 p.m. to 11 p.m. shift was astonishingly high. The head nurse had no choice but to relay these concerns to the intensive care unit's medical director. Several hospital officials were notified; however, although many people were highly suspicious of Jones, there was no official evidence that she was to blame for the deaths.

The most common problem the children were experiencing was unexplained bleeding. A likely cause was the drug Heparin, an anticoagulant. However, even if the children were receiving overdoses of the medication, there were other possible explanations other than purposeful overdose. The medical director had several bottles of the medication tested, but all of the results were normal. Intravenous bottles and tubing were also tested for bacteria, and again, the results did not indicate anything unusual.

One day in early October, there were eight emergency situations in the pediatric intensive care unit. This large number was strange by itself, but what proved to be even stranger was that all of the emergency code situations involved Jones' patients. On October 15, Jones was stopped before she gave a child approximately 300 times the amount of Heparin needed. After this incident, the staff was told to pay close attention to the Heparin supply and usage and nurses were ordered not to give Heparin to any patient without another nurse present. Also, residents were instructed to take blood samples from any child who died.

Jones continued to exhibit strange behavior. Her personal visits to the hospital became more frequent. At one point, she spent 17 days in the hospital. During this time, no children died in the pediatric intensive care unit. Although hospital officials were still monitoring the situation in the unit, no direct actions were taken. During this time, a clerk began complaining about missing supplies in the unit. This same clerk also noted that on about ten separate occasions, the crash cart was open when no emergency situations had occurred.

December was another bad month in the pediatric intensive care unit. That month, seven children died; six of whom died on the 3 p.m. to 11 p.m. shift. In January of 1982, blood tests from one sick child revealed that the child had received two overdoses of Heparin on two separate days, both during the 3 p.m. to 11 p.m. shift. A review of patients' charts however, was ruled inconclusive and the investigation continued.

Later that month, in a meeting with hospital officials and a lawyer, the medical director of the pediatric intensive care unit voiced his concerns about Jones. The final decision was not to terminate Jones because of the potential for a lawsuit. Instead, the committee decided to convert to an all registered nurse staff in the unit. All licensed vocational nurses were offered other positions at the hospital.

Jones elected not to stay at the hospital. One of the residents there was about to start her own clinic and asked Jones to join her staff. There was a six month period between Jones' resignation from the hospital and the time when she would begin her new job at the clinic. In this time, she first took temporary positions and then was offered full-time work at a hospital. She only stayed at this position for about one month before she resigned.

The new clinic in which Jones was employed opened at the end of August 1982. By October, several children had stopped breathing, experienced seizures, and were rushed to the nearest hospital while from the pediatrics office during routine visits. One child died after her second visit to the clinic and her second emergency trip to the pediatric intensive care unit at the nearby hospital.

Because of the high number of emergencies at the clinic in such a short time, an investigation was initiated. Jones' employer found a bottle of Succinylcholine with needle holes in the top. However, to her knowledge, this drug had never been used in her clinic. She also found invoices for the purchase of three bottles of the drug, although she could only find two bottles at the clinic. Both Jones and her employer, Dr. Holland, agreed to take polygraph tests about the emergencies at the clinic. Both were found to be

untruthful on many of the questions posed. However, later in another polygraph examination, Dr. Holland was found to be truthful when asked similar questions. Jones was told that under the circumstances she would not be able to work in the clinic any longer. As suggested by her lawyer, Jones left the town where she had been living and working for such a short time and moved about 200 miles away. Jones began working at a state school for mentally retarded adults. In April, Jones married a 19 year old nurse's aide.

In the course of the investigation, tests for Succinylcholine were performed on the body of the child who died after her visit to the clinic where Jones worked. The results indicated that the drug was present in the child's body before her death. Authorities also investigated other deaths at the hospital where Jones worked in the pediatric intensive care unit.

After a Grand Jury hearing, eight indictments were issued against Jones. She was charged with seven counts of injury to a child and one count of murder. At her arraignment, Jones pled not guilty to all eight charges. Her bond was set at $225,000. After a request for decreased bond was denied, Jones' family paid the entire amount to release her from jail. Jones was eventually found guilty of one count of murder and one count of injury to a child. She was later sentenced to 159 years in prison (Davis, 2001; Elkind, 1989; Hickey, 2002; Kelleher & Kelleher, 1998; Lane & Gregg, 1995; Linedecker & Burt, 1990).

Terri Rachals

Terri Rachals, a White female, was born in 1962 in Hopeful, Georgia. At two years of age, Rachals was adopted by a couple by the name of Maples who lived in Albany, Georgia after her birth mother had a nervous breakdown. Rachals was the only child of her adoptive parents. Her adoptive father was a retired Naval officer and her adoptive mother was employed by the Marine Corps. in a civil service position. When Rachals was six years old, she moved back to Hopeful from Albany with her adoptive parents.

As a child, she was described as caring, shy, and self-conscious. Childhood friends also described Rachals as compassionate. She performed very well in school and was a studious child. When Rachals was 11 years old, her adoptive mother died of a stroke. Her adoptive father did not deal well with this loss and became an alcoholic.

As Rachals progressed into adolescence, she formed close relationships with several of her friends' mothers. She knew that she wanted to be a nurse from childhood and she was an active volunteer with the elderly and the sick. As a teenager, Rachals continued to excel in school. Prior to her senior year in high school, she left her home to live with a cousin in Albany. She continued her stellar academic record and completed her senior year of high school.

After graduation, she enrolled in Albany Community College where she studied nursing. During this time, she joined a local church and met her future husband, Roger Rachals. The two were married in 1980. One year later, Rachals received her Associate's

Degree in nursing and began working at a local hospital in the surgical intensive care unit.

After about four years of marriage, the Rachals had a son. She continued employment at the hospital and usually worked the 3 p.m. to 11 p.m. shift. Around this time, Rachals approached a colleague and confessed that her husband was beating her. Other than this accusation of domestic violence, Rachal's life seemed to be uneventful.

However, in the fall of 1985, the hospital began experiencing a higher than usual death rate in the surgical intensive care unit. All of the deaths were attributed to cardiac arrest. An internal investigation was launched. At this point however, the investigation focused on the possibility of faulty equipment and produced no viable leads.

In November, the death toll rose to its highest rate. Further investigation produced evidence that Rachals was on duty and usually present at all of the deaths. Drugs were tested to insure that they contained the correct ingredients. In several blood samples, traces of Potassium Chloride were found. However, during this time of heightened security, no additional suspicious deaths were occurred, so this finding was not investigated further.

The months of December and January were uneventful, and it seemed as if things were back to normal in the unit. Security measures were terminated at the end of January but, by the first of February, another suspicious cardiac arrest had occurred. At that time, an investigation by the Georgia Bureau of Investigation focused in on Rachals.

In the middle of March, Rachals was arrested and charged with one count of murder. The investigation continued; however, before law enforcement had concluded

their investigation, Rachals confessed to injecting five patients with lethal doses of Potassium Chloride. Soon after her confession, Rachals was formally indicted on six counts of murder and twenty counts of aggravated assault. No pattern of victim selection was discovered. The victims ranged in age from young children to elderly patients.

During her trial, Rachals remitted her confession and stated that she was confused by investigators. She told of childhood sexual abuse by her adoptive father, a claim that he denied. Rachals also stated that she suffered from fugues in which she would experience amnesia about what she had done and where she had been at certain times.

The defense psychiatrist concluded that Rachals suffered from a dissociative disorder which, when under stress, causes periods of amnesia and personality change. He testified that individuals who suffer from this disorder are very open to suggestion and this could be the reason for Rachal's early confession.

However, the psychiatrist for the prosecution disagreed with the defense psychiatrist's diagnosis. He explained the Rachal's suffered from low self-esteem and depression but he found no symptoms of any type of dissociative disorder. In his opinion, Rachals knew right from wrong when she was injecting patients at the hospital.

In the end, Rachals was convicted of one count of aggravated assault. She was acquitted of six counts of murder and nineteen counts of aggravated assault. At 25 years old, Rachals was sentenced to 17 years in prison (Hickey, 2002; Kelleher & Kelleher, 1998; Linedecker & Burt, 1990).

Bobbie Sue Robinson

Bobbie Sue Robinson is a White female who was born in October of 1952 in Woodlawn, Illinois. She and her six siblings grew up in a trailer in an economically deprived area. Four of her five brothers suffered from Muscular Dystrophy and two of them died before Robinson reached her mid-thirties. Neighbors recall that Robinson was devastated by these tragedies.

Robinson is remembered as a shy, loving, and trusting child with few school friends. She was overweight and suffered from Myopia. However, she received good grades in school, was a member of the choir, played the organ, and was very religious.

After graduating from high school in 1973, Robinson attended nursing school with the intention of becoming a geriatric nurse. After three years in nursing school, she graduated with a registered nurse degree and began working in towns near her home.

Robinson married Daniel Dudley after becoming a nurse. Soon after their marriage, the couple wanted to have a child. Robinson was extremely upset when she learned that she was unable to have children, and became very depressed. This depressed state lifted when the couple adopted a child. However, it was not long before Robinson again became depressed and eventually sought professional help. She was diagnosed with Schizophrenia and prescribed medication for her condition. The medication, however, only seemed to worsen her condition.

Robinson's son was hospitalized, and according to her husband, Robinson was to blame because she had given her child an overdose of her medication. Her husband also claimed that this was not the first overdose their child had suffered at the hands of his mother. In fact, Dudley accused Robinson of giving their son overdoses of medication on

at least three other occasions. Subsequently, Dudley filed for divorce and was awarded full custody of their son.

In the next few years, Robinson suffered from many physical and psychological problems. She was in and out of the hospital and had many surgeries. She also spent over a year in a state mental health facility. When she was released she felt better and began working as a nurse again.

The first non-temporary job she held was at a nursing home in Greenville, Illinois. Soon after she began employment there, other staff members noticed that she exhibited strange behavior. Most notably, Robinson began fainting while on duty. After a few of these incidents where doctors could find nothing wrong with Robinson, the nursing home staff began to postulate that she was faking the fainting spells to get attention. Next, Robinson used scissors to stab her vagina repeatedly and had to be rushed to the hospital. She was terminated from her job at the nursing home and was urged to seek professional mental help.

Instead of heeding the advice to see a doctor, Robinson applied for a nursing license in Florida and moved to St. Petersburg. She found a church in the area and attended regularly: However, she still suffered from unknown medical problems and continued to frequently visit to the hospital. She first accepted short-term positions in the Tampa Bay area and eventually was hired by a nursing home in St. Petersburg. She began working as the shift supervisor on the 11 p.m. to 7 a.m. shift.

Soon after Robinson was hired, patients began dying at the nursing facility. However, because so many of the residents were terminally ill, the growing number of deaths was not suspicious. Then, on the evening of November 26, 1984, five patients

died. That night, local police received an anonymous call from a woman stating that a serial murderer was operating at the nursing home. The next morning, Robinson suffering from a stab wound in her ribs, claimed that she was attacked by an intruder in the nursing facility.

Police began investigating Robinson after her claims of an attacker did not produce any leads. They discovered her history of Schizophrenia, undiagnosable illnesses, and termination from her job in Illinois. When investigators shared the information they gained with Robinson's supervisors, she was fired from her job as night-shift supervisor.

Robinson responded by filing a worker's compensation claim against her former employer because of the stabbing incident that allegedly occurred while she was on duty. The psychiatrist who evaluated Robinson for the nursing home's insurance company described her as suffering from borderline Schizophrenia and Munchausen Syndrome, and concluded that she most likely stabbed herself.

Robinson was not doing well psychologically, so she admitted herself to a local hospital for treatment. While in the hospital, her nursing license was temporarily suspended because she was believed to be a danger to herself and others.

After her release, Robinson met and married Rob Terrell, an unemployed plumber. The couple moved into a one-room apartment in downtown Tampa. They adopted a dog that Robinson subsequently overdosed with heartworm medication. However, after being rushed to an emergency veterinarian's office, the dog survived.

Shortly after the couple's move to Tampa, Robinson was again admitted to a local hospital for psychiatric treatment. At this time, her nursing license was suspended for

five years, and it was specified that she would not get it back unless she could prove that she was not a threat to herself or the public and that she was able to work competently in the field.

With neither Robinson nor her husband employed, the couple could not afford to keep their apartment, so they moved into a tent. However, they did not stay in this residence very long because Robinson was arrested and charged with two counts of murder and one count of attempted murder at the St. Petersburg facility where she was formally employed. An investigation had been initiated after Robinson's stabbing incident and authorities had gained information regarding Robinson's entire career, from Illinois to Florida. She was officially charged with four counts of murder and one count of attempted murder by asphyxiation and/or drug overdose. All of the attacks had occurred in November of 1984.

Robinson's case never went to trial. Instead, she accepted a plea bargain and was sentenced to 65 years in prison for second degree murder and an additional 30 years in prison for first degree attempted murder. She is currently incarcerated in Florida and is scheduled to be release in February of 2022 (Kelleher & Kelleher, 1998; Linedecker & Burt, 1990).

Efren Saldivar

Efren Saldivar was born in September of 1969 in Brownsville, Texas. He was born to Mexican immigrants who had one other child. When Saldivar was a very young child, the family moved to Los Angeles where Saldivar's father worked as a handyman and his mother was a seamstress. His mother was a Jehovah's Witness and taught her children that the only way to get into Heaven was by doing good deeds in life.

As a child, Saldivar had an extroverted personality. By all accounts, he was well liked by his teachers but noted as an underachiever. However, when Saldivar entered high school, he did not fit in well with his peers. He joined the school band, but did not have many friends. He was overweight and, although he tried to impress the girls at his school, his efforts were not rewarded. He became withdrawn and failed out of his senior year of high school.

At this point, Saldivar did not know what he wanted to do with the rest of his life. Within one year, however, he had made a decision. After seeing a friend who was enrolled in a technical healthcare school, Saldivar became interested in the healthcare field. He attained his high school equivalency diploma and enrolled in the same school where his friend was taking classes: The College of Medical and Dental Careers in North Hollywood.

Within one year, Saldivar had completed his training as a respiratory therapist and began working the 11 p.m. to 7 a.m. shift at Glendale Adventist Hospital. Although he was employed in the healthcare field, Saldivar was not interested in helping others. He was concerned only with the technical side of his job. In fact, he requested the 11 p.m. to 7 a.m. shift to avoid contact with others.

After some time at the hospital, Saldivar began working part-time for other facilities as well. The next several years seemed uneventful for Saldivar. He continued to work as a respiratory therapist and was considered a competent employee by his colleagues. However, during this time, he stopped taking Zoloft, a medication often prescribed to alleviate depression.

In 1997, Saldivar was implicated by a co-worker of harming patients because of the high number of deaths that occurred on Saldivar's shifts. However, after an investigation, no evidence was found to support the co-worker's claims. After this accusation, several other employees became aware of the many deaths on Saldivar's shifts. They began joking that Saldivar had the "magic touch".

On one of Saldivar's days off, a few of his co-workers decided to play a joke on him and put someone else's clothes in his locker. Inside the locker they found empty syringes, Morphine, Succinylcholine chloride, and Pavulon. There was no reason that Saldivar should have access to any of these materials, let alone have them in his possession. Instead of informing hospital supervisors and the police, the group that found Saldivar's collection of drugs and paraphernalia told no one of their discovery because of the fear that they would be disciplined for breaking into the locker.

After some time, however, one of the respiratory therapists who opened Saldivar's locker told the story to a man she met at a bar. Believing that he could profit from the information, the man called the hospital and reported what he had heard. At this point, the hospital notified the police and an official investigation was launched. When the police questioned Saldivar's co-worker who had accused him a year ago of harming patients, he confessed to breaking into the locker and described the contents of the locker.

In March of 1998, Saldivar was given a polygraph examination by police. During the examination, he admitted to killing at least 100 patients in nine years, either directly or indirectly. However, he claimed that he did not begin killing patients directly until 1997, approximately eight years after he began working and killed his first victim by indirect means.

He confessed that he had killed one patient by connecting two tubes that caused the patient to suffocate. He also killed a patient by an injection of Pavulon, a paralyzing drug. However, he stated that the majority of the deaths were the result of withholding life-saving medications or procedures. According to Saldivar, all of his killings were mercy killings and his main criteria for choosing which patients would die was whether they were responsive. He claimed that he only killed unresponsive patients.

After his confession, Saldivar was arrested and placed in jail. The following day his home and locker at work were searched, but nothing incriminating was discovered. Because of the lack of evidence, Saldivar was released from jail. After his release, he was fired from his job as a respiratory therapist and his license was suspended. He began speaking publicly about the investigation and denied any wrong doing. He claimed that he had fabricated the confession because of pressure from investigators and his depressed mental state.

The investigation continued as police assembled a list of all patients who had died either on Saldivar's shifts, or within an hour of his shifts. For the next year, investigators worked on this list; speaking with family members and hospital staff in an attempt to put together an inclusive list of possible victims. They began exhuming bodies to look for traces of drugs, but for six weeks, nothing unusual was found in any of the bodies. One of the drugs that was reportedly seen in Saldivar's locker was Succinylcholine Chloride. If Saldivar injected this drug into his victims to kill them, the investigation would be hindered because most likely, there would be no traces left in any of the bodies. Succinclycholine Chloride breaks down very quickly in the body and is virtually

undetectable after a period of time. However, by August of 1999, traces of the drug Pavulon had been identified in six bodies.

In January of 2001, Saldivar was arrested. During questioning, he claimed that he did not kill for any personal pleasure. He changed his motive from mercy to the desire to decrease his amount of work at the hospitals. Saldivar claimed that he did not know the exact number of victims because he had stopped keeping track after he had killed 60 victims in 1994, although he thought it was over 100. He confessed to killing approximately two to three individuals at Arcadia Methodist Hospital and approximately ten others at Glendale Memorial, two hospitals were he was employed part-time. Out of a total of nine years of killings, only one potential victim survived Saldivar's attack. He admitted to attempting, but failing, to kill one victim at Glendale Adventist Hospital in 1997. He claimed that two other respiratory therapists had also participated in the killings and that he acted as their "lookout". This claim was never substantiated as both implicated individuals denied the accusation.

With six bodies testing positive for Pavulon, no more exhumations were issued: Investigators had enough evidence to get Saldivar sentenced to life in prison. In March of 2002, in exchange for life in prison instead of the death penalty, Saldivar pled guilty to six counts of first degree murder and one count of attempted murder. He was sentenced to six consecutive life sentences for the killings and 15 additional years for attempted murder. He is currently incarcerated in California's North Kern Prison (Adler, 2001; Lieberman, 2002; Robinson, 2001; Whitaker, 2002).

Jane Toppan

Born as Nora Kelly in Boston in 1854, Toppan was adopted and given the name Jane after her birth mother died. All accounts of her childhood state that Toppan grew up as a normal child with a loving family. She attended church and performed well in school.

The first signs of mental instability occurred when Toppan was a young adult, after her fiancé left her for another woman. She withdrew from her family and friends and attempted suicide twice.

At age 26, Toppan entered nursing school at a hospital in Cambridge, Massachusetts, and began working there as well. After a patient under Toppan's care died suddenly, she was fired from this position. Although no accusations were made, it was the opinion of many that Toppan's dismissal was due to the death of the patient. She continued to work in hospitals and is suspected of killing over 100 patients during the next decade.

After working in hospitals for some time, Toppan's next career move was into private nursing, where she spent the next 11 years. In 1901, a family of four died under Toppan's care, one after another, over a period of six weeks. The first to die was Mattie Davis. Toppan was asked to stay and care for the rest of the family who all seemed to be very ill. Toppan's next victim was Davis' daughter, Annie Goodman. Goodman was ill and when her condition began worsening, Toppan called for a doctor. When the doctor arrived, Goodman was already dead. Captain Alden Davis was Toppan's next victim. He was found dead in his bed one morning after Toppan had served him a nightcap the

previous evening to calm his nerves. Mary Gibbs, another family member, was the next to die.

When Gibb's husband returned home from the sea and learned that Toppan had refused to allow autopsies on the bodies, he became suspicious and notified the police. One of the deceased's bodies was exhumed and when an autopsy was performed, traces of Morphine were found. By this time however, Toppan had moved from the area. When the police found her, she was living in New Hampshire and practicing private nursing.

Police escorted Toppan back to Massachusetts for questioning. Meanwhile, the bodies of Toppan's former patients were exhumed and additional traces of Morphine were found. While in jail in Barnstable County, Toppan confessed to committing up to 70 murders, including that of her foster sister. However, she is suspected of killing over 100 patients.

Her trial was held in June of 1902, where Toppan was diagnosed as insane by the psychiatrist attending the trial. She was sent to Taunton State Asylum for the criminally insane where she spent the rest of her life until her death in August of 1938 (Albright, 2002; Lane & Gregg, 1995).

Results: Sample Characteristics

To facilitate comparisons with the existing research, information was gathered concerning sex, race, age at first murder, childhood family situation, birth order, reported childhood abuse, marital status, occupation, method of murder, number of victims, and victim characteristics. In addition, three other characteristics: sexual orientation, shift worked, and mental disorders were identified for inclusion in this study (see Table 2). Although other characteristics of serial killers have been identified in previous research, only those that apply to this current sample are discussed in this section. Other characteristics will be addressed later in the comparison of the findings of this study and those of previous research.

As shown in Table 2, the group consisted of 10 males and 7 females. Sixteen of the 17 offenders in this sample were White while one individual was Hispanic. Notably, no Black institutional serial killers were identified.

Age was defined as the age of the offender at the time of the first murder. The majority of the sample (n = 12) committed their first murder between the ages of 20 and 29 years old. The overwhelming majority of the sample (n = 16) committed their first murder between the ages of 20 and 39 years old.

Sexual orientation was determined for 14 of the offenders. The majority of the sample (n = 8) was heterosexual, with 5 others identified as homosexual. One individual was reported to be bisexual.

Childhood family situation was defined as the type of household in which the offender was raised. Information for this category was found for 13 of the offenders. The majority (n = 8) of the individuals in this sample were raised by both of their

biological parents. Three of the offenders were raised by adoptive families, and 2 others were raised in single parent homes by one of their biological parents. One individual in this sample was raised by family members other than his biological parents.

Birth order was determined for 7 of the 17 individuals. Three of the offenders were classified as only children; that is, they did not have any siblings. Two individuals were the third born children in their families. One offender was the first born child in his family and another was the fourth born child in his family.

Information on reported childhood abuse was located for 7 of the 17 offenders. Reported childhood abuse is any type of abuse described by the offender. Claims of abuse were not substantiated in any of the cases. Four individuals in the sample claimed to have experienced some form of abuse as children. Three of those 4 offenders reported experiencing sexual abuse as children. One offender reported verbal/emotional abuse as a child. Three individuals reported no abuse as children.

Reports of mental disorders were identified for 10 of the individuals in the sample. Mental disorders include any disorder described in the *Diagnostic & Statistical Manual of Mental Disorders* (American Psychiatric Association, 1994), as well as time spent in mental institutions. For the other 7 individuals, no mention of mental illness was found in any of the sources reviewed.

Marital status was determined for 16 individuals in the sample. The majority of the offenders (n = 9) were single. Four of the offenders were married, while 3 others were divorced.

Most of the individuals (n = 12) in this sample were employed as nurses at the time of the murders. Three of the offenders were employed as nurse's aides. One individual was a doctor and another was a respiratory therapist.

The shift that the offenders worked was mentioned for 8 of the 17 individuals. Four of these offenders worked the evening shift (3 p.m. to 11 p.m.) and 4 others worked the night shift (11 p.m. to 7 a.m.).

The majority of the offenders (n = 13) used the method of lethal injection to kill their victims. Two offenders used asphyxiation to kill their victims. One individual used both poison and asphyxiation as the method of murder, while another used lethal injection and asphyxiation.

The mean number of victims was 7.80 per offender and was determined using information on 15 of the 17 offenders. Two cases in this sample were not included in this analysis because the individuals had been charged, but not yet convicted, of serial murder at the time of this study. The mean number of victims was calculated using the number of victims that each offender was convicted of killing. However, many offenders in this sample were strongly suspected of many more murders. Because of this, the mean number of victims must be treated with considerable caution because the actual number is, in all probability, higher.

A common characteristic in serial murder is evidence of sexual assault by the offender (Hickey, 2002; Ressler, Burgess, & Douglas, 1988). However no reports of sexual assault were found for any of the 17 individuals in this current sample.

Regarding victim age, information was found for 15 of the 17 offenders. The majority of the offenders (n = 9) murdered only elderly victims. The term elderly is

defined, for the purpose of this study, as individuals of post-retirement age. Five individuals murdered victims of many different age groups while one individual murdered only children.

For victim sex, the majority of the offenders (n = 14) murdered both males and females. One individual murdered only males and another individual murdered only females. One individual, although convicted only of the murder of one male patient, was strongly suspected of many other deaths of both male and female victims.

Table 1

Research Sample

Sample	Sex	Method	Occupation	Location	Number of Victims Charged	Number of Victims Convicted.	Number of Victims Suspected	Victim Characteristics
Joseph Akin	M	Lethal Injection	Nurse	Alabama (possibly Georgia, but not proven)	1	1	17	32 year old male paraplegic
Richard Angelo	M	Lethal Injection	Nurse	New York	6	4	6	Elderly
Robert Diaz	M	Lethal Injection	Nurse	California	12	12	Over 60	Elderly
Jeffrey Feltner	M	Asphyxiation	Nurse's Aide	Florida	2	2	7	Elderly
Kristen Gilbert	F	Lethal Injection	Nurse	Massachusetts	4	4 counts of murder 2 counts of attempted murder		Male veterans
Gwendolyn Graham	F	Asphyxiation	Nurse's Aide	Michigan	5	5		Elderly females Most vulnerable victims
Donald Harvey	M	Lethal Injection/ Asphyxiation	Nurse's Aide	Kentucky & Ohio	37	37	Admitted to over 60	2 neighbors, lover's father, terminally ill patients (many elderly)
Vicki Jackson	F	Lethal Injection	Nurse	Texas	4	Trial pending	20	Mostly elderly
Genene Jones	F	Lethal Injection	Nurse	Texas	1	1	Up to 47	Infants & young children
Orville Majors	M	Lethal Injection	Nurse	Indiana	7	6	Up to 100	Elderly 2 males 4 females

Continued on the next page

Table 1 (continued)

Sample	Sex	Method	Occupation	Location	Number of Victims Charged	Number of Victims Convicted	Number of Victims Suspected	Victim Characteristics
Terri Rachals	F	Lethal Injection	Nurse	Georgia	6	1 aggravated assault	Up to 20	The victim of the aggravated assault was elderly. Other suspected victims range in age from young children to elderly. All were patients on the surgical intensive care unit.
Bobbie Sue Robinson	F	Lethal Injection	Nurse	Florida	4 counts murder 1 count attempted murder	Plea bargain: 4 counts 2nd degree 1 count attempted	12	Elderly
Brian Rosenfeld	M	Lethal Injection	Nurse	Georgia	3	3	Up to 201	Elderly
Efren Saldivar	M	Lethal Injection/ Asphyxiation	Respiratory Therapist	California	6	6 counts murder 1 count attempted murder	Admitted up to 200	Elderly 1 victim was retarded
Michael Swango	M	Lethal Injection	Doctor	New York & Ohio	4 (3 in Long Island, 1 in Ohio)	4	Suspected of 23 in U.S. & Africa. Charged with killing 5 victims in a Zimbabwe hospital.	
Jane Toppan	F	Lethal Injection	Nurse	Massachusetts	31	No trial, diagnosed "insane" and institutionalized	Over 100	
Richard Williams	M	Lethal Injection Succinylcholine	Nurse	Missouri	10	Trial pending	Up to 41	Elderly 9 males 1 female

Results: Comparison to Existing Data

Through previous research, a set of characteristics of serial killers was generated and used as the basis for collecting information on the sample in this current research (Hickey, 2002; Holmes & Holmes, 1998; Kelleher & Kelleher, 1998; Ressler, Burgess, & Douglas, 1988). The following characteristics were identified for this current sample and compared with previous research findings: sex, race, age at first murder, childhood family situation, birth order, reported childhood abuse, marital status, occupation, stalking, method of murder, type of offender (organized or disorganized), type of goal (affective or instrumental), number of victims, sexual assault on victims, and victim characteristics.

Research has identified serial murder as a predominantly male crime. In his analysis of serial killers, Hickey (2002, chapter 5) reported that roughly 90% of the cases he reviewed involved male offenders. Of the 17 offenders included in this analysis, 10 (58.8%) were male. Although the number of males in this sample was greater than the number of females, the *proportion* of females was much greater than in other serial murder cases. This indicates that females may be participating in institutional serial killing at a much higher rate than other types of serial killing.

Investigations into the race of serial killers have found that most serialists are White (Hickey, 2002; Holmes & Holmes, 1998; Ressler, Burgess, & Douglas, 1988). This current analysis supports this conclusion, with 16 (94.1%) of the 17 offenders being White. However, the proportion of White serialists in this study is much higher than in other research.

Most serialists were between the ages of 25 years and 35 years old when they committed their first murder (Hickey, 2002; Holmes & DeBurger, 1988; Keeney, 1992). This finding is generally true for institutional serial killers. Twelve (70.6%) of the 17 offenders studied were between 25 and 35 years of age when they committed their first murder. The mean age of this current study's sample when they committed their first murder was 28.76 years.

Research has found that serial killers are likely to have been raised in non-traditional family situations, such as single parent households or adopted families (Hickey, 2002; Keeney, 1992). This finding was not supported by the current study. Information on childhood family situations was found for 14 of the 17 individuals in this current sample. Of the 14 individuals, 8 were raised by both of their biological parents, 3 were adopted as children, and 2 others were raised in single parent households by one of their biological parents. One offender was raised by family members other than his biological parents. Consequently, institutional serial killers appear to have come from more traditional family backgrounds than the larger population of serial killers.

Research has suggested that serialists are often the first born or oldest children in their families (Ressler, Burgess, & Douglas, 1988). This finding was not replicated in this current study. However, information on birth order was established for only 7 of the 17 offenders in this current sample. Of those 7 offenders, only 1 individual was the first born child in his family. Three of the 7 offenders were the only children in their families.

Childhood abuse and/or neglect has been reported in the cases of many serial killers (Hickey, 2002; Holmes & DeBurger, 1988; Ressler, 1992; Ressler, Burgess, & Douglas, 1988). Information on this topic was inconclusive because data on abuse and/or

neglect was only found for 7 of the 17 individuals. Of those 7 offenders, 4 reported experiencing some type of abuse or neglect as children, while 3 reported no history of abuse.

Serial murder offenders have been found to be of varied marital statuses (Hickey, 2002). Marital status was identified for 16 of the 17 institutional serialists and found to reflect that pattern. The majority of offenders (n = 9) were single, while 4 offenders were married, and 3 were divorced. Thus, there appears to be no unique aspect to the marital status of institutional serial killers when compared to serial killers in general.

Research has found that serial killers often engage in stalking behaviors before killing their victims (Hickey, 2002; Ressler, Burgess, & Douglas, 1988). Stalking can be displayed in different forms such as stranger stalking and stalking fantasy (Hickey, 2002). Stalking behavior, per se, was not mentioned in any of the depicted cases of institutional serial killers. Further, evidence of stalking fantasy, described as mentally acting out the murder before it is actually committed (Hickey, 2002), was not discovered among this sample.

Methods of murder have been found to differ between male and female serialists (Hickey, 2002; Keeney, 1992; Kelleher & Kelleher, 1998). While males usually use overt methods, such as stabbing or bludgeoning (Hickey, 2002), female serialists generally use covert methods of murder such as poisoning, lethal injection, or asphyxiation (Hickey, 2002; Holmes & Holmes, 1998; Kelleher & Kelleher, 1998). The findings of this current study do not support the previous data in that all 17 offenders in this sample used covert methods of murder to kill their victims, most notably the injection of a lethal substance. Given the setting, this is not surprising. In fact, it was the

covert nature of their killings that allowed a number of the offenders to engage in their activities over a sustained period of time.

Research has identified two types of serialists, organized and disorganized offenders. As described by Ressler, Burgess, and Douglas (1988), organized offenders are usually of average to above average intelligence, socially competent, employed in skilled professions, and demonstrate some premeditated plans in their lethal behaviors. In contrast, disorganized offenders are usually of below average intelligence, socially immature, and employed in unskilled professions. The findings of this current study seem to suggest that professional caregivers who kill in institutional settings are organized offenders. Twelve of the 17 offenders in this current study were employed at the time of the murders in nursing, a skilled profession that requires a minimum of average intelligence.

Two types of goals have been identified for committing serial murder: affective/psychological and instrumental/practical. Research has found that males are likely to be motivated by affective goals (Hickey, 2002; Holmes & DeBurger, 1985; Ressler, 1992), while females have been found to be motivated by both types of goals (Hickey, 2002; Keeney, 1992). Institutional serialists appear to be motivated by affective goals. Several of the offenders confessed that they enjoyed the emergency situations that surrounded an overdose or death. No financial motive and/or gain was discovered for any of the offenders in this current study.

Because the majority of the male offenders in this sample remained in one geographic area while committing their murders, they are classified as place-specific serialists. Hickey (2002) reported that for male place-specific serial killers, the average

number of victims ranged from 12-20. For female serialists, the average number of victims ranged from 7-9. This current study supports Hickey's finding on female serialists, but is lower than his finding on male place-specific serialists. The average number of victims for this study was calculated using 15 of the 17 offenders. Two individuals had been charged, but not yet convicted, of serial murder at the time of this study. The average number of victims in the current study was 7.80. For males, the average number of victims was 8.22, slightly higher than the average of 7.17 for female serialists. These conclusions were calculated using the number of victims that each offender was convicted of killing. The actual number of victims may be much higher for both males and females because many of the offenders, although convicted of only a few murders, were strongly suspected of many more murders.

Research has found that sexual assault is often a characteristic of serial murder (Ressler, Burgess, & Douglas, 1988). Even recent research on males who kill elderly victims exclusively found that sexual assault is often present (Hickey, 2002). However, no evidence of sexual assault on any victim was mentioned for any of the 17 individuals in this current sample.

Victim characteristics have been found to differ between male and female serialists (Hickey, 2002). For male serialists, young females seem to be the most likely victims. Females in general are often targeted by male serial killers. In fact, Hickey (2002) found that approximately 40% of the males in his study murdered females exclusively. Children and the elderly have also been found to be popular targets for male serial killers (Hickey, 2002). For female serialists, patients in institutional settings have been found to be the most likely victims (Hickey, 2002).

The findings of this current study support one of the previous research findings on victim characteristics in that 58.8% of the sample murdered exclusively children or the elderly. Of the 17 offenders in this sample, victim age groups were established for 15 individuals. Of these 15 offenders, 9 murdered elderly victims exclusively, while 1 offender murdered only children. Hickey (2002) found that many serialists chose their victims by vulnerability. This finding appears to be supported by the victim age groups in this current study.

Previous findings on victim sex selection were not supported with this current research. In fact, of the 15 offenders for whom victim age groups were established, 12 killed both male and female victims. One individual, although convicted only of the murder of one male patient, was strongly suspected in many other deaths of both male and female victims. These results may provide support for Hickey's (2002) finding on the role of vulnerability in victim selection. If the offenders in this current study chose their victims based on vulnerability, it is likely that no pattern of victim sex selection would be established.

Table 2

Sample Characteristics (n = 17)

Category	n (percentage)
Sex	
Male	10 (58.8%)
Female	7 (41.2%)
Race	
White	16 (94.1%)
Hispanic	1 (5.9%)
Age	
20–29	12 (70.6%)
30-39	4 (23.5%)
40+	1 (5.9%)
Mean Age	28.76
Sexual Orientation	
Heterosexual	8 (47.1%)
Homosexual	5 (29.4%)
Bisexual	1 (5.9%)
Unknown	3 (17.6%)
Childhood Family Situation	
Biological, two parent home	8 (47.1%)
Biological, single parent home	2 (11.8%)
Raised by other family members	1 (5.9%)
Adopted	3 (17.6%)
Unknown	3 (17.6%)
Birth Order	
First born	1 (5.9%)
Third born	2 (11.8%)
Fourth born	1 (5.9%)
Only child	3 (17.6%)
Unknown	10 (58.8%)
Reported Childhood Abuse	
Yes	4 (23.5%)
No	3 (17.6%)
Unknown	10 (58.8%)

Continued on the next page

Table 2 (continued)

Category	N (percentage)
Marital Status	
Single	9 (52.9%)
Married	4 (23.5%)
Divorced	3 (17.6%)
Unknown	1 (5.9%)
Occupation	
Nurse	12 (70.6%)
Nurse's Aide	3 (17.6%)
Doctor	1 (5.9%)
Respiratory Therapist	1 (5.9%)
Shift	
Evening	4 (23.5%)
Night	4 (23.5%)
Unknown	9 (52.9%)
Method of Murder	
Lethal Injection	13 (76.5%)
Asphyxiation	2 (11.8%)
Poison & Asphyxiation	1 (5.9%)
Lethal Injection & Asphyxiation	1 (5.9%)
Mental Disorder?	
Yes	10 (58.8%)
Unknown	7 (41.2%)
Average Number of Victims	7.8
Victim Characteristics	
Exclusively Elderly	9 (52.9%)
Exclusively Children	1 (5.9%)
Other	5 (29.4%)
Unknown	2 (11.8%)

Discussion

This study explored the phenomenon of serial murder in institutional settings. More specifically, it focused on the characteristics of the individuals who commit this type of crime. Once established, these characteristics were compared to those identified in existing research on serial murder.

The results of this study suggest that professional caregivers who kill in institutional settings share many characteristics with the general population of identified serial killers: However differences between these groups were also discovered. In fact, the characteristics explored in this research were almost equally divided between those that support the existing research findings on serial killers and those that do not. The characteristics of this current sample that were similar to those identified in previous research include sex of offender, race of offender, the offender's age at first murder, marital status of offender, number of victims, and victim characteristics. The characteristics that differed from those identified in previous research include sex of offender, the offender's childhood family situation, the offender's birth order, method of murder, number of victims, and victim characteristics.

There may be more similarities between professional caregivers who kill in institutional settings and other serialists than are evident in the results of this study. For example, this study found that despite the gender division in the sample, all of the offenders used covert methods of murder such as lethal injection or asphyxiation. This finding did not support previous research in that males have been found to use overt methods of murder (Hickey, 2002), while females usually use covert methods of murder (Hickey, 2002; Holmes & Holmes, 1998; Kelleher & Kelleher). This difference may

actually represent a similarity in how offenders choose their methods of murder. It is possible that for many serialists, the method of murder is chosen out of convenience. For an institutional serialist, the most convenient method of murder could be lethal injection or asphyxiation, whereas another serialist might find other methods more convenient.

Kirby (1998) found that gender identity did not determine the method of murder in her sample of all female serialists and those male serialists who were employed in caregiving positions at the time of the murders. In fact, Kirby concluded that the offender's occupation was the determinant factor for the method of murder, supporting the notion that convenience may be a factor in determining method of murder.

Another example of an identified difference that could actually represent a similarity is victim sex selection. Research on serialists has found that males often target female victims (Hickey, 2002). However, the results of this current study indicate that most of the offenders, both male and female, killed victims of both sexes and did not seem to specifically target individuals because of their gender. The commonality that exists here may be vulnerability. Although research states that male serialists are likely to target female victims (Hickey, 2002), victim vulnerability has been noted as well (Hickey, 2002; Holmes & Holmes, 1998; Kelleher & Kelleher, 1998). In the general population, females, along with children and the elderly, represent rather vulnerable populations. However, in institutional settings, all patients are vulnerable. Therefore, vulnerability could account for the lack of victim sex selection in institutional serial killers.

One interesting finding of this study is the prevalence of female institutional serialists. Although male offenders dominated the sample, females accounted for 41.2%

of the sample. This percentage is much higher than Hickey's (2002) finding that females accounted for approximately 17% of identified serialists. Cases of female serialists are rare: However, it seems that when females do commit serial murder, they are likely to do so in institutional settings (Hickey, 2002).

Another characteristic that was explored was the physical appearance of the offenders, specifically the offenders' weights. Information on this characteristic was derived from written accounts as well as photographs of the offenders. Although the classification of "overweight" was derived subjectively, it was an interesting variable to explore because of the connection of body image, self-esteem, and depression. Also, the occurrence of childhood obesity could be linked to social stigmas and teasing by peers. The results of this analysis were indeterminate because of the lack of data. However, of the 12 offenders for whom data on weight was available, 7 were classified as overweight.

Although information on the shift worked by the offenders was located for only 8 of the cases, it is interesting to note that none of the offenders worked the 7 a.m to 3 p.m. (day) shift. All 8 of the offenders worked either the 3 p.m. to 11 p.m. (evening) or 11 p.m. to 7 a.m. (night) shift. This finding could indicate that these offenders chose shifts where supervision was minimal and therefore the opportunity to commit murder was greater than on the day shift.

Policy Implications

A present problem in the healthcare field is the lack of employees (Hickey, 2002). Because of this need for healthcare professionals, institutions may be less likely to thoroughly check applicants' references. This practice was discovered in several of the

cases in this current sample. If the offenders' backgrounds and references had been checked more carefully, many of the victims might still be alive.

Another area of policy implications is that of supervision in the institutions. The findings of the investigation into the shifts worked by the offenders in this current study indicate that more supervision is needed, especially during evening and night shifts. Additionally, suspicious behavior by employees should be investigated more thoroughly and acted upon in a timely manner.

Finally, research has indicated that oftentimes, if an elderly person dies in a nursing home, no examination is performed on the body (Lavin, 1990). A modification of this procedure could ease the apprehension of institutional serialists and accelerate the resolution of cases.

Limitations of the Study

There were two main limitations of this study: the use of secondary data analysis and the small sample size. The exclusive use of secondary data sources can reduce the reliability and validity of the findings in two ways. First, by nature, secondary sources may not be as reliable as primary sources. Media sources such as newspaper articles, do not report methods for data collection, therefore it is often difficult to determine the reliability and validity of their sources and conclusions. Secondly, data was inefficient for several variables in this analysis due to utilizing secondary sources as the sole source of data. The second limitation of this research was the small sample size of 17 offenders. With a small sample size, generalizability is limited. However, because of the specific topic of this study, the small sample size could not be avoided. All known institutional serialists who operated in the United States were included in this study.

Suggestions for Future Research

Because this research was exploratory in nature, suggestions for future research are numerous. First, additional research on this topic should attempt to use primary data sources such as interviews with the offenders and their acquaintances. Information compiled from primary data sources could produce more accurate and in-depth case studies and characteristics of the offenders.

This study focused on professional caregivers who committed serial murder in institutional settings in the United States. Other countries, such as England, have experienced this type of serialist as well (Hickey, 2002). A review of those cases and a comparison with the United States cases could be informative.

One characteristic that has been noted in previous research as common in male serialists is the presence of an intense fantasy life, often involving a stalking fantasy (Hickey, 2002; Ressler, Burgess & Douglas, 1988). This finding was not supported by this current research; however, it was difficult to evaluate due to the use of secondary data sources. In future research, if primary sources are utilized, this characteristic should be explored thoroughly because it appears to figure so predominantly in the psychological characteristics of serial killers.

An interesting inclusion in two previous works on the subject of serial murder was Munchausen Syndrome by Proxy (Holmes & Holmes, 1998; Kelleher & Kelleher, 1998). This disorder is characterized by an individual, in the role of a caregiver, intentionally making another individual ill (American Psychiatric Assocation, 1994). The theorized reasoning behind this action consists of two components: control over another person and psychological gain from being the "hero" (Holmes & Holmes, 1998; Kelleher

& Kelleher, 1998). It is interesting to note that this disorder was only mentioned in previous research in discussions on female serialists. While not completely established, it appears to have been present in several male serial killers in this current study. Research on the prevalence of this disorder in institutional serialists could produce worthwhile results.

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