

**Caring to Death:
A Discursive Analysis of
Nurses who
Murder Patients**

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Abstract

Murder is not a phenomenon that sits comfortably with the typical image of nurses and yet the number of cases of nurses accused and convicted of murdering patients is mounting. The nursing literature is quiet on the subject and therefore what is generally known on the topic predominantly comes from the media. An analysis of this seemingly unfathomable phenomenon is required to re-consider the problem and understand from new perspectives how and why this is happening. The aim of the study is to provide information for health professionals and organisations that will help them work together to recognise situations in which murder by nurses can occur.

The research question is: How do the various discourses surrounding murder committed by nurses on patients in the course of their work shape the definition and treatment of these crimes? A discursive analysis of texts guided by a number of discourse theorists is undertaken to reveal the social construction of murder of patients by nurses. Texts related to the media and professional reporting of over 50 cases of registered nurses, enrolled and licensed nurses and assistants were retrieved from searches of Factiva, CINAHL and MEDLINE between 1980 to 2006. The software program JBI-NOTARI[®] (Joanna Briggs Institute, 2003b) houses the texts and facilitated analysis. Discursive constructions are reported in four findings chapters and include: the profile of murderous nurses; types of murders; contexts in which murder takes place; factors that aid detection and apprehension; legal processes that guide charges, convictions and punishment; and finally the reactions of the public, the profession, the regulators and the families. The murder of patients by nurses is construed as a combination of extraordinary nurses, extraordinary deeds in ordinary contexts.

While members of the nursing profession may not be held accountable for the actions of aberrant nurses who murder there is a responsibility to understand how hospitals and units form crucibles in which murder can take place. The recommendations from this study relate to both practice and research. Practitioners are recommended to critically reflect on structures and processes

For the victims...

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Declaration

This work contains no material which has been accepted for the award of any other degree or diploma in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text.

I give consent to this copy of my thesis, when deposited in the University Library, being made available in all forms of media, now or hereafter known.

Signature John Gregory Field

Date

CHAPTER 1

Introducing the Study

From time to time cases come before courts of law throughout the world involving a health professional who has been charged with having murdered her or his patient. Among these cases it is not uncommon for the defendant health professional to be charged with the murder of a number of her or his patients. Indeed, there have been some notorious cases, perhaps the most notable of which has been that of Dr Harold Shipman who was suspected of the murder of some hundreds of his patients in England. He was charged with the murder of a number of these patients in 1999. Eventually he was convicted of the murder of fifteen of them (Peters, 2005). Typically, discussions of medical murder have focussed on the medical profession.

In contrast, there is appreciably less attention given to murder in relation to the nursing profession. Relatively few nurses have been convicted of murdering patients. Leaving aside the technical requirements of the law in any given jurisdiction, murder cases will generally tend to focus on motive, opportunity and means. In the case of medical practitioners, history has shown that motive is generally financial gain, romantic interest or pleasure in killing (Camp, 1982). A further motive more often attributed to medical practitioners than other health professionals is that of ending the suffering of patients; that is, mercy killing. However, when medical practitioners prematurely end the lives of patients in order to end suffering, it most commonly passes unnoticed or unremarked. Rarely are such cases prosecuted. It does not alter the fact that the medical practitioner has committed murder - it just means it does not enter the records. In the context of this work, mercy killing is discussed only to the extent that it is raised in mitigation against charges of murder included in this study. Opportunity for medical practitioners to murder patients generally arises as a consequence of the independent nature of their practice, as does the means, which is typically a poison. There is nothing in the literature to suggest what set of conditions is likely to result in a nurse murdering his or her patient or patients.

The practice of nursing is usually characterised by close working relationships with other nurses and health professionals generally. One implication of this is that the opportunities for nurses to murder a patient or patients would be largely constrained by the proximity of other staff. However, the cases that do exist clearly demonstrate that this is not always so. Where a patient (or a number of patients) is murdered by a nurse, the nursing staff working in the ward or unit typically find themselves sharply criticised for not having identified the problem before the patient was killed. This dissertation explores many examples of this such as in the cases of Beverley Allitt (N. Davies, 1993b) and Genene Jones (Elkind, 1990b), both of whom were able to kill babies on multiple occasions before their apprehension. This suggests that opportunity can arise even in the absence of independent practice. Access to means is almost as readily available for nurses as doctors. The question of motives is one of the more curious aspects. Why would a nurse kill his or her patient? And, *a fortiori*, why would a nurse kill a number of his or her patients? This is an area of investigation that is likely to lead to valuable insights into medical murders committed by nurses. For this reason, it is highly significant for health care organisations which have recently come to recognise the need for risk management in relation to the potential for medical practitioners to commit murder (Dyer, 2000; James & Leadbeatter, 1997; O'Neill, 2000). It is now clear that they need equally to engage in risk assessment and if necessary, risk management with respect to murder by nurses.

The obvious locations of discourse are the professional literature and the public media (including newspapers and magazines) along with legal transcripts from the cases. In this study the first two of these locations have been used extensively to reveal discourses at a number of levels. The legal transcripts of the cases have not been used to any significant extent because, although they record the voices of the accused, the witnesses for both prosecution and defence, and the judges, the somewhat contrived and highly stylized nature of the court injects an artificiality into the dialogue which at once serves to distort the discourses and render them unrepresentative of the constructions of murder by nurses that prevail in the wider community. It is these constructions that the study sought to reveal.

The general fascination with murder that is described in Chapter 2 of this work extends to this project itself. When people ask what it is that I am studying, I usually respond by saying,

“nurses who murder patients”. The immediate response is usually, “oh, you mean when nurses are involved in euthanasia?” I say, “No, I mean nurses who intentionally kill patients whether or not they have a terminal illness”. The inquirer then usually looks at me in a way that says, ‘as if that would happen’ and then asks if there are any such cases. They are then astonished to learn that there are indeed more than a few such cases and then I am inundated with questions about who would do such a thing and why. And all the while they are thinking, what kind of twisted mind would dream up such a topic for their study? In the face of this, I feel compelled to offer an explanation of how this study came about.

I am by training a mental health nurse and a lawyer. Although the practice of mental health nursing may share the closest interface with the law of any sphere of nursing, they are very different professions. These two disciplines are steeped in entirely different traditions and perspectives that constitute very different lenses through which to gaze upon the world. Merging these traditions and perspectives in one mind necessitates a superimposition of one lens on the other to produce a gaze that is qualitatively different from either of the constitutive parts. The whole is greater than the sum of its parts in this case and, for me, the distorted gaze came to focus on a specific phenomenon: nurses who murder patients.

For two decades I have been teaching law and ethics to student nurses in undergraduate and graduate nursing programs. Along the way, I noticed cases where health professionals, some of whom were nurses, had murdered patients. Each time this happened, it focussed my attention and I found myself thinking increasingly about the significance of this phenomenon. I reflected on the place of health professionals in our society and how trusted nurses are by the communities they serve. I thought about how vulnerable that trust made healthcare consumers in the face of what seemed to be rather a lot of cases. Initially I thought there were not too many nurses involved and where there were nurses involved, they seemed generally to be assistants in nursing or enrolled nurses rather than registered nurses. As I confronted more cases, I wanted to know the extent of the phenomenon so I began to actively look for such cases. I found that there were cases all over the world but they seemed to be particularly common in the United States of America (USA). It is possible that any differential between the USA and other countries on this measure could be attributable to better detection and greater media coverage but, notwithstanding this, I began to think about what might make one society more fertile ground than another for the generation of such cases. It began to look increasingly like registered nurses played a more prominent role than I had anticipated. Then along came Harold Shipman to demonstrate just how deadly one miscreant health professional could be and to confirm the vulnerability of the community. By now, although conscious of the potential harm to the profession, I was completely

immersed in seeking to discover the nature of this phenomenon of nurses that intentionally kill patients. I wanted to know why it happens, but more than this, I wanted to know what sense the trusting public made of nurses that murder. I was, and remain, convinced that the vulnerability of the community outweighs any considerations of impact on the profession and that addressing the issue will eventually strengthen the nursing profession. Thus was this study conceived.

There is a considerable body of literature around the notions of professions, disciplines and institutions that serve to identify their characteristics. Moreover, history is replete with examples of thinkers who have blended disciplines such that the combination affords fresh perspectives on routine phenomena. The application of a legal analysis through the eyes of a psychiatric nurse afforded just such a different perspective on the conduct of nurses engaged in the intentional killing of patients and sheds light where little has been focussed in the past. Moreover, a common reaction of both lay people and nurses when confronted with cases of nurses killing patients is to categorise those aberrant nurses as 'mad'. It seems beyond the capacity of the average individual to accept the notion of rational murder for base motives in those who are purportedly the givers of care. The effect of this is to shield such individuals from accountability for their actions. This seems at once to do a disservice to those members of society who are afflicted with mental illness whilst serving to justify the murderous behaviour of the nurses.

In the case of murder committed by nurses on patients, there is a great need for light. The more I thought about this matter, the more questions it raised. As a relatively well informed and skilled mental health nurse, how could I have been unaware of the prevalence of nurses murdering patients – and *a fortiori*, being also a qualified lawyer. Did this mean it was an invisible phenomenon? It clearly is not, if one goes looking for it. Is it a case of where one looks? That is best answered by two observations. The first is that the most obvious source of information on the issue – the professional nursing literature – is virtually silent on this subject. The second is that when cases come to light, there is a great deal of publicity in the media. How can either nurses or the community they serve remain ignorant of, or at least, oblivious to the phenomenon? Does this tell us more about the capacity of society to at once ignore and deny phenomena that are regarded as too corrosive of society to be accepted or acceptable in any form? Whether this is discussed with nurses or with the members of the general public, the ignorance, revulsion and fascination are almost always all present. The need for light is pressing and the generation of questions is unstoppable. That is as well, for the nature of a discursive study such as this is dependent upon the generation of questions to drive the analysis, which is itself interrogative of texts that constitute discourses.

The study examines and analyses the English language literature primarily of Western developed countries around cases in which nurses are brought to trial on charges of murdering a patient or patients in the course of their nursing work. The semantics of the term nurse is explored in this thesis but for the purposes of this study, if a convicted defendant was characterised as a nurse in the mass media, the case was included in the study. Through a discursive analysis I examine the prevailing discourses and attempt to identify the conditions in contemporary nursing, affiliated disciplines and the general public that shape murder by nurses.

The overriding purpose of the study is to reveal and explicate the dominant discourses that affect the portrayal of nursing in cases of behaviour currently perceived to be aberrant. The research question is:

How do the various discourses surrounding murder committed by nurses on patients in the course of their work shape the definition and treatment of these crimes in society?

In pursuing this question another is addressed, namely:

How have these meanings come about?

The significance of this work lies in increased appreciation of the complexity of acceptable practice at a time when a key principle of health care – the sanctity of life – is under pressure from a variety of sometimes contradictory phenomena. It is under pressure, for instance, from the redefinition of death; from the pro-euthanasia lobby; from resource limitations; and from the general devaluing of older people in our society.

The first question is addressed by applying archaeological techniques of discourse analysis to the texts surrounding these cases. The latter question is addressed by applying genealogical techniques of discourse analysis to those same texts. The result is an emergent problematisation in the Foucauldian sense (Castel, 1994) of murder in nursing. The study utilises a newly developed and recently released software program called JBI-NOTARI® (JBI, 2003, 2007) to analyse the texts and

this is used in the study to produce new insights into the utilisation and application of the software. There is no previous example of its use for this purpose. This brief introductory summary is intended only to signal the direction of the study. Each of these matters relating to the approach and methods adopted in the study are treated in considerably greater detail in Chapter 4.

The structure of this thesis reflects the discursive approach to the research questions. In depth discussion of the background literature constitutes Chapter 2. To imbue the reader with a sense of the frequency, nature and dimensions of the phenomena, Chapter 3 catalogues all of the cases located in English language literature from the period 1980-2005 (i.e. the period with which the study is concerned). It is these cases that form the substance of this study and for each case Chapter 3 provides such details as identity, nursing status, location, number of known victims, method of killing, motive, attitude of the perpetrator, the penalty imposed, and any other information that has been discovered. The methodology and methods used in the study are examined in Chapter 4 while Chapters 5-8 present the findings of the study. Chapter 9 concludes the work and posits a theoretical description of the phenomenon that gives rise to a number of recommendations for practice, research, regulation and policy.

Whilst it is conventional to locate the methodology chapter of a dissertation prior to the data sections, here Chapter 3 with its summary of all the cases used precedes the methodology section. In so doing, I have emulated the style of Foucault who habitually developed his work, and then retrospectively explicated his methodology in future works. This is a corollary (or perhaps a luxury) of the postmodern approach that I explore more fully in Chapter 4 where I address issues of methodology and methods.

In preparation for the examination of the phenomenon of murder of patients by nurses, the next chapter examines the nature of the phenomenon of murder in Western developed societies generally but particularly in Australia. It explores aspects as diverse as the history of the status of murder, the law relating to murder, types of murder including medical murder, and the nature of those who murder. In particular, there is an emphasis on coming to grips with the serial killer because one of the realities to emerge in this study is that in almost all cases, only those nurses who are serial killers are caught and convicted.

Chapter 2

Murder

Synopsis

This chapter is intended to afford a context in which to locate the phenomenon of murder by nurses. It presents a discursive account of the concept of murder in Western society throughout history and includes the origins of the ethical and legal prohibitions on murder, an outline of its legal development and its place in contemporary society. This chapter also addresses the species of murder that has been characterised as medical murder by Camp (1982) who used the term in relation to murders committed by medical doctors on patients. Here, however, it is used in a broader sense to include murder of patients by any health care provider including nurses. This serves as a prelude to the analysis of bodies of texts and the discourses constructed by those texts. It is this analysis that constitutes the core of this work.

Introduction

Murder holds a morbid fascination for people. This is evident by the interest generated in the media when a murder occurs. The more bizarre, the greater the number of victims, the more prominent the murderer – all these aspects fuel interest and enthusiasm. This fascination is perhaps even more clearly illustrated by the huge number of both fictional and true murder stories published each year and the vast number of copies consumed by enthusiastic readers. So extensive is the catalogue of fictional murder stories that there is little to be gained by dealing further with them here beyond noting their pervasive nature and the extent of their creativity. It would be a rare person indeed who had never read a fictional tale of murder.

Some writers have sought to bridge the gap between fact and fiction. For example, *Murder 'Whatdunit'* (Gaute & Odell, 1984) is represented as 'the mechanics of murder, its investigation and detection ... a guide for murder mystery fans'. This same partnership produced *The Murderers' Who's Who* (Gaute & Odell, 1980) and this raises the issue of murderers being turned into celebrities. This is always a hazard when biographical accounts of murder are produced. It has been a particular feature among so-called mass murderers and indeed, there is evidence to suggest that for some, this is one of the motivating factors in their crimes.

Among the true murder stories we find such volumes as *The Family* (Sanders, 1971) a biographical account of the murders orchestrated by Charles Manson and *Helter Skelter* (Bugliosi & Gentry, 1974), yet another account of the same case, and the story of Charles Sobraj (Neville, 1980), to mention but a couple among dozens of examples. We find anthologies of the exploits of murderers, such as John Mortimer's *Famous Trials* (Mortimer, 1984). In this case, although the book is entitled *Famous Trials*, inclusions are exclusively murder trials and given the scope of trials available, this in itself says something of the fascination with murder. So too does the fact that this book was reprinted three times in its first year of publication. What is more, it was simply an abridged version of a series that had been around since 1948.

If this is not enough to persuade one of the fascination that murder holds for people, then consider the modern trends in movie-making. Here again, enormous numbers of

films released each year are murder stories. What is more, the technological development of this medium has worked towards making more real, more gruesome, more savage, more intrusive and more horrific this steady diet of violent death that passes for entertainment. Clearly something had to evolve to compensate for the passing of the ritualised public executions so popular in medieval times but this tells us much about the nature of people. So too does the emergence of the notorious 'snuff movies' – movies in which the murder is real and for which there is only what might be regarded as a niche market. This is, of course, the extreme edge of murder as entertainment. That there is any market at all for such movies says much about both those who would make such movies and those who would watch them. It is tempting to dismiss any mention of these movies because of their extreme nature, but one would hope that most of the matter dealt with in a study that deals with nurses who murder patients is at the extremes of human conduct.

Serial murder holds a particular fascination in the arena of entertainment. This has been very evident in films such as *'The Silence of the Lambs'* (1991) based on the book of the same name (Harris, 1988). The anarchic Internet has afforded safe haven to those with a penchant for serial murder insofar as there are now websites devoted to the topic. For example, there is an American cable television network known as *CourtTV* (more formally, the *Courtroom Television Network*) which is owned by Time Warner. It is effectively mainstream but it has a website called *CourtTV Crime Library* which on its home page has an index for serial killers, all neatly categorised, organised and sensationalised (www.crimelibrary.com/serial_killers/index.html). There are still other sites that celebrate the infamy, or at the very least contribute to the high profile or even cult following, of particular serial killers such as Charles Manson (e.g. www.charliemanson.com). The importance of such websites for this study is confined to an awareness of their existence and their potential to create another level of discourse around the phenomenon of interest.

This fascination with murder is but one dimension of a highly ambivalent, confused attitude to murder. Another dimension is fear. Some authors argue that fear of murder in a general societal sense is relatively new. Seagle (1932) argues that 'horror of murder is a modern phenomenon'. It may be linked with an increasing remoteness of individuals from death more generally and the resultant impaired ability to deal

with human mortality. It may also be related to the real or perceived incidence of murder. In the context of present day Australia, efforts are under way to determine whether this perception has a factual basis. A national study, the National Homicide Monitoring Study (M. Davies & Mouzos, 2006) being carried out through the Australian Institute of Criminology and now in its 18th year, is intended to provide an accurate picture of the incidence and characteristics of murder in Australia. However, this issue will always be confounded by constantly improving methods of detection. There can be no doubt that in the past many murders escaped detection because of the absence of any means of detection; for example, murders by poison for which there was no means of detection at the time.

This ambivalent attitude toward murder – this confusion of fascination, horror and fear - reflects the complexity of murder and its place in society. At the same time, it demonstrates the need to establish context through an exploration of the nature of murder before examining in depth the specific phenomenon of nurses who intentionally kill patients.

Thou Shalt Not Kill – the law of homicide

This Mosaic proclamation affords a clear indication that from its earliest days the Judaeo-Christian ethos has proscribed the killing of our fellow human beings. However, the simplicity of this Biblical edict that thou shalt not kill (Exodus 20:13, n.d.) belies the complexity of its interpretation and application. This study of nurses who murder patients begins with a consideration of the life and fortunes of the law of homicide since Moses clambered off his mountain for it aids in setting the context of the discourses explored as the object of this thesis. However, this consideration must be prefaced by a qualification. Homicide is socially constructed. The various categories of lawful and unlawful homicide have been constructed over centuries. As is the case with most social construction, the categories of homicide have emerged as the product of societal interaction, and possibly of more significance, reaction to specific behaviours. We need to be mindful of this in understanding homicide.

Homicide Defined

The beginning point in this discussion is the meaning of the word homicide which is clarified before the specific meaning of murder is addressed. A dictionary definition has homicide as a noun having two meanings, these being '*1. the killing of a human being by another*' and '*2. a person who kills a human being*' (J. Pearsall & Bill Trumble, 1995, p.677). Whilst this is a very general definition, a specialist legal dictionary gives only slightly more precision to the term in defining it as '*1. A killing, lawful or unlawful, of one human being by another*' or '*2. Unlawful killing with or without the intent to kill or do grievous bodily harm ...*' (Nigh & Butt, 1997, p.556).

The generality of these definitions is problematic in terms of the application and interpretation of the edict 'thou shalt not kill'. For instance, '*A killing, lawful or unlawful*', immediately admits the possibility of legal homicide. This raises the issue of the categorisation of homicides. Since this is a practice in which all societies engage, here it is important to understand the issues and principles underlying such categorisation. As Nettler (1982) astutely observes, our attitude toward homicide is ambivalent and there is no universal concept of wrongful homicide. Sigmund Freud (Freud & Brill, 1938) argued that the '*... basis of taboo is a forbidden action for which there exists a strong inclination in the unconscious.*' The classification of homicide rests on, and changes with, moral assumptions (Nettler, 1982, p.1). Nettler asserts that ethical studies '*...commonly note that our morals only prohibit what we are inclined to do. The inclination may be infrequently expressed, but moral commandments would be vacant if they were directed against impossibilities rather than proclivities*' (Nettler, 1982, p.1). Many others have expressed similar views. For example, Quentin Crisp wrote:

I expect that rape and murder, either separately or mixed together, fill the fantasies of most men and all stylists. They are the supreme acts of ascendancy over others; they yield the only moments when a man is certain beyond all doubt that his message has been received. Of the few who live out these dreams, some preface rape with murder so as to avoid embracing a partner who might criticize their technique. (Crisp & Kettleback, 1984)

These matters of morality are of central importance when considering homicide. The point of the commandment writ in stone was and remains a prohibition on killing other people. The law has reinforced this to a large extent over the centuries since Moses but not in any absolute sense. To begin with, homicide has not historically stood at the top of the hierarchy of crimes. Both heresy and treason have been considered to be more important, more heinous.

When looking at historical accounts of law in Australia, it is important to consider the evolution of the Common Law in England for that is the original source of contemporary Australian law. In the early days of the development of the common law system in England, the law of homicide was considerably more capricious even than it is today. For a long time the law suffered badly from the blurring of boundaries between criminal and civil actions. For instance, the doctrine of *parens patriae* had much greater significance in 15th Century England than it does today. The people were the Monarch's subjects in every sense of the word. That meant he or she had a vested interest in the people so if a subject died in unusual circumstances, that death would necessitate a coronial inquiry. Note that historically, the Coroner was an officer of the Crown charged with responsibility for maintaining the rights of the property of the Crown. Among the Crown's property were his or her subjects. Note also that should a subject be killed, any chattel that brought about that death was forfeit to the Crown by way of deodand (Baker, 1979, p.322). This was perhaps an early form of life insurance but it was also subject to gross abuse by avaricious and sometimes impecunious monarchs such that many an unfortunate subject who had accidentally run down and killed another person while driving their horse and carriage forfeited that horse and carriage. This common law doctrine remained in force until 1846. Its abrogation came about when application of the rule to railway locomotives brought it to public attention.

Under the common law, homicide was subject to the law of pardons. The death penalty was available for all homicides and it was the prerogative of the Monarch to grant a pardon. It was said by Pollock and Maitland that '*... the man who commits homicide by misadventure or in self defence deserves but needs a pardon ...*' (Baker, 1979, p.429). Over time, the pardon for such homicides became routine but murder was singled out for exclusion from even those pardons expressed to be a pardon for

all felonies. By the 1400s, murder had moved from being confined to secret or stealthy killings to being a ‘... *malicious, premeditated or deliberate killing.*’ (Baker, 1979, p.429). This lay the foundation for the present categorisations of homicide.

A fundamental preoccupation in the law of homicide is that of fault. The law has dealt with the complexities of this notion in terms of culpability as will be seen below. It has, however, also dealt with those complexities through artifices, legal fictions and contrivances as it has striven to achieve rationality and coherence in the law pertaining to homicide. Unfortunately, the intricacies of this struggle lie beyond the scope of this study but they are explored in detail by Yeo (1997).

A killing must contain three elements to satisfy a legal definition of homicide. The victim must be a human being; death must be brought about by the act or omission of one or more human beings; and it must occur during the Queen’s peace (Simester & Sullivan, 2000, p.320). Each of these elements is worthy of some consideration here. The status of being a human being is itself legally defined and it is not possible to commit homicide if the victim is not human. An example of where this becomes an issue is the situation of a human foetus which does not attract full human status until after birth. The interests of the foetus are protected by law but not by the law of homicide (Simester & Sullivan, 2000, p.320). There is considerable law relating to the issue of the status of the foetus but it lies outside the ambit of this project.

The second element to be addressed here is that the death must be brought about by the act or omission of one or more human beings. The law provides for four species of homicide – justifiable homicide, excusable homicide, manslaughter and murder. They are presented in order of increasing culpability.

Justifiable homicide:

A homicide not subject to criminal prosecution. A justifiable homicide carried with it condemnation rather than blame and accordingly entitled the accused to acquittal, entailing no forfeiture and requiring no pardon. (Nigh & Butt, 1997, p.655)

In jurisdictions having capital punishment¹ it is the notion of justifiable homicide that allows the state to execute those persons convicted of capital crimes² and sentenced to death. The case of a police officer who in the legal exercise of a particular duty kills a person who resists or otherwise impedes the execution of that duty would fall within the ambit of justifiable homicide, as would the case of any other properly authorised officer of the state. This would be so where the homicide was committed in response to a felonious attack on the officer by the deceased person (*Zecevic v DPP* (1987) 162 CLR). This is distinguished from excusable homicide.

Excusable Homicide: This is ‘...a killing to which the law would ordinarily attach some degree of blame, but which it excuses, such as where the killing is by misadventure or in self-defence...’ (*R v Semini* [1949] 1 KB 405). Note that under Australian law this falls within justifiable homicide (Nigh & Butt, 1997, p.444).

Manslaughter: The next level of culpability in homicide is termed manslaughter which under Australian law includes every ‘...unlawful killing at common law or under statute which is not murder...’ (Nigh & Butt, 1997, p.721). Note that manslaughter is always available as an alternative verdict in murder cases.

Murder: Finally, there is murder which can be defined in the following way:

The unlawful killing of a human being with the intent to kill or do grievous bodily harm and, depending on the particular jurisdiction, in other circumstances specified in the relevant statutory offence: for example (NSW) Crimes Act 1900 s.18(1)(a); (Qld) Criminal Code s.302. Such circumstances include where the person foresees the probability of death, or (in some jurisdictions) grievous bodily harm resulting from his or her actions (*R v Crabbe* (1985)156 CLR 464; 58 ALR 417) and where death is occasioned during the commission of a serious criminal offence. (Nigh & Butt, 1997, p.768)

It is of course this last category of homicide that is the focus of this study so some time is spent examining the present state of the law relating to murder and current

¹ The death sentence.

² Crimes for which the maximum penalty that may be imposed is the death penalty.

knowledge about murder and murderers. The notion of euthanasia is also located in this context.

The Phenomenon of Murder

It is only in relatively recent times in Western societies that homicide has assumed its prominence as a common source of fear and trepidation (Seagle, 1932). More importantly, the dependence of homicide on moral assumptions for its classification means that the level of culpability attaching to the homicide is highly contingent upon the circumstances of the case and also changes over time. The relationship between the legal definition of homicide and justice is equally circumstantial.

Having identified what murder is, at least in law, a snapshot of the state of murder in Australia may assist in contextualising this study. As noted earlier, concern in Australia in the 1980s about a perceived increase in the nature and violence of murder led to the implementation of the National Homicide Monitoring Study (NHMS) which has continued for the past 17 years (M. Davies & Mouzos, 2006). Listening to news reports and reading newspapers gives one a perception of an epidemic of murder. In Australia in 2006 there were just 283 murders, of which one was infanticide³, 26 were manslaughter and 256 were murder. This number of 256 murders is about average for Australia and in 2006, approximately 90% were solved (M. Davies & Mouzos, 2006, p.38). Of the cases where an offender has been identified, the overwhelming majority involved one victim and one offender (approximately 78%). Approximately 16% of cases involved multiple offenders with one victim and 5% involved multiple victims with one offender. Only one incident involved multiple victims and multiple offenders (p.39).

The time of day makes little difference although 6:00am to noon seems safer than 6:00pm to midnight. Weekends are a little more dangerous than weekdays but there seems to be very little seasonal variation in the numbers of murders. Being at home continues to be the most dangerous place in terms of the risk of being murdered, with approximately 63% of murders occurring in the home compared with approximately 25% on the street or in an open area (M. Davies & Mouzos, 2006, p.42). Not

surprisingly, the great majority of murders (approximately 63%) occur in areas of greatest concentration of population, that is, in major cities.

About 19% of murders are committed during the commission of another crime such as robbery, arson or sexual assault. The major motives for murder in Australia in 2006 included revenge (10); domestic dispute (74); money or drugs (20); alcohol related argument (20); and other argument (19) (M. Davies & Mouzos, 2006, p.58). Of those murders that were solved, approximately 88% were committed by males, compared with females who committed only approximately 13% of Australian murders in 2006. There are other gender related differences. Of murders committed by females, only about 7% involved the murder of a stranger, compared with 29% in the case of males. On the other hand, in two thirds (66%) of all murders committed by women in Australia in 2006, the victim was a family member or an intimate of the offender. This compares with approximately only one third (36% in the case of murders by males. There is almost no difference between males and females in the percentage of murders of friends or acquaintances. Caucasian males aged between 15 and 25 years remain the most dangerous people in our society, so far as murder is concerned. Some comment on weapons of choice helps to dispel public perceptions on this matter also. The use of firearms has steadily declined in Australia and only 14% of murders in 2006 involved a firearm. Against that, knives or sharp instruments were used in one third of murders. This concludes the snapshot of murder and murderers in Australia and demonstrates that the nature of the phenomenon is quite well understood.

Even so, society is not relaxed about this phenomenon. There is a sense, especially among the families of victims, that those who murder do not receive sufficiently harsh penalties from the Courts. It has been shown that the law is fairly precise in its formulation of what constitutes murder. It has also been shown that this precision is somewhat attenuated in the application of the law to actual cases because of the evolution of the attitudes and views of society. Although the law will always lag some way behind current developments in society, it must necessarily sit at least reasonably comfortably with prevailing social values if it is to continue to command

³ Infanticide is classified separately from other similar offences and occurs when a mother causes the death of a baby (willfully or through omission) within the first twelve months of the life of the baby.

the respect of those whom it regulates. When the law slips too far out of kilter with the views of society, the citizens will refuse to comply with those laws. In extreme cases this may lead to revolution. Although generally conservative, law-makers tend to be mindful of this possibility and in Western style democracy at least, this has proved fairly effective. The law must be dynamic.

There are two main respects in which law can change. It can change the definition of a crime. This has been the vehicle for considerable social engineering through the law but this is not the place to digress on examples. The other respect in which change is likely to occur is that of penalty. For society to be comfortable with its legal system, punishments meted out to perpetrators by courts must be perceived to fit the crime. In the context of the contemporary Australian legal system there are regular challenges to the existing law with respect to both definition and penalty. Some examples relevant to murder that serve to illustrate the impact of such challenges are useful here by way of adding depth to the contextualisation of murder of patients by nurses.

In terms of the definition of murder, the Australian legal system has been wracked in all of its jurisdictions by calls to exclude voluntary euthanasia - mercy killing - from this crime and to make it lawful. The issue of euthanasia is as yet too contentious within society for there to be sufficient agreement to go down this path. Legislative attempts to achieve this change in one jurisdiction did not achieve sufficient political support in the national Parliament to survive (Amarasekara, 1997; Kline, 2002). Whilst the issues of the debate lie outside the scope of this discussion, the relevance of the example in the context of this thesis will not be lost on the reader. Examples of calls for penalties to be adjusted to fit the crime with respect to murder are commonplace. Often these come from the families of victims who feel that the punishment given to the perpetrator was inadequate. In other cases the penalty may be perceived as too harsh. A highly relevant example of this latter situation can be found in the South Australian case of Johnstone (Unreported, Supreme Court (SA), 21 January, 1987) a case of mercy killing committed by a 62 year old man when his mentally ill wife could bear her suffering no longer.

The trial judge – the now somewhat infamous Mr Justice Bollen – sentenced Johnstone to the mandatory sentence of life imprisonment as he was statutorily obliged to do. Justice Bollen made it absolutely clear that he would have preferred to impose no penalty at all and in reality he achieved this end through a creative application of his power to set the non-parole period. He set that period at ten days to run from the time that the defendant first came before the court. It was his view that Johnstone's actions were motivated by deep compassion and love for his wife and that neither the punitive nor the preventive elements of sentencing demanded an actual stay in prison. The press welcomed this decision as a victory for the law, justice and common sense (P. Turner, 1987, p.11). This was not the case with the legal system. The Crown appealed on the basis that the non-parole period was manifestly inadequate (Johnstone (1987) 45 S.A.S.R. 482 at 485). Among other things, the Crown argued that the non-parole period did not reflect the importance of society's maintenance of the sanctity of life and that the trial judge had given insufficient weight to the question of general deterrence. This case caused the judiciary considerable anguish at every level so it is worth examining the outcome of the appeal and the comments of the Court. The Chief Justice characterised the case as both important and distressing. Chief Justice King said that it was natural to be deeply moved by the sad predicament in which the defendant had found himself but he also said that it would be wrong to allow one's pity to blind one to the stark reality of what the defendant had done:

Cases such as this present great difficulty to the sentencing judge and to an appellate court. People cannot be permitted to take life in defiance of the law, however altruistic their personal motives may be. It is the responsibility of the court to impose punishments which will maintain respect for the law and deter others from defying it. (Johnstone (1987) 45 S.A.S.R. 482 at 485)

On the subject of the non-parole period in a case such as that of Johnstone where the defendant was moved by his wife's plight and her entreaties for his assistance, King CJ acknowledged that there is considerable scope for compassion and leniency in setting that period. Notwithstanding this, it was his view that the gravity of the crime and the need for deterrence cannot be overlooked. Thus:

When those factors are given their proper weight, it is difficult to visualise a case, even the most compassionate of cases, in which the ends of punishment could be served adequately other than by a substantial non-parole period probably of some years.

The nominal non-parole period which the learned sentencing judge imposed and the remarks which accompanied it, lead me to the conclusion that his Honour allowed his understandable pity for this unfortunate man to cloud his appreciation of the necessity for the non-parole period to affirm the values which the law enshrines and to deter people from disregarding. I think that the failure to give proper weight to those factors had caused the sentencing process to miscarry. (Johnstone (1987) 45 S.A.S.R. 482 at 485)

Now, on the basis of these comments one might think the outcome of the Crown's appeal would be a foregone conclusion. However, appellate courts have no less creativity than trial courts. In this case, King CJ relied upon a well-established principle that in a Crown appeal, an error in the sentencing process will not inevitably lead to intervention by the court. He acknowledged that there are times when the ends of justice are served by establishing the correct principles and standards of law without interfering with the result in the particular case. The non-parole period stood. The Court declared that it was not to be treated as a precedent. In effect the status quo was maintained and the political dimension of the case was assuaged. It did not result in any change in the law and the dilemma for judges, lawyers and citizens remains.

This case graphically illustrates the capacity for the law to move or to stand still. It also reveals the capacity of the law to sidestep issues until society reaches a more consensual view on a given matter. Most of all, it demonstrates the priority accorded the sanctity of life within our legal system and our society. It demonstrates that wherever possible, the wilful taking of life will be construed as murder. This is a strong prohibition and it begs the question of just who would contravene a prohibition that carries with it in many jurisdictions the penalty of death or, as is the case in at least some Australian jurisdictions, a mandatory life sentence. Notwithstanding the availability of non-parole periods that are sometimes

excessively lenient, this is a high risk activity. Again, this begs the question – who would commit murder and why?

Murderers

Murderers have attracted a good deal of attention from psychologists, sociologists, psychiatrists, criminologists and a raft of other behavioural scientists. As noted in the introduction to this chapter, the general public also demonstrates a lively interest in murderers and this is evident from the attention that murderers receive in newspapers, magazines and current affairs programs on radio and television. Few individuals could not name at least a few of our most notorious murderers. Everyone wants to know what kind of person is likely to wilfully kill other human beings. Murder generates multiple discourses among which are popular discourses, the legal discourses, the religious discourses, the academic discourses and the cultural discourses.

A snapshot of Australian murderers has already been presented. Now, what is known on the subject is briefly reviewed as another step in setting the context of murder by nurses. There are three key issues to be considered. Firstly, what are the demographic characteristics of murderers. Secondly, are there cultural determinants that can be discerned among murderers? Thirdly, are there identifiable categories among the motives for murder?

Demographic characteristics

Demography is the study of statistics, deaths, disease, etc., as illustrating the conditions of life in communities (J. Pearsall & Bill Trumble, 1995, p.379). In this case we are examining the community of murderers and seeking to identify the common characteristics of its members. Age, sex, work and wealth are the four major indicators usually used by sociologists as both descriptive and explanatory tools and they are the basis of this examination. According to Nettler, (1982, p.14), the significance for action of all four of these factors is contingent upon the cultures in which they function. With this qualification there are some demographic characteristics of murderers that can be asserted with confidence.

There is a significant body of evidence that demonstrates that males more frequently lethally attack others than do females (Brookman, 2005). However this needs to be treated carefully because, to a greater or lesser extent, social situations will inhibit or facilitate manifestations of this biological given. The result is that females in one culture may be more murderous than males in another culture (Nettler, 1982, p.17). However, this does accord with the experience in Australia (M. Davies & Mouzos, 2006). It also means that age and sex distributions among murderers will vary in time and place with the kind of lethal attack that is prevalent. For example, as Morris and Blom-Cooper (1964) have shown, where murders are disproportionately domestic such as in England and Wales during the period of their study, then the age of killers will be higher than in countries such as the United States where, during that same period, murder was more commonly the murder of strangers as an accompaniment of robbery (Zimring, 1977).

Nevertheless, it is safe to say that generally speaking, the most lethal class of human being is a male between the ages of 14 years and 40 years. However, according to Nettler:

(a)pproximations toward equality of sex roles are accompanied by a convergence, but not equality of murder rates. Conversely the more sheltered the lives of women the more they are "protected" by men and segregated from civic life, the greater the differential in favour of the homicidal activity of males. It is in "modernizing" countries, as opposed to the traditionally sex-segregated lands, that the proportions of men and women arrested for violent crimes move closer together (1982, p.20).

Thus, although it is a variable factor, it is true that gender is a significant determinant in assessing propensity for committing murder. So too is age but not in isolation from gender, as we have seen in Australia (M. Davies & Mouzos, 2006).

The third and fourth demographic characteristics to be examined are work and wealth. Like sex and age, work and wealth are not easily separated in this context. There are popular views about how they fit together. For example, it is widely believed that city centres are inherently more dangerous places than elsewhere. There are perceived to be many more deviants such as street people and criminals

connected to city centres, and related to this, an associated increase in the risk of murder. The evidence suggests that this is not always the case. While more people in metropolitan areas are murdered, more people live there so the percentage rates may be significantly lower. Moreover, Canadian murder rates in the countryside have been shown to be higher than metropolitan rates (Schloss & Giesbrecht, 1972). There are hazards involved in trying to generalise from the literature on this subject in terms of establishing characteristics of murderers on the basis of work and lifestyle. The literature is complex and the evidence can be misleading and in the context of this study which revolves around nurses, is unlikely to shed a great deal of light. For this reason, and without implying they are unimportant, I am going to take the liberty of exploring them no further. Still, whilst this is but one aspect of this study, the current state of knowledge about murder and murderers is important to the extent that comparisons between nurses who murder and murderers generally may be enlightening. This brings us now to the particular form of murder that throughout this study is referred to as medical murder.

Culture and Murderers

Among those who study murder and murderers, many will argue that culture plays a role. A common position is that murder occurs more commonly in some groups than others because those groups accept or even support the use of violence as a legitimate means of settling quarrels or upholding honour (Alvarez & Bachman, 2003a). In the USA subcultures have formed along ethnic lines, on the streets in the forms of gangs and particularly within those groups within society who are economically, socially and politically disadvantaged relative to other groups. The use of violence has escalated among those groups and the age of participants in that violence continues to fall. Such developments are far less conspicuous in Australia.

Murderers' Motives

In providing a snapshot of Australian murders, it is evident from the National Homicide Monitoring Study that the motives are predominantly revenge; domestic disputation; pursuit of money or drugs; alcohol related argument; and other arguments other than drug related or alcohol (M. Davies & Mouzos, 2006, p.58). This resonates with findings in the USA and also in the UK where the motives are

primarily domestic disputes, confrontation (non-relational), homicide in the course of commission of a crime, racial violence and revenge (Brookman, 2005, p.50). This does not include those rarer murders committed by the serial killer where the motive is essentially dominance, control and power, often in connection with satisfaction of uncontrolled (and perhaps uncontrollable) sexual and sadistic desires.

Medical Murder

Thus far in this work I have alluded to the murder of patients by health professionals on a number of occasions. There are many examples of murder by medical practitioners. A brief catalogue will cast up some familiar names, most notably that of Dr Harold Shipman. His notoriety stems from the fact that he is probably Britain's worst ever serial killer of any variety. Dr Michael Swango in the USA was another doctor who murdered patients and of course, there was Dr Joseph Mengeles and the other doctors of the Nazi death camps. There was a long history of decidedly dangerous medical practitioners before that as shown in the book *100 Years of Medical Murder* (Camp, 1982). Dr Shipman is but one among many. In more recent times the possibilities for doctors to murder have been reduced by increased supervision. However, there remains considerable opportunity and around the world there continues to be cases in which medical practitioners are charged and convicted for the murder of patients, and sometimes for the murder of large numbers of patients.

It has to be said that the cases of medical practitioners convicted of the murder of patients are very rare, particularly when the overall number of health professionals is taken into account. Statistically the number is tiny. There is probably another group of health professionals who murder patients who go undetected but again this hidden burden is still likely to be very small. There have been some cases of health professionals other than medical practitioners and nurses murdering patients but these are rarer still. However, the reality is that one case is one too many, and this tiny group account for the deaths of a significant number of patients. An important factor shared by medical murderers is the propensity for serial killing which means that this discussion would be deficient without some commentary on serial killers.

The Serial Murderer

It seems to be the serial murderer that most fascinates us. The notion of an individual who kills his fellow human beings with a cold, calculating rationality challenges the idea that such a person must be deranged. Bear in mind the human proclivity for dismissing such individuals as abnormal, as psychotic, as psychopaths. Research reveals a very different picture. According to Sears (1991), there is a clear profile of the typical serial murderer.

The typical profile includes an early home life where there is not a stable, nurturing atmosphere (FBI, 1985). It is characterised by physical or psychological abuse and probably at least one parent is be absent. Sears (1991, p.43) points out that:

... fueled by the frustration of their inability to experience social and sexual relationships and their exposure to abuse and neglect as children, serial killers' fantasies eventually center upon sex and violence. They become fascinated with pornography and sadistic sexual behaviour.

In most cases the serial murderer has sufficient insight to conceal these preoccupations from friends and family so that they present as a normal, healthy individual. Certainly there is usually no overt sign of serious mental illness such as delusions or frank psychosis. They do, however, generally satisfy the criteria for a diagnosis of sociopath or psychopath or antisocial personality. The basis of this diagnosis is an absence of feelings of guilt, conscience, remorse, regret or pity. Also consistent with this diagnosis is the inability to learn from experience and emotional immaturity reflected in very poor impulse control.

Sears (1991) indicates that serial murderers are commonly intelligent, articulate, charming and charismatic. These qualities are used by the serial murderer to control and manipulate those around him (it is typically a male) to achieve his own ends. They are also careful to avoid leaving clues that may lead to detection. These attributes are tempered to some extent by a low tolerance for frustration and many serial murderers are prone to violent outbursts of temper when their low threshold is exceeded. They often have high energy levels and low sleep requirements, frequently use alcohol or drugs prior to killing, and generally their need to kill escalates over time.

Serial murderers tend to have an outward appearance of success and are usually considered successful professionally. Appearances can be deceptive and in reality, most serial murderers have a poor to mediocre record of achievement. Even so, serial murderers tend to be very egocentric and crave the attention of others. Thus when caught, the media attention is often some compensation. Typically, serial murderers commit their crimes between the ages of 20 and 35 years, select their victims carefully, generally select strangers, mostly pick them up off the street, and will almost always select victims of same sex, age and hair colour. According to Sears, (D. Sears, 1991) serial murderers engineer a situation where they have complete control of their victim. They will usually kill only one at a time.

Before leaving this profile of the serial murderer, it will be obvious that it has been constructed on the basis of a review of cases of serial killers who were motivated to commit sexual violence. Thus, the insights and understandings generated by that analysis are unlikely to provide an accurate profile for offenders such as Harold Shipman and other medical practitioners who commit serial medical murder. That is even more likely to be the case with respect to nurses who commit medical murder. It is hoped that this present study contributes to an improved understanding of the profile of those health professionals who would commit serial murder of patients.

Murder by Nurses

Murder by nurses does not appear to have been researched to any great extent. There are instances that have occurred and often these cases have made headline news for protracted periods. A number have even been the subject of books but they do not seem to have penetrated the public consciousness. Perhaps the public does not want to know about such things. This study explores just such matters.

Conclusion

This Chapter has sought to provide an account of homicide and murder in our society to provide a platform for understanding the phenomenon of murder by nurses. Of necessity it has been kept brief and this has meant that many topics of great interest

but lesser relevance are glossed over. Nevertheless, the material covered does afford a sense of the place of homicide in our society including our ambivalent attitude, our confusion of revulsion, horror and fascination. I have alluded to the enormous anxiety in society associated with murder which may appear to be disproportionate to what is a relatively small number of murders, at least in Australia, each year. Understanding all forms of murder is essential to the wellbeing of society, and understanding medical murder committed by nurses will be of considerable interest to health professionals and patients alike. However, before exploring this phenomenon, a catalogue of the cases encountered in this study is provided in the next chapter.

Chapter 3

The Cases

Synopsis

Do nurses murder their patients? An examination of the media and other sources reveals a number of examples of nurses wilfully taking the lives of their patients. To get some sense of the nature of the phenomenon under study here, the 48 cases that form the focus of this study are identified, described and categorised. This is an important step in achieving clarity around the phenomenon of murder committed by nurses upon their patients. At the same time, these cases serve to establish the existence of the phenomena as a prelude to its examination.

Introduction

The cases used in this study are drawn from the period 1980 – 2006. Within that 25 year period, the focus is almost exclusively on those cases that have resulted in the nurse being convicted of murder. In some instances cases involving a lesser charge have been included – most notably those involving a plea bargain where a nurse who has clearly murdered a patient or patients and has been charged with that murder is given the opportunity to plead guilty to a lesser charge in order to secure a conviction.

At the end, a handful of cases are described where either the nurse has been acquitted or the case is atypical in some respect. Elsewhere in this work these cases are discussed because, whilst not necessarily constituting proven cases of murder by nurses, the discourses contained within them reveal pertinent dimensions of that phenomenon. The categorisation contained in this chapter provides the basis for cross-referencing in later chapters to assist the reader in quickly locating the details of a given case as the various discourses and constructions of nurses who murder their patients are explored and illustrated. The categorisation begins with those cases of nurses who have been convicted of the murder of one or more patients (Registered Nurses (RN) Enrolled Nurses (EN) and Assistants in Nursing (AIN)). Inevitably, the variations in levels of training, education, and structure of nursing among and between

countries ensure that there will be some inaccuracies and ambiguities in this categorisation. This is compounded by the attitude of the media (and perhaps the general public) that a nurse is a nurse is a nurse. I have addressed this matter of the semantics of nursing in considerable detail in Chapter 7 so I am merely noting it here. At the end of this Chapter a chart summarising the details is included to further assist in the navigation of the cases.

Registered nurses convicted of the murder of patients.

The Case of Christine Ackley (USA)

Christine Ackley was accused of the murder of Edgar Sasser, aged 69. She was a 38 year old home-care nurse and he was her patient. The charges in relation to Sasser

included first degree murder which in the particular jurisdiction can attract the death sentence. It was alleged that she administered to Sasser a lethal dose of muscle relaxant before dumping his body in a garbage can which she then dumped. She confessed to having killed Sasser so she could steal his credit cards and pay off a debt she owed her parents. Ackley had intended that the death should look like suicide but, afraid that it might not, she decided to dump his body. Ackley pleaded not guilty by reason of insanity. However, her defence was rejected and she was convicted of murder with deliberation, felony murder, aggravated robbery of an at-risk adult, robbery, theft and fraudulent use of a credit card. She was sentenced to life imprisonment without parole and 36 years imprisonment for aggravated robbery and theft on 17 December, 2004 (Rocky Mountain News, 2004b, p.31).

The Case of Joseph Dewey Akin (USA)

The case of Joseph Dewey Akin features prominently in this study because, although convicted of only one murder, he was involved in close to 100 emergency situations, many of which he is suspected of having precipitated. The story and its legal processes are complex and the commentary reveals much about the constructions of murder by nurses. Akin was charged with the 1991 murder of Robert J. Price of Birmingham while Price, 32, was a patient at Cooper Green Hospital and Akin was working there as a nurse. It was alleged that Akin injected Price with a fatal overdose of lidocaine which is a local anaesthetic and heart medication. The prosecution argued that Akin got a thrill from hearing the man's heart rate monitor trip its alarm and from watching hospital workers race to save him (McIntosh, 1992a, p.1).

Akin was convicted but successfully appealed, not because of any doubt about whether or not he was guilty, but because the Appeals Court ruled that the judge erred when he did not dismiss a potential juror who said she thought Akin was guilty. The defence argued that Price died of natural causes and that the lidocaine was mistakenly administered during efforts to resuscitate him.

Akin was also suspected in at least 17 suspicious deaths at North Fulton Regional Hospital in Roswell, Georgia, where he worked in 1990. However, he was never charged in relation to these deaths. (Associated Press, 1997a, 1998; The Associated Press, 1998)

The Case of Sonia Caleffi (Italy)

Sonia Caleffi is an Italian woman who after working as a nurse at the age of 34 was arrested over the deaths of five patients in one month. The Italian police said that the list of her alleged victims would almost certainly be much longer. Caleffi admitted to injecting air into the veins of three women and two men by means of a syringe at a 900-bed hospital at Lecco near Milan and to thus causing their deaths by embolism and respiratory failure. She recorded the details in a notebook at home.

Four other deaths at the hospital were also suspicious, in the opinion of the prosecutor, Anna Maria Delitala. It was reported by hospital staff that in the case of each death, Signora Caleffi had cleared the hospital room of family members and other nursing staff, remaining alone with her victim. Apparently Caleffi:

... would then leave the room "in an extremely agitated state" several minutes later, calling for assistance to help the dying patient. Police said that Signora Caleffi had admitted that she had killed patients in her care although her lawyer asserted that she had injected the air not to kill the patients but to make them ill so that she could heroically save them. Instead, they had all died. (Owen, 2004, p.46)

In July, 2006, Caleffi was convicted of the murder of 12 patients and was suspected of three others. She was sentenced to 20 years in prison. (Owen, 2004; Sunny, 2006).

The Case of Charles Cullen (USA)

Charles Cullen was convicted in New Jersey, USA, of the murder of 22 patients and the attempted murder of 3 others. Cullen of Bethlehem, Pennsylvania, was a divorced Navy veteran who lived quietly with his girlfriend who was a nurse in Pennsylvania. Cullen was arrested on December 12th, 2003 and charged with murder after the death of a Roman Catholic clergyman who was a patient at Somerset Medical Center. He was also charged with the attempted murder of a 40-year-old woman at the same hospital. After being arrested, he told authorities he had administered overdoses of drugs to these patients and had killed many others in his 16-year nursing career. Cullen was ordered to be held on \$1 million bail.

Ultimately, he claimed to have killed as many as 80 but investigators believe the number was nearer 40.

Cullen may well have one of the longest prison sentences ever handed down. On March 2nd, 2006, Cullen was sentenced to 11 consecutive life sentences in New Jersey, to be ineligible for parole for 397 years. On March 10, 2006 Cullen was brought into the courtroom of Lehigh County, Pennsylvania where he was sentenced to an additional six life sentences for the murder of patients in that state. Cullen currently faces 18 life sentences in prison to be served consecutively (Hepp & Frassinelli, 2006, p.1; Perez-Pena, 2003, p.6).

The Case of Lucy de Berk (The Netherlands)

Lucy de Berk is a 41 year old Dutch nurse who was charged with killing 13 patients and attempting to murder five others between February 1997 and September 2001 by giving them lethal doses of substances like potassium and morphine while working in several hospitals in The Hague. She was sentenced to life imprisonment for the murder of three children and an elderly woman in her care. She was acquitted of killing or trying to kill 11 more patients, including a 91-year-old UN war crimes judge.

De Berk had denied the charges, although she had written in her diary that she had given in to her compulsions and she had been characterized by the prosecution as a 'psychopath'. Her actions were deliberate, pre-meditated and calculated. Her victims included a six year old child who had physical and mental disabilities. In September 2001, a co-worker of De Berk reported concerns after an infant had died whilst in the care of De Berk (AP, 1996),(Cowan, 2003, p.16; de Hemptinne, 2004).

The Case of Robert Diaz also known as David Richard Diaz (USA)

In 1981 Robert Diaz, a Coronary Care nurse working at the Community Hospital of the Valleys in Perris, California, was arrested and charged with the murder of twelve patients over a twelve-day period – eleven murders at the Community Hospital of the Valleys and one murder at the San Geronio Pass Memorial Hospital where, although Diaz had worked just one shift, a patient had died in exactly the same way as the other eleven victims. It was alleged that he had injected the patients with Lidocaine. The evidence came from samples taken from exhumed bodies which

showed overdoses of Lidocaine. Lidocaine and morphine had been found at Diaz's home. He was convicted of on March 29, 1984 and sentenced to twelve death sentences – one for each of his victims. (M. Taylor, 1994, p.6).

The Case of Timea Faludi (Hungary)

This case involved Timea Faludi, a nurse in Hungary, who was arrested in 2001 and charged with several counts of attempted homicide and wilful endangerment of the lives of four persons in her care. She confessed to administering lethal doses of drugs to several seriously ill elderly patients between 2000 and 2001, putting the number at 40. She later retracted the confession, saying she made up stories to get attention. The nurse was convicted of one charge of murder and six charges of attempted homicide and wilful endangerment of lives. Faludi was sentenced to nine years in prison but the prosecution appealed against the leniency of the sentence and it was then increased to 11 years. (AP, 2003c; Calgary Herald, 2002, p.18).

The Case of Alison Firth (England)

This Scottish nurse was sentenced to life imprisonment after being convicted of the murder of an 84 year old patient. After her arrest for the murder of 84 year old Alice Grant, Alison Firth was characterised by the media as the 'lazy nurse' because her motive was thought to be that it was easier to murder the woman than to care for her. Her victim suffered from dementia, was bedridden, could not speak and was dependent on staff at Aidan House nursing home in Gateshead, Tyneside, for her every need. Firth was heard to have said that she wished Alice would hurry up and die so it would give her (Firth) something to do.

Firth was struck off the Register in 2002. Two other patient deaths were investigated (including one exhumation) at the Aidan House and her previous work history was closely scrutinised, consisting of 27 jobs during her 16 years of nursing. No further charges were laid, however. (Armstrong, 2001; Blacklock, 2001a, 2001b, 2001c, 2001d; Starrs, 2001; Stokes, 2001; Wainwright, 2001; Webber, 2001a, 2001b)

The case of Benjamin Geen (UK)

Benjamin Geen, 25, a registered nurse in England, was characterised as a 'killer for kicks' or a thrill-killer. He was charged with 18 counts of causing grievous bodily harm and subsequently with the murder of two elderly patients.

The offences relate to "unexplained respiratory problems" experienced by elderly patients at Horton General Hospital in Banbury, Oxfordshire. Geen was alleged to have committed the offences between December 2003 and February 2004 while working as a nurse at the hospital. The two murder charges relate to the deaths of David Onley, 77, and Anthony Bateman, 67, two elderly men who were patients at the hospital in January 2004. Geen was arrested on arrival at work and was found, at the time, to have a syringe of muscle relaxant in his pocket. All of the victims had been injected with drugs such as insulin and muscle relaxants. Eventually, Geen was convicted of the two murders and 15 attempted murders. He was sentenced to 17 life sentences and a non-parole period was set at 30 years. (Simpson, 2006c; R. Smith, 2006; The Times, 2006).

The Case of Kristen Gilbert (USA)

A registered nurse employed at Veterans Administration Medical Center in Leeds, Massachusetts, Kristen Gilbert was charged with the murder of four patients and the attempted murder of three others. Kristen Gilbert, aged 33, was convicted and sentenced to life imprisonment without possibility of parole. This was a particularly interesting case at a number of levels. Gilbert was convicted in a State that does not have the death penalty. However, Veteran's Administration hospitals are Federally administered and the death penalty is available for murder committed within Federal jurisdiction, as was the case here. It was only after extensive deliberation that the death sentence was rejected in this case. (K. Burge, 2003).

The Case of Stephan Letter (Germany)

Less than a month after Stephan Letter began work at a hospital in Sonthofen in Germany deaths mounted. He was charged with giving lethal injections to 28 men and women. Most of the victims were elderly but one was only 40. The injections were a mixture of the sedative midazolam, the anaesthetic etomidate and the muscle relaxant lythemon. Suspicion was aroused when drugs were reported missing and unsealed vials were found at his home. Letter admitted killing sixteen elderly patients at another hospital; when questioned he said he could not remember all the murders.

In 2006 he was found guilty of 12 murders, 15 manslaughters and one illegal mercy killing. Letter was sentenced to life in prison. The investigation of his crimes was massive with over 80 deaths examined and 40 bodies exhumed (Harding, 2006, p.18; Pohl, 2006).

The Case of Christine Malevre (France)

This was the case of a nurse who was arrested in Paris in July, 1998 following an investigation into suspicious deaths. She initially admitted to helping 30 patients to die, claiming she had engaged in mercy-killing. The families of a number of her victims denied that their relative had sought assistance to die and psychiatric assessments found that she not acting out of mercy but had a morbid fascination with illness and knew what she was doing. Initially charged with manslaughter, charges were upgraded to murder on the basis of the psychiatric reports. Eleven suspicious deaths were involved, but for four of these there was insufficient evidence to sustain charges. In the final result, Malevre was convicted of six counts of assisting or causing the deaths of terminally ill patients in a lung hospital in Paris. She was acquitted on the seventh count of murder. She was sentenced to 10 years imprisonment. She was also banned for life from the nursing profession. She appealed her case and, on appeal, her sentence was increased to 12 years. This case has been reported as the first time a medical professional has been tried for such a crime in France (Guyot, 1998, p.13; Jeffries, 2000, p.22; Souchard, 2003).

The Case of Cheryl A. May (USA)

This is a case in which the nurse, Cheryl A. May, clearly murdered the patient but was able to plea bargain for a lesser charge – criminal recklessness. Conviction for murder could have resulted in a prison sentence of 65 years but criminal recklessness only attracts a maximum sentence of 8 years in Indiana where the case occurred. However, the plea bargain also involved an agreement by May to surrender her nursing license and to never work as a nurse again.

May's crime consisted of overdosing a 69 year old patient with a narcotic drug (Roxanol) because she hated him on 17th August, 1997 (AP, 1998a, 1998b, 1999b).

The Case of Luvuyo Mgwatyu (South Africa)

This nurse working at Fort England Hospital (a psychiatric hospital in Grahamstown, Eastern Cape Province, South Africa) was charged with the murder of a 69 year old mental patient, Mr Mthutuzeli Tshakaza. The charge simply stated that Mr Mgwatyu 'did upon or about 10 July 2001 and at or near Fort England Hospital ... Grahamstown, ... did wrongfully and intentionally kill one Mthutuzeli Beacham Tshakaza' (Greyling, 2003a). Mr Mgwatyu pleaded not guilty, claiming that he had been attacked from behind by Tshakaza and that he had pushed Tshakaza back into his chair. However, two of Mr Mgwatyu's colleagues who had been on duty in the ward testified that they had seen him kicking and trampling the abdomen of Mr Tshakaza who was lying on his back on the floor. It was found at post-mortem examination that Mr Tshakaza had died (4 days after the incident) from injuries occasioned by a lot of blunt force to the abdomen.

The Court characterized the conduct of Mr Mgwatyu as a sustained and vicious assault, convicted him of murder and sentenced him to 12 years imprisonment (Greyling, 2003a, 2003b; Mientjies, 2001).

The Case of Aida Nureddin Mohammad (Egypt)

In this Egyptian case, Aida Nureddin Mohammad, 25, was accused of the murder of 12 patients and faced a specimen charge of killing one of her patients, Abdel Kader Mohammad Ibrahim, 47. Mohammad was labelled "angel of death" by Egyptian police. Prosecutors claimed that her motive was revenge against 37-year-old neurologist Hisham Abu Rahma because he rejected her advances. All of her alleged victims were patients of Rahma.

Aida Nureddin Mohammad worked for seven years in Alexandria University's intensive-care ward neurology department. Her colleagues there regarded her as a model nurse until her arrest. She was convicted of the murder of Abdel Kader Mohammad Ibrahim and sentenced to death. She appealed this sentence on the basis

of its severity and was awarded a new trial. (Agence France-Presse, 1998a, 1998b, 1998c, 1998d) (Agence France-Presse, 1998e).

The Case of James Mullins (USA)

In this case the charge was not murder and it is a good example of the fine distinctions between the various categories of homicide that were discussed in Chapter 2. James Mullins was charged with involuntary homicide. The whole situation may have been a case of the 'straw that broke the donkey's back' but the net result was that Mullins killed the patient. James Mullins was a nurse with over 20 years experience who was working in a Palm Beach, Florida Veterans Affairs hospital. It seems that Mr Mullins suffered from post traumatic stress disorder as a result of combat duty in Vietnam. A 53 year old man was admitted to the hospital with back pain. For reasons that are not apparent, Mr Mullins injected the patient with propofol, a strong sedative that depresses respiration and which he was not authorised to administer. In this case, the intravenous bolus dose of propofol led to the patient's death. Mullins subsequently told another nurse of his actions and a doctor 'reported that he thought it was unusual for Mullins to administer propofol since it was not prescribed, Mullins was not authorised to administer propofol, and (that) was not an appropriate drug for' [the patient].

Mullins resigned two weeks after the patient's death, applied for disability benefits and began seeing a psychiatrist. On one visit to the psychiatrist Mullins had with him a fully loaded Glock handgun which he handed to the psychiatrist in its holster, stating that he had forgotten to check it at the door. However, he was nevertheless charged for taking a firearm onto the VA hospital grounds and subsequently convicted of that offence. He was sentenced to 6 months in prison on that count. Mullins apologised and was sentenced for the involuntary homicide to two years imprisonment (AP, 2001e, 2002a; Douthat, 2003, p.3; Engelhardt, 2001, p.1; Hartnett, 2001, p.1; Spencer-Wendel, 2002, p.3; The Palm Beach Post, 2001, p.5).

The Case of Colin Norris (England)

The nurse in this case was charged in 2006 with the murder in two Leeds hospitals of four elderly patients and the attempted murder of a fifth. The alleged victims were all elderly and the deaths resulted from overdoses of insulin. A total of 72 cases have

been reviewed at the Leeds General Infirmary. The nurse denies all charges and the case is yet to be heard. (Dudgeon, 2006; Thornton, 2005; Wainwright, 2005; Wilkinson, 2005).

The Case of Terri Rachals (USA)

This 25 year old nurse was employed at the Phoebe Putney Hospital in Albany, Georgia in the surgical intensive care unit. She was accused of killing six seriously ill patients by injecting them with potassium chloride and the case came to trial in 1986. Arraigned on twenty charges, she was found guilty on just one charge of aggravated assault for injecting a patient with potassium chloride. It was argued that she suffered from chronic depression and other disorders such that she was unaware of the things that she was doing and the Court found that she was indeed mentally ill. She served a 17 year sentence, being released from the Savannah Womens' Transitional Center in 2003. (Manners, 1995b, pp.170-209).

The Case of Hal Speers Rachman (USA)

The case of Hal Speers Rachman, a 39 year old nurse, is the only case that came to light in this study where the nurse engineered the administration of an unprescribed injection of insulin by other nurses with the intent of bringing about the death of the patient. His motive was theft and his method was to phone the hospital where a man who employed him as his private nurse had been admitted. He convinced the nurses that he spoke with that he was the patient's treating doctor and ordered an injection of insulin. The patient – who was not diabetic – died four days later. The patient was dying from AIDS but the insulin may well have hastened his demise. In the result, Rachman pleaded no contest to attempted murder (and forgery) and was sentenced to 9 years in prison.

The case is significant because it undermined the confidence of hospitals in their protocols and procedures for the making and acceptance of telephoned medication orders.(AP, 1986b; *Houston Chronicle*, 1986b; *New York Times*, 1986).

The Case of Michaela Roeder

Michaela Roeder was a German ICU nurse who was convicted of the murder of five patients and the attempted murder of another between 1985 and 1989 in Wuppertal,

Germany. She was referred to as the 'Angel of Death' as so many of these nurses has. However, in her case it preceded any suspicion and was an epithet attached out of sympathy because so many patients died on her shifts. She was convicted and sentenced to 11 years in prison. (Lavin & Journey, 1990, p.1; Moss, 1988b, p.1; St Petersburg Times, 1987, p.6; The Associated Press, 1988) (Germany). (AP, 1989b, p.6; Petty, 1989; The Times, 1989a, 1989b)

The Case of Brian Kevin Rosenfeld (USA)

Brian Kevin Rosenfeld negotiated with prosecutors to reach a plea bargain that saw him plead guilty to the murder of three elderly nursing home patients. The deal saw Rosenfeld sentenced to 3 consecutive life terms in prison with no possibility of parole for 25 years. The judge also ordered that should he ever be released from prison, he was never again to work in a nursing home. The Court was no doubt influenced by the fact that Rosenfeld had allegedly made a jailhouse confession wherein he admitted murdering 23 patients in various nursing homes.

The case is significant for the fact that this nurse was dismissed from 14 nursing homes in 5 years, with a number of his employers subsequently admitting that they had received complaints about his abuse of patients. (Beauge, 1990, p.3; Nohlgren & Journey, 1990b, p.1; 1991b, p.1).

The Case of Bobbie Sue Dudley Terrell (USA)

This woman was a nursing home supervisor in Florida when she was charged with the deaths of four elderly patients and the attempted murder of a fifth patient at North Horizon Health Care Center in St. Petersburg. At about the same time, Terrell's nursing license was suspended. This was allegedly because she had mental problems - not because of the murder allegations. Terrell was arrested in March, 1986 when it was alleged that she had killed these four patients either by strangulation or injecting them with insulin. In fact, the investigation began in November, 1984. There was a clear epidemic of deaths where Dudley was working. Dudley was the night

supervisor at St. Petersburg North Horizon Health Care Center in November, 1984, where 12 patients at the 50-bed facility died in two weeks.

Bobbie Sue Dudley Terrell had a particularly difficult childhood and serious psychiatric difficulties that make it difficult to understand how she came to be in a responsible position in charge of residents in a nursing home. It also makes it difficult to understand how charging her with murder could have been appropriate in such circumstances.

In the result, Terrell pleaded guilty to reduced charges of second-degree murder and was sentenced to a combined term of sixty-five years in prison. (Lavin, 1990; Lavin & Journey, 1990; St Petersburg Times, 1987a; The Associated Press, 1988).

The Enrolled Nurses convicted of the murder of patients.

The case of Beverley Allitt (England)

Among nurses, Beverley Allitt is perhaps the most infamous of nurses who have been convicted of murder. An enrolled nurse (EN), she was convicted of the murders of 4 young children in the UK in 1990. She was charged with the attempted murder of another 9 children. Her modus operandi was to inject the children with unprescribed drugs – usually potassium or insulin – causing them to arrest. She would then ‘discover’ the child arresting. Her motive was the attention she derived from being at the centre of the action. She was also suspected of the murder of an elderly person in a nursing home but there was insufficient evidence to lay any charges in relation to that matter. She was committed for life to a hospital for the criminally insane on the basis of suffering from Munchausen’s Syndrome by Proxy. (N. Davies, 1993a).

The case of Roger Andermatt (Switzerland)

Roger Andermatt is Switzerland’s worst known serial murderer. It was reported that he was a Swiss citizen who moved to Germany after his parents' divorce, but returned to Switzerland in 1990 and trained as a nurse assistant. I have taken this to mean he is an enrolled nurse but it may be that he was an assistant in nursing. Andermatt was 36 years old when he was sentenced to life imprisonment for the murder of 22 people between 1995 and 2001. He selected his victims from among the elderly residents of care homes in central Switzerland. He killed them with tranquilisers or smothered them with a plastic bag or a cloth. His victims, aged between 66 and 95, were in need of high levels of care and in many cases, were suffering from Alzheimer's disease. In addition to those he was convicted of murdering, Andermatt was also found guilty of attempting to murder five more people. He claimed that he had simply been ending people’s suffering but the Court rejected his claims of mercy-killing. There was also a suggestion that he had done it to ease the workload. Switzerland was shocked by this case and it caused them to re-think – however temporarily – their relaxed approach to euthanasia. In an interesting twist to the case, Andermatt was ordered to pay 75,000 Swiss francs (€48,500) compensation to dependants of four of

his victims and court costs of 191,000 francs (€123,500). (AP, 1990; *St. Petersburg Times*, 1989, p.1).

The Case of Vickie Dawn Jackson (USA)

At the age of 36, this 40 year old nurse was charged with the murder of 10 patients at Nocona General Hospital in Texas in late 2000 and early 2001. It was alleged that, in each case, Vickie Dawn Jackson had administered lethal doses of mivacurium chloride, a muscle relaxant that temporarily stops a person from breathing and can be fatal.

In the three months ending February, 2001, the hospital which only had 38 beds, noticed an unusually high number of deaths and reported the matter. Investigators exhumed 10 bodies and in each case they found traces of mivacurium chloride. Attention focused on Jackson for a number of reasons but primarily because she was on duty at the time of all of the deaths identified as involving the muscle relaxant.

These were not mercy killings, however, because although elderly, some of these patients were fit and healthy. In some cases they would have been discharged from hospital the next day, had they not been murdered in the meantime.

Although continuing to protest her innocence, in the face of overwhelming evidence, Vickie Dawn Jackson pleaded no contest to the charges. This means that while not pleading guilty, no case is put on her behalf to rebut the case put by the prosecution. This generally leads to a fairly swift trial, conviction and sentence and that was so in the Jackson case. Ironically, in a state noted for its use of the death penalty, Vickie Dawn Jackson was able to avoid the lethal injection, instead being sentenced to life in prison. (AP, 2006c, p.2; Brown, 2005a).

The Case of Genee Jones (USA)

A licensed vocational nurse (LVN) Genee worked for years on the paediatric intensive care ward of the San Antonio Medical Centre Hospital. She left under a cloud following many suspicious incidents where children and babies collapsed and died. Circumstantial evidence stacked against Genee but the hospital management

and some medical staff ‘... refused to fire her for fear of litigation and scandal. They were the ones who sent her out into the world without a word or warning – just a warm letter of recommendation.’ (Elkind, 1990, p.394). She found a new position working with a paediatrician in a country town in the region where the unheralded emergencies kept occurring usually following an injection administered by Genee.

Genee was eventually charged and convicted, in 1984, of the murder of Chelsea Celland a fifteen month old after injecting her with succinylcholine a muscle relaxant. She was sentenced to ninety nine years. In a second trial she was charged with administering intravenous heparin to a baby and sentenced to sixty years in prison. Genee’s lawyers appealed both convictions and lost. She will be given automatic parole in 2017. The investigation at San Antonio was discontinued but the estimates are that maybe fifteen children and babies were murdered. (Elkind, 1990a).

The Case of Orville Lynn Majors (USA)

Between 1993 and 1995, a number of patients died in suspicious circumstances at Vermillion County Hospital, Indiana where Orville Majors was employed as a nurse. Investigating police found containers of epinephrine and potassium chloride in Major’s vehicle. In 1999 he was convicted on six charges of murder by administration of lethal injections of either epinephrine, potassium chloride or both. Majors had denied all charges. There was a seventh charge of murder against Majors, which he also denied, but that ended in a mistrial when the jurors were unable to reach agreement. For the murders of which he was convicted, Majors was sentenced to 360 years in prison. (AP, 2000c, 2001a; Forliti, 2000; M. Smith, 2002b).

The Assistants in Nursing convicted of the murder of patients

The Case of Jeffery Feltner (USA)

Jeffrey Feltner was a slightly built assistant in nursing (AIN) suffering from AIDS who was charged with the murder of seven elderly nursing home patients. The murders came to light when Feltner began calling radio stations to confess. Death was caused by asphyxiation – probably caused by strangulation – and the motive was ostensibly to ease the patient’s suffering. Feltner admitted the phone calls but denied his confessions when confronted by police and subsequently was charged and

convicted for to making harassing phone calls, trespassing and making a false statement. He served 127 days for his trouble. He repeated the pattern the following summer but the police were investigating the cases that he had confessed and then retracted. Most of the patients had been cremated but in the case of one woman, it was possible to exhume her body and sufficient evidence was found to support a case of suffocation. Feltner was charged with that patient's murder, convicted, and sentenced to life imprisonment. (AP, 1990; St. Petersburg Times, 1989).

The case of Michaela Giersberg (Germany)

Michaela Giersberg was a nursing assistant at a nursing home outside Bonn. She was convicted in February, 2006 of the killing of nine women at the nursing home between 2003 and 2005. She was convicted in Bonn, Germany on four charges of murder; four charges of manslaughter; and one charge of mercy killing. The women were aged between 79 and 93. Death was caused by suffocation with a pillow or a towel. She was sentenced to imprisonment for life. (AP, 2006a, 2006b; Calgary Herald, 2006; CP, 2006; Reuters, 2006).

The Case of Gwendolyn Graham (USA)

This is one of that hand-full of cases involving more than one perpetrator. An AIN, Gwendolyn Graham's accomplice was Catherine May Wood. Together they murdered a number of elderly patients in the Alpine Manor Nursing Home in Grand Rapids, Michigan. The patients were suffocated. In terms of the number of victims, there were relatively few. Graham was convicted of just 5 out of a total of 8 alleged murders, for which she was sentenced to a total of six life sentences without possibility of parole. She was convicted on Sept. 20, 1989, in Kent County Circuit Court of five counts of first-degree murder and one count of conspiracy to commit murder.

What distinguishes this case from most others is the motive, the multiple perpetrators and their relationship. Graham and Wood were in a lesbian relationship and their motive was the sexual thrill of killing these elderly patients. Wood testified she served as a lookout while Graham smothered the patients by placing washcloths over their mouths and noses, and as reported by Grand Rapids Press (1993, p.3), Wood also testified that she went along with Graham's plan because she feared Graham

would end their relationship as lovers. The God-fearing community of Grand Rapids was 'shocked to its core' by this case. (Cauffiel, 1997).

The Cases of Maria Gruber, Irene Leidolf, Stephanija Meyer and Waltraud Wagner (Austria)

Four Austrian nurses – Maria Gruber (aged 19), Irene Leidolf (aged 21), Stephanija Meyer (aged 43) and Waltraud Wagner (aged 23) – were employed at Lainz General Hospital in Vienna. Together they were involved in the murder of patients. It began with Wagner who injected morphine to kill a patient, ostensibly to end the patient's suffering. The team changed its method so that one member held the patient's nose while another poured water into the victim's mouth until they drowned in their bed. Because elderly patients frequently have fluid in their lungs, it was an unprovable crime. Their crime was discovered because they were at a tavern having a drink when they were overheard discussing one of their murders. In 1989, they subsequently confessed to 49 murders but were suspected of as many as 200. Gruber was sentenced to 15 years in prison after being convicted of two counts of attempted murder; Leidolf was sentenced to life imprisonment having been convicted of five charges of murder and two of attempted murder; Meyer was sentenced to 15 years in prison having been convicted of one charge of murder (2nd degree) and seven charges of attempted murder; and Wagner was sentenced to life imprisonment after being convicted of 15 murders and 17 counts of attempted murder. (AP, 1991c; Prinz, 1989a; Protzman, 1989; Alison Smale, 1991; Traynor, 1991; J. Zalud, 1991; Jola Zalud, 1991).

The Case of Edson Guimaraes (Brazil)

In this case from Brazil, a nurse's aide named Edson Guimaraes was charged with the murder of four patients at Rio's Salgado Filho Hospital. For two years the administration had been aware of a high death rate in the hospital's emergency intensive-care unit but had been unable to account for it. Then an investigation was triggered by the recording of an excessive number of deaths on the unit.

Guimaraes admitted that he had killed five patients out of mercy but also tried to profit from their deaths. It seems that he was aware that mortuary staff received what might be called a commission on referrals to undertakers. He decided that he might

be able to get in on the act because the commission was paid to the first person to advise the funeral company and was contingent on the funeral company getting the job. In any event, Guimaraes saw an opportunity to make some money and it seems he started hastening the demise of patients in his care. Usually these were critically ill patients – accident victims, those suffering from cancer, strokes, heart attacks and the like. Guimaraes is suspected of involvement in the deaths of as many as 131 patients. He was convicted and sentenced to 69 years in prison. It became necessary to provide him with a cell on his own because the other prisoners wanted to kill him. (EFE, 2001; Goering, 1999c, p.2; 1999d, p.31).

The Case of Donald Harvey (USA)

This nurse's aid pleaded guilty in 1988 to 37 murders in Ohio and Kentucky, later confessed to poisoning 58 people, and still later claimed up to 87 victims. He said he acted out of mercy, killing a severely injured patient with a small but lethal dose of cyanide but the evidence against him suggested otherwise. He also smothered some patients. Harvey killed with a variety of poisons and kept track of it all in neatly bound journals. On one occasion he claimed that he can recall the face and name of almost every victim. However, the prosecutors involved in the case did not believe that Harvey had killed as many patients as he claimed. This was one of the many cases where prosecutors traded the death penalty for a guilty plea partly so that they could spare grieving families a trial but also because they knew that Harvey was the only person who could account for every victim.

Psychiatrists described Harvey as a sadistic, compulsive killer who knew exactly what he was doing and killed for pleasure. Harvey claimed to do it out of compassion but he poisoned people other than patients and used agents such as arsenic and hepatitis virus for the purpose. In one case it appears that he poked a coathanger up a patient's urinary catheter. The man died from the resultant injuries and infection some days later. Harvey was sexually abused from an early age which may have contributed to a personality disorder. There are some reports that Harvey liked to think that he was cleverer than other people (including doctors) and that this was how he got away with his murders for so long. This is consistent with what is known about serial killers generically. Harvey was sent to prison for life and his first parole hearing is due in 2047. (Whalen & Martin, 2005).

The Case of Wanda Kanner (Ohio, USA)

The case of 49 year old Wanda Kanner is a little different to most of those in this work. Kanner was not a registered nurse but is referred to as a nurse in some accounts and as a caregiver in others. In 2001 she was the personal caregiver for a 49 year old woman with multiple sclerosis. It was alleged that she allowed her patient to choke to death on a bagel whilst knowing that the patient was unable to feed herself or swallow solids. It was further alleged that her motive lay in the fact that she was having an affair with the husband of the patient. Kanner denied the charges of murder and involuntary manslaughter, contending that she had soaked the bagel in milk prior to feeding it to her patient. A grand jury indicted Kanner on the charges and she pleaded guilty to involuntary manslaughter. In April, 2004 she was sentenced to five years imprisonment. (Hiaasen, 2003, 2004; Kropko, 2004a, 2004b, 2004c; Mabin, 2004; Milicia.J., 2003; Nichols, 2004a, 2004b).

The Case of Daisuke Mori (Japan)

Daisuke Mori is a Japanese assistant nurse who was arrested on January 6th 2001 on suspicion of attempted murder. The case that brought this to pass was an alleged attempt to kill an 11 year old girl admitted to the 18-bed Hokuryo Clinic in Sendai, Japan. She was admitted with suspected appendicitis but her condition deteriorated dramatically within half an hour of admission. It is alleged that Daisuke Mori administered muscle relaxant via the girl's intravenous infusion of saline and antibiotics. She did not die but became comatose. It is also reported that after Mori began working at Hokuryo Clinic in March 1999, at least eight patients died under peculiar circumstances, including a five-year-old boy with asthma who died in the clinic while his mother had returned home to collect clean clothes for him. Police suspect 11 other patients deteriorated after Mori interfered with their intravenous drips. There was suspicion among Mori's colleagues but no one raised the alarm. According to an article in the BMJ, he was even nicknamed "Fast-Change Mori" because the condition of his patients often reversed course quickly, and dramatically, without a reasonable explanation. The accuracy of the article is open to question, however, as they mistakenly reported that Mori was a registered nurse whereas he

was in fact an assistant nurse. (Kurita, 2005a, 2005b; *Kyodo News*, 2001b, 2004a, 2004b; *The Daily Yomiuri*, 2001a; *The Yomiuri Shimbun*, 2001a, 2001b, 2001c).

The case of Shermike Rainey (USA)

Shermike Rainey was an 18 year old AIN who pleaded guilty to conspiracy to commit first-degree murder in the death of Willie Mae Ryan, 81, in the Dallas County Nursing Home, El Dorado, Arkansas. Ryan was beaten by Gayla Anne Wilson using lead knuckles on July 30, 2003. Ryan died at a Pine Bluff hospital two weeks later. Rainey was sentenced to 30 years in prison in August. She also testified against Wilson.

At the time of entering her guilty plea, Rainey said in court that she held the elderly woman down while Wilson struck Willie Mae Ryan in the face seven or eight times with the lead knuckles. Rainey said Wilson had taken the lead knuckles from a blood-pressure measuring bag. The blows crushed Ryan's facial bone into her sinus cavities and caused bleeding on the brain, bruising, scratches, and swelling on her head and mouth. Rainey said the beating was administered in retaliation for Ryan being disrespectful. (AP, 2004a, 2005, Davis, 2004, *Democrat-Gazette*, 2004).

The Case of Heidi Tenzer (USA)

Heidi Tenzer was an AIN who was charged with the death of an 83 year old man, William Neff, at Alterra Clare Bridge in Pennsylvania in September, 2000. This was primarily a facility for people suffering from dementia. The case is a little unusual for the way it came to light. A nurse recorded the cause of death as failure to thrive but the undertaker contacted the coroner because of a bruise on Neff's left side that was approximately 300 millimetres square and still black and blue.

Tenzer was sentenced to 30 years in prison for what in the state of Pennsylvania in the USA is termed 3rd degree murder (defined as such under the *Crimes & Offences* (Title 18) legislation) but in Australia would be categorised simply as murder. She was held to have kicked and stomped Neffs. The provocation was that he had soiled his bed. It was 2:00am, Tenzer had just worked a double shift and was apparently suffering from depression and anxiety. The kicking and stomping left Neffs with five

broken ribs, a punctured lung and internal bleeding. His injuries went unnoticed for more than two days, and Neffs died several days later.

That such extensive injuries could go unnoticed for days is a matter of considerable concern and Neffs' death had several other sequelae. The facility director, a second staff aide, a registered nurse and an outside hospice nurse were all indicted on felony neglect and other charges but subsequently pleaded guilty to the lesser charge of misdemeanour neglect. All three had testified against Tenzer. The registered nurse was not offered a plea because he had been directly assigned to Neff's care between his bashing and his death but failed either to notice or to report his injuries. (AP, 2002b, 2003b; Caruso, 2003; Rubinkam, 2003a, 2003b).

The Case of Martha U (The Netherlands)

Identified under Dutch privacy laws only as Martha U – a nursing home worker, was sentenced in 1996 to nine years in prison for killing four elderly patients by injecting them with insulin at the Vliethoven nursing home in the northern Dutch town of Delfzijl. She admitted the killings but said she had done it out of sympathy. Psychological tests carried out after her arrest in September 1995 showed that Martha U was mentally unstable at the time of the killings and that there was a risk of her repeating the offences. The three-judge court found that only four of the nine murder charges had been proven. The killings started in 1992, but suspicion surfaced only in 1995 when a doctor suspected foul play in the death of a 90-year-old man. (AP, 1996).

The Case of Gayla Ann Wilson (USA)

Gayla Ann Wilson, aged 44, was accused of fatally beating an 81-year-old Dallas County Nursing Home resident. Wilson is accused of beating Willie Mae Ryan, 81, with brass knuckles on July 30, 2003. Ryan died at a Pine Bluff hospital two weeks later. Wilson and 17 years old nurses aide Shermika Rainey were charged with murder. Rainey's case was described earlier in this Chapter. She gave evidence against Wilson and was given 30 years in prison. Wilson was to go to trial in late 2004. Wilson, 44, faces either life in prison without parole or execution if she is found guilty. Prosecutors are seeking the death penalty. (AP, 2003g, 2004c, 2004e, 2005e; Bowers, 2004; Davis, 2004; The Associated Press, 2003).

The Case of Catherine May Wood (USA)

Catherine May Wood was the accomplice of Gwendolyn Graham whose case is described earlier in this Chapter. A nurse's aide, Wood was accused of helping to kill nursing home patients. She pleaded guilty to murder and conspiracy. Just days before Gwendolyn Graham, her co-defendant and alleged lesbian lover went on trial, Wood testified for the prosecution in Gwendolyn Graham's trial on five counts of first-degree murder and a count of conspiracy to commit first-degree murder in the deaths at Alpine Manor Nursing Home.

Wood said she and Graham discussed killing up to 20 patients and she admitted to helping Graham kill Marguerite Chambers, 60, on Jan. 17, 1987. This testimony formed part of a plea bargain and two open murder charges against Wood were dropped in exchange for her guilty pleas to second-degree murder and conspiracy. These charges carry a maximum sentence of life in prison, with parole possible after 10 years. This compares with the 6 life sentences without possibility of parole that was finally imposed on Graham.

The deaths that led to the charges against Wood and Graham were originally thought to be from natural causes until the police began an investigation in response to Wood's ex-husband saying that his former wife had confessed to him. (Cauffiel, 1997).

Charges of murder; conviction of lesser crimes

The Case of Richard Angelo (USA)

Richard Angelo was employed as an emergency medical technician and Charge Nurse at the Good Samaritan Hospital, Long Island, New York State. Angelo was arrested in late 1987 when he was arrested for attempting to murder a patient by injecting Pavulon into the patient's IV fluid. Angelo was charged with the murder of ten patients. He claimed that he was motivated more by the idea of saving people than killing them but he just was not very good at it. It was patients themselves – his intended victims – who caught him. They reported his conduct to a nurse who took steps to ascertain what was happening. He said he had used two muscle relaxants, Anectine and Pavulon, but at the time no test existed that would detect Anectine. Of

the 33 bodies exhumed, 8 tested positive for Pavulon. Of those eight, two had been prescribed the drug, and in two others, the deaths could not be attributed to Pavulon. Investigators were confident that the remaining four patients had been killed by Pavulon, and Mr. Angelo was convicted of the four deaths.(AP, 2005e; Associated Press, 2005).

The Case of John Bardgett (USA)

In 2001 John Bardgett was employed at the Harborside-Northwood Nursing Home in Bedford, New Hampshire. That year he was accused of the murder of two elderly residents of the nursing home by lethal injections of morphine in the absence of a doctor's orders. In February 2003 Bardgett was acquitted of the murders of the two women but a plea bargain saw him plead guilty to the charge of administering morphine without a doctor's order for which he received a two year suspended sentence and surrendered his nursing license. (AP, 2001b, 2003e; Macomber, 2003; Villeneuve, 2003; Weber, 2001, 2002).

The case of Pamela Jenkin (Australia)

Pamela Jenkin was a registered nurse employed at Charters Towers Hospital where she had worked for about 17 years in March, 1990 at the time she was charged with the murder of a terminally ill patient. In May the same year, after the exhumation of the body of another patient who had died at Charters Towers Hospital, she was charged with the murder of that patient also. This charge was subsequently dropped for lack of evidence. Four other bodies were exhumed but no other charges were laid. The remaining charge of murder was prosecuted but eventually Jenkin was ordered discharged by the Court because the prosecution had failed to bring the case to court for more than a year. The prosecution appealed that decision but in the end, the case concluded at this point. It is included here because, in the case of Australia, no case of a nurse murdering a patient or patients has been successfully prosecuted. There is generally too little evidence. (Cadzow, 1991, p.10).

Charges other than murder

The Case of Kathleen Atkinson (UK)

I have included this case as testament to the heightened sensitivity of the profession in the years immediately following the case of Beverley Allitt. Between 1991 and 1995 Kathleen Atkinson, an RN, was employed at the Royal Victoria Infirmary, Newcastle upon Tyne as an intensive care nurse. During this period, the city coroner requested the police to investigate the deaths of four patients aged 12, 15, 69 and 77. There was a suspicion that life-sustaining drugs had been withheld. Kathleen Atkinson was suspended from her duties and two months later was dismissed. She was subsequently arrested and charged with two counts of attempted murder and one of incitement to murder. These charges were withdrawn after she had spent three months in custody.

Kathleen Atkinson, 52, was charged with two counts of attempted murder and one of incitement to murder. The charges related to claims that she withdrew treatment from dying patients and in one case gave a pensioner an extra dose of morphine. These charges were withdrawn but not before Atkinson had spent three months in custody. She has always denied the allegations.

Notwithstanding her denials, Atkinson was dismissed from the Royal Victoria Infirmary, Newcastle upon Tyne on account of the allegations. She had faced disciplinary proceedings and then been dismissed. She brought a claim of unfair dismissal against the Newcastle NHS Hospitals Trust which she lost on the basis that the Tribunal found there was evidence of breach of rules about nurses withdrawing or prescribing drugs but it is interesting that the doctor who was the clinical director of support services and who chaired the original disciplinary inquiry at the Royal Victoria Infirmary, felt free to tell the unfair dismissals tribunal that he was still convinced that the allegations about Atkinson were true. (Clixby, 2004; Littleton, 2003a, 2003b, 2003c; Phillips, 2004; The Journal, 2003a, 2003b, 2003c; Wilkinson, 2001a, 2001b, 2001c).

The Case of Samantha Carr (Australia)

Samantha Carr was a 45 year old assistant in nursing who was working as a privately employed, live-in nursing assistant and companion in Sydney in November, 1990. Carr took an instant dislike to her new but elderly employer and decided to kill her with a large overdose of her prescribed medication. She began overdosing Mrs Fitzgerald on the Saturday but Fitzgerald fell over and required hospital treatment. On the Sunday, it is alleged that Carr again attempted to overdose Mrs Fitzgerald. Again, Mrs Fitzgerald collapsed so Carr advised their next door neighbour that she was dead. The doctor was contacted, an ambulance was called, the patient was still alive and was successfully treated. Carr freely admitted that she had attempted to kill Mrs Fitzgerald. She was charged and tried for attempted murder but the Supreme Court directed that her confessions could not be relied upon as Ms Carr suffered from paranoid schizophrenia, had withdrawn her confessions and admitted that she had made them up to get attention. She was acquitted of the charges.

The Case of Michael Coons (USA)

Michael Coons was a nurse when he administered morphine to four elderly nursing home patients who later died. He claimed that he never exceeded doctors' orders. A state report concluded that the nurse gave patients excessive doses of morphine. There was disagreement over whether the four deaths were caused by morphine. The facility involved was fined \$6,000 over the matter because the State investigation had found that the center repeatedly failed to provide basic care or services to the residents which resulted in the four deaths in 1997 and 1998. The facility blamed the State Board of Nursing for not providing more information about Coons, 45, of Dallas, before he was hired.

Coons did have a history, however. The Board had found that Coons, while working at a Dallas hospital, told emergency medical technicians to give the drug epinephrine to a patient. In a second incident, he diverted an ambulance to another hospital. In a third, he ordered a drug for an emergency room patient. No patients were harmed. In response to this history, the board ordered Coons to complete a course on record-keeping and nursing practice and to work under the direct supervision of another registered nurse. The latter restriction was still in place when Coons worked for the

Sheridan Care Center in 1997 and 1998. It was nursing colleagues of Coons who instigated the Sheridan investigation by alerting the daughter of one of the victims. Coons had allegedly been diagnosed as bipolar and was on medication. Prior to further investigation by The Board of Nursing, Coons' nursing license expired so the Board had no authority to do so.

The matter was pursued by relatives of the victims and a Grand Jury was convened but in the result, it did not indict Coons. There were no winners in this case and nurses lost the right to administer morphine on a doctor's standing order. (AP, 2000a, 2000b; Frazier, 2000; Tims, 2000a, 2000b; Tims & Maves, 2000).

The Case of Peggy Couse (USA)

Peggy Couse, 43, who was employed as a nursing supervisor at Twin City Health Care in Gas City, Indiana, pleaded guilty to charges that she tried to kill an 83-year-old nursing home patient, Virgil Dailey, with a lethal dose of morphine. While Dailey died in January 2003 from complications of pneumonia, prosecutors alleged that the death occurred shortly after Couse gave him an overdose of morphine. Witnesses told investigators they saw Couse give morphine to Dailey just hours before he died from pneumonia at the nursing home. In February 2003, in response to suspicion about Couse's distribution of narcotics to patients and co-workers without authorization, Dailey's body was exhumed.

Toxicology tests performed more than a month after Mr. Dailey's death showed traces of morphine in the liver. However, authorities could not confirm that the morphine caused the death. Couse pleaded guilty to charges of attempted murder and dispensing medications without a license. She now faces a prison sentence of 20 years as part of the agreement with prosecutors who dismissed three additional felony drug charges against Couse. Couse could have been sentenced to 50 years in prison had she been convicted by a jury of the most serious charges. (Twedt, 2003b, p.6).

The Case of Rhea Henson (USA)

In 1999 Rhea Henson, aged 50, was working as a nurse at Inova Fair Oaks Hospital in Fairfax, Virginia. She was suspected of having administered morphine overdoses to two terminally ill patients. The Board of Nursing immediately suspended her license and indicated that Henson had told the Board that she had administered the morphine as an act of mercy. Subsequently it was shown that the morphine had not been the cause of death in either case. In 2000 Henson pleaded guilty to the charge of distribution of a controlled substance and received a two-year suspended sentence. She also agreed that she would not seek to have her license re-instated. (AP, 1999b; Washington Times, 2000).

The Case of Amanda Jenkinson (UK)

Employed as an intensive care nurse at Bassetlaw District General Hospital, 46 year old Amanda Jenkinson was charged with attempted murder but convicted of causing grievous bodily harm to a patient by interfering with the patient's ventilator. After spending three years in prison, her conviction was overturned in 2005 following referral by the Criminal Cases Review Commission. The evidence on which she was convicted was described as fundamentally 'flawed, inaccurate and misleading'. (Cusick, 1996; Duce, 1997; Laurance, 2001; McFerran, 2004; *Nottingham Evening Post*, 2006; O'Kane, 1996).

The Case of Susan Nelles (Canada)

Susan Nelles was a nurse employed at the Hospital for Sick Children in Toronto. A number of infants died mysteriously in the paediatric cardiac unit where she worked. The babies died from poisoning which was alleged to have resulted from massive overdoses of digoxin. She was charged in 1981 with the murder of four infants but during the preliminary hearing the Crown argued that there were 24 babies who had died during the relevant timeframe and in equally suspicious circumstances. During this preliminary trial, evidence of the additional babies' deaths was admitted under the rules of 'similar fact' evidence. The Crown also led evidence of the rosters of staff in the paediatric cardiac unit that showed that Nelles was on duty at almost all of the times of the relevant infants' deaths. Unfortunately for the Crown, it also showed that she was not on duty at the time of some of the relevant deaths including the death of one of the infants with whose murder she had been charged. Not only was this a problem for the prosecution but the evidence led by the Crown in relation

to rostering of staff also showed that another nurse was rostered on at the times of all of the relevant deaths.

The presiding judge at the preliminary hearing, Mr Justice Vanek, directed that Nelles be discharged on all four charges of murder. In an interesting aside to the case, Ms Nelles responded by launching a civil action for malicious prosecution which was successful. (H. Levy & Lu, 2001; Lu, 2001; Makin, 2003; Jennifer Prittie, 1998; J. Prittie, 1998).

The Case of Barbara Salisbury (UK)

Barbara Salisbury, a 47 year old nurse, was found guilty of trying to kill two elderly patients at a Cheshire hospital in order to free up more beds. Salisbury had been a ward sister at Leighton Hospital in Crewe. She faced four charges of attempted murder but denied all charges. She was subsequently cleared of two charges, convicted of the remaining two, and was sentenced to two five-year sentences to run concurrently at Chester Crown Court on Friday, 18th June, 2004.

The jury found her guilty of two counts of the attempted murder of May Taylor, 88, and Frank Owen, 92. She was found not guilty of the attempted murder of James Byrne, 76, and Reuben Thompson, 81. Overdoses of diamorphine were said to have been administered by the nurse. She was also accused of laying the patients on their backs, causing them to drown in their own lung secretions between 1999 and 2002. Salisbury had no criminal record and had been treated in hospital for depression from August 2002 to July 2003. Salisbury, who is married with two children, denied all of the allegations and told the court she could not remember any of the patients. Salisbury's motive is still unknown as she had denied the charges throughout the trial. (Bagnall, 2007; Barbuti, 2005; Batchelor., 2004; Bourne, 2004; McFerran, 2004; Probert, 2005a, 2005b, 2005c).

The Case of Sandra Palmer (Australia)

A 51 year old registered nurse, Sandra Palmer, was charged with the attempted murder of an 84 year old patient in the Tweed Heads Hospital on July 26th, 1999. It was alleged that Palmer had used a technique colloquially known as the 'Catholic Drop'; this had involved picking up the frail patient and dropping her on her bed.

The patient, Katherine Pichi, allegedly died within 12 minutes of the nurse's action. Palmer denied the charge and was subsequently acquitted. (Dibben, 2001; Dorries, 2001; *Gold Coast Bulletin*, 2001).

The Case of Richard Williams (USA)

The Truman Memorial Veterans Hospital in Columbia, Missouri had a series of mysterious deaths between March and July of 1992. The mystery remained unsolved until 2002 when, using new testing technology, police believed that they had solved the mystery and charged nurse Richard Williams with 10 counts of murder. The tests showed that 10 people who had died whilst Williams was on duty had been administered succinylcholine immediately before their death. The investigating officers calculated that a patient was twenty times more likely to die when Williams was on duty. However, in 2003 the homicide charges against Williams, 37, were suddenly dropped after the prosecutor said the tissue testing was flawed and could not be used to prosecute him. The same prosecutor was confident that he had the right man but needed the evidence to be able to prove it. It seems that control samples of tissue also showed the presence of the residue of succinylcholine). (Twedt, 2003a, p.6).

The Case of Daillyn Pavia (USA)

I have included the case of Daillyn Pavia by way of contrast. In strict legal terms, her conduct was quite clearly murder. However, it constituted authentic euthanasia and the reactions of all involved show in sharp relief how different are the attitudes of society when comparing mercy killing and murder. After Pavia had clearly precipitated the death of a patient, she was charged with murder and the matter went to trial. Pavia could have faced life in prison without the possibility of parole if convicted. What she wound up with was probation and a five year suspension of her nursing license, having pleaded guilty to voluntary manslaughter. (Bryan, 2001, p.1; Bryant, 2003, p.1; Salter, 2001).

Table 2.1 The Cases

Name	ACKLEY, Christine	AKIN, Joseph Dewey	ALLITT, Beverley	ANDERMATT, Roger
Age at time of conviction	38	35	23	32
Sex	F	M	F	M
Nationality	US	US	English	Swiss
Nursing Status	RN	RN	EN	EN
No. of murder convictions	1	1	4	27
No. of murders alleged	2	100+	13	27
Number of murders claimed/admitted	1	0	0	27
Method of Killing	Lethal injection	Lethal injection	Lethal injection/ Suffocation	
Motive	Theft	Attention	Attention	Mercy/easing workload
Confession	Y	N	N	Y
Psychiatric condition	N	N	Y	N
Sentence	Life	15 (pleaded guilty to Manslaughter to avoid a 3 rd hearing)	Life	Life
Victim profile	Disabled adult	Adults	Babies/infants	Elderly nursing home patients
Co Accused	N	N	N	N

Name	ANGELO, Richard	CALEFFI, Sonya	COONS, Michael	COUSE, Peggy
Age at time of conviction	25	38	?	43
Sex	M	F	M	F
Nationality	US	Italy	US	US
Nursing Status	RN	RN	RN	RN
No. of murder convictions	1	12	0	1 attempted
No. of murders alleged	10+	15	1	1
Number of murders claimed/admitted	0	5	0	1 attempted
Method of Killing	Lethal injection	Injected air into veins	Lethal injection	Lethal injection
Motive	Attention	Attention	Maintained innocence	
Confession	Admitted to administering drugs to necessitate resuscitation so he could play the hero.	Y	N	Y
Psychiatric condition	Y	N	Y	N
Sentence	61 years to life	20 years	0	TBA
Victim profile	ICU?CCU patients	No information	Terminally ill patients	Elderly nursing home patients
Co Accused	N	N	N	N

Name	CULLEN, Charles	DE BERK, Lucy Quirina	DIAZ, Robert Rubane	DUDLEY, Bobby Sue TERRELL
Age at time of conviction	43	41	46	35
Sex	M	F	M	F
Nationality	US	Dutch	US	US
RN	RN	RN	RN	LVN
No. of murder convictions	29 killed 6 attempted	7 killed 3 attempted	12	3
No. of murders alleged	40+	21	19	4+1 Attempted
Number of murders claimed/admitted	40+	0	0	0
Method of Killing	Lethal injection	Lethal injection	Lethal injection	Insulin or strangulation
Motive	?	?Attention/ Power	?	Unknown
Confession	Y	N	N maintained innocence	N
Psychiatric condition	N	Y	?	Y
Sentence	Life x 18	Life	Death (remains on Death Row)	65 years
Victim profile	ICU/CCU Patients	Babies- through to elderly patients	CCU	Elderly
Co Accused	N	N	N	N

Name	FALUDI, Timea	FELTNER, Jeffery	FIRTH, Alison	GEEN, Benjamin
Age at time of conviction	25	26	36	25
Sex	F	M	F	M
Nationality	Hungarian	US	Scottish	English
Nursing Status	?	EN	RN	RN
No. of murder convictions	1 murder, 6 attempted murder	1	1	2 murder, 15 attempted
No. of murders alleged	40	7	3	2 murder, 15 attempted
Number of murders claimed/admitted	40	7	0	0
Method of Killing	Lethal injection	Suffocation with a pillow	Lethal injection	Lethal injection
Motive	Sexual thrill	Mercy killing	Convenience	Thrill/power
Confession	Y	Y later retracted	N	N
Psychiatric condition	N	Y	N	N
Sentence	9 years increased to 11 years	Life	Life	Life x 17
Victim profile	Elderly	Elderly	Elderly	Hospital patients
Co Accused	N	N	N	N

Name	GIERSBERG, Michaela	GILBERT, Kristen	GRAHAM, Gwendolyn	HARVEY, Donald
Age at time of conviction	27	33	25	23
Sex	F	F	F	F
Nationality	German	US	US	Austrian
Nursing Status	AIN	RN	EN	EN
No. of murder convictions	4 murders, 4 attempted, 1 mercy killing	4	5	Attempted murder x2
No. of murders alleged	9	4, 2 attempted	8	49
Number of murders claimed/admitted	0	0	0	?
Method of Killing	Suffocation with pillow	Lethal injection	Suffocation	Drowning bed, lethal injection
Motive	Unknown	Thrill/power	Sexual thrill	Power, control, pleasure in killing, mercy
Confession	Y retracted	Alleged to have confessed to ex husband	N	Y
Psychiatric condition	N	N	N	N
Sentence	Life	Life imprisonment without possibility of parole	Life x 6	15 years
Victim profile	Elderly nursing home patients	VA Hospital Patients	Elderly	Elderly nursing home patients
Co Accused	N	N	Catherine Wood	Maria Gruber, Ilene Leidolf, Stephanija Mayer

Name	JACKSON, Vickie Dawn	JENKIN, Pamela	JONES, Genene	KANNER, Wanda
Age at time of conviction	40	42	33	49
Sex	F	F	F	F
Nationality	US	Australian	US	US
Nursing Status	LVN	RN	LVN	AIN
No. of murder convictions	10	0	1	1
No. of murders alleged	20	2	15	1
Number of murders claimed/admitted	0	0	0	0
Method of Killing	Lethal injection	Lethal injection	Lethal injection	Choked on bagel
Motive	? Attention, power, control	Prosecution alleged mercy killing	Attention power, control	Mery/Affair with victim's husband, Accident
Confession	N maintained innocence	N maintained innocence	N	N
Psychiatric condition	Y	N	N	N
Sentence	Life	Discharged by court	99years + 60 years concurrent	5 years
Co Accused	N	U	N	N

Name	LEIDOLF, Ilene	LETTER, Stephan	MAJORS, Orville Lyn	MALEVRE, Christine
Age at time of conviction	21	27	38	33
Sex	F	M	M	F
Nationality	Austrian	Swiss	US	French
Nursing Status	AIN	EN	LVN	RN
No. of murder convictions	5	12	6	0-6 counts assisting or causing deaths of terminally ill
No. of murders alleged	5	28	7	11
Number of murders claimed/admitted	?	16	26	30
Method of Killing	Drowning in bed, lethal injections	Lethal injections	Lethal injection	?
Motive	Power, control, pleasure in killing, mercy	Claimed compassion, more likely power	Power control, pleasure in killing	Mercy killing?
Confession		Y	N	Y – retracted
Psychiatric condition	N	N	N	Y
Sentence	Life	Life	360 years	12 years
Victim profile	Elderly nursing home patients	Mostly frail elderly; one victim as young as 40	Hospital patients and others who offended him in some way	Terminally ill patients
Co Accused	Mayer	N	N	N

Name	MARTIN, Justin W.	MAY, Cheryl A.	MAYER, Stephanija	MULLINS, James
Age at time of conviction	19	33	43	56
Sex	M	F	F	M
Nationality	US	US	Austrian	US
Nursing Status	AIN	RN	AIN	RN
No. of murder convictions	1	0	0	1
No. of murders alleged	1	1		1
Number of murders claimed/admitted	1	0	?	0
Method of Killing	Torture and Abuse	Lethal injection	Drowning in bed, lethal injection	Lethal injection
Motive	To get a reaction	Hated the patient	Power control, pleasure in killing, mercy	Unknown
Confession	Y		Y	N
Psychiatric condition	N		N	Y
Sentence	35 years		15 years	2 years
Victim profile	Elderly nursing home patient		Elderly nursing home patients	Hospital patients
Co Accused	N	N	Maria Gruber, Ilene Leidolf, Stephanija Mayer	N

Name	MGWATYU, Luvuyo	MOHAMMAD, Aida Nureddin	MORI, Daisuke	NORRIS, Colin
Age at time of conviction	27	25	29	29
Sex	M	F	M	M
Nationality	South African	Egyptian	Japanese	Scots
Nursing Status	RN	RN	LVN(EN)	RN
No. of murder convictions	1	1	1 murder, 4 attempted	0
No. of murders alleged	1	12	10	4, 1 attempted
Number of murders claimed/admitted	0	0	0	0
Method of Killing	Kicking and stomping	Drug overdose	Lethal injection (spiked IV)	Lethal injection
Motive	Rage	Revenge	Uncertain but possibly revenge on senior MO	Maintained innocence
Confession	N	Y-?coerced	Y – retracted	N
Psychiatric condition	N	N	N	N
Sentence	12 years	Death, but on appeal, awarded new trial	Life	?
Victim profile	Elderly	Hospital patients in neurology ICU	All ages	Elderly hospital patients
Co Accused	N	N	N	N

Name	PAVIA, Daillyn*	RACHALS, Terri	RACHMAN, Hal Speers	RAINEY, Shermika
Age at time of conviction	32		46	18
Sex	F	F	M	F
Nationality	US	US	US	US
Nursing Status	RN	RN	RN	AIN
No. of murder convictions	1	0	1 Attempted	1
No. of murders alleged	1	6	1 attempted	1
Number of murders claimed/admitted	Q	0	0	0
Method of Killing	Lethal injection	Lethal injection	Insulin overdose	Held victim down while co-accused beat her with lead knuckles
Motive	Mercy	?	Theft	Coercion
Confession	Y	N	N	Y
Psychiatric condition	N	Y	N	N
Sentence	5 years suspended	17 years	9 years	30 years
Victim profile	Elderly, end of stage terminal illness	ICU/CCU patients	AIDS sufferer	Elderly
Co Accused	N		N	Wilson, Gayla Ann

Comment [H1]: Which is she John - she is reported in the AIN section in Chapter three

Name	ROEDER, Michaela	ROSENFELD, Brian K.	SALISBURY, Barbara	ROEDER, Michaela
Age at time of conviction	30	34	47	34
Sex	F	M	F	F
Nationality	German	US	British	US
Nursing Status	RN	Orderly then LVN	RN	AIN
No. of murder convictions	5 murders, 1 attempted	3	2 attempted murder	1
No. of murders alleged	17	23	4 attempted	1
Number of murders claimed/admitted	0	Unofficially 23	0	0
Method of Killing	Lethal injection	Drug overdose	Lethal injection	Bashing
Motive	Unknown – suggested passion for power	Unknown suggested passion for abuse	Free up beds	Rage
Confession	Y	Y allegedly to cellmate	N	Y
Psychiatric condition	N	N	N	Y
Sentence	11years	Life	5 years	30 years
Victim profile	ICU patients	Elderly	Elderly	Elderly
Co Accused	N	N	N	N

Name	ROSENFELD, Brian K.	SALISBURY, Barbara	TENZER, Heidi	U, Martha
Age at time of conviction	34	47	34	U
Sex	M	F	F	F
Nationality	US	British	US	Dutch
Nursing Status	Orderly then LVN	RN	AIN	AIN
No. of murder convictions	3	2 attempted murder	1	4
No. of murders alleged	23	4 attempted murder	1	9
Number of murders claimed/admitted	Unofficially 23	0	0	4
Method of Killing	Drug overdose	Lethal injection	Bashing	Lethal injection
Motive	Free up beds	Rage	Sympathy	?
Confession	Y allegedly to cellmate	N	Y	Y
Psychiatric condition	N	N	Y	Y
Sentence	Life	5 years	30 years	9 years
Victim profile	Elderly	Elderly	Eldeerly	Elderly
Co Accused	N	N	N	N

Name	VAN OORT, Christie	WAGNER, Waltraud	WILSON, Gayla Ann	WOOD, Catherine May
Age at time of conviction	26	32	44	26
Sex	F	F	F	F
Nationality	Canadian	Austrian	US	US
Nursing Status	EN	EN	EN	AIN
No. of murder convictions	1	15 murders 17 attempted	1	5x2nd degree murder
No. of murders alleged	2	200	1	5
Number of murders claimed/admitted	0	39	0	5
Method of Killing	Choking	Drowning in bed, lethal injection	Beating to death with brass knuckles	Suffocations
Motive	?	Power, control, pleasure in killing, mercy	Rage – 'retaliation for disrespect'	Sexual thrill
Confession	Y	Y retracted	N	Y
Psychiatric condition	N	N	N	N
Sentence	50 years	Life	Unknown	20 to 40 years imprisonment
Victim profile	Elderly	Elderly	Elderly nursing home residents	Elderly
Co Accused	N	Maria Gruber, Ilene Leidolf, Stephanija Mayer	RAINER, Shermika	Gwendolyn Graham

Chapter 4

Study Design

Synopsis

This study sets out to deconstruct contemporary public and professional discourses surrounding the subject of the murder of patients by nurses. Deconstruction seeks to reveal the assumptions (or conditions) that give rise to social constructions of phenomena and to understand the social practices that arise out of these constructions. Such an undertaking requires the careful and thoughtful design of a process of discursive inquiry that is methodologically sound (bearing in mind that this may be construed by some postmodernists as a contradiction in terms). This chapter describes the methodology and methods adopted.

Introduction

The development of the study design is not linear and the various vicissitudes and adaptations that emerge are identified and explored. This work can be viewed as a “postmodernist” endeavour and in nursing research at least, there is a tendency to over-justify such an approach because of the dominance of modernist approaches to inquiry associated with the traditional scientific method and the ubiquitous clinical trial. No such justification is offered here. Rather, this section on methodology and methods focuses on the literature that situates new paradigm inquiry with the pursuit of understanding and perspective transformation (Denzin & Lincoln, 1994; Reason & Rowan, 1981).

The methodology of any study is critical to its soundness and thus, to its credibility. Some consideration of the meaning of the word makes that immediately apparent. Methodology has its roots in the ancient Greek language. Two Greek words – *meta* (higher order) and *hodos* (way) – gave rise to *methodos* meaning the pursuit of knowledge or orderly mode of investigation. Over time, the meaning of words change and words come to have new meanings and connotations and thus, method has come to mean a system or way of obtaining an object. Methodology – *methodos* + *ology* (discourse or speech around a particular subject) – has come to mean the study of method (Hoad, 1996). By method is meant the specific process used to locate the knowledges and understandings sought by a particular project. It will be apparent from the foregoing that the methodology provides the basis for the methods. It constitutes the theoretical frameworks that should at once form the basis of selection of the method and the explication of that method. That is to say, good research design demands that ontological and epistemological considerations should guide the researcher in the selection of methods appropriate to the question being asked.

Paradigm

In terms of a worldview or perspective this study is constructivist. Social constructionism is identified by Denzin and Lincoln to be an ‘epistemological stance’ taken by some qualitative inquirers. Schwandt (1994) explains that social

constructionists contend that society is constructed by the use of language – the ways we speak, write and argue (Schwandt, 1994). The questions are not related to the meaning of phenomenon but how discourses develop, are sustained and change in context. A constructivist epistemological stance is an a priori condition for a deconstructive endeavour just as is the analysis of discourse.

Methodology

This study is essentially a discursive analysis informed predominantly by the work of Foucault but also other discourse theorists such as van Dijk and Schiffrin (Schiffirin, Tannen, & Hamilton, 2003) and Torfing (1999). Foucault describes the need for scholars to develop an archaeology and a genealogy of discourses if they seek to make new sense of social phenomena and of the social constructions and practices that shape contemporary understandings of them. While his approach was initially considered to be unconventional and lacking in academic rigour, in recent years his work has been acknowledged as ground-breaking. His great contribution lay in his ability to generate new interpretations of the present (sometimes styled as an ontology of the present) through shedding new light on standard versions of history and society. Standard approaches to history research the truth as it happened over time based on the evidential record. They are linear and teleological in nature. Foucault, in contrast, uses space rather than time as the guiding paradigm of his archaeological investigations of history. The effect of this is that it allows him to draw linkages between disparate discourses. This is evidenced in much of his writing. It is exemplified in *Discipline and Punish* (Foucault, 1977).

From *Discipline and Punish* comes the term ‘problematization’ in its earliest and barest forms and this study involves a problematization of murder by nurses. In later refinements of his thinking on the matter of problematization, Foucault explains that he wanted to know if it was possible:

...to describe the history of thought as distinct from both the history of ideas (by which I mean the analysis of systems of representation) and from the history of mentalities (by which I mean the analysis of attitudes and types of action (schémas de comportement). It seemed to me that there was one element that was capable of describing the history of thought

– this was what one could call the element of problems or, more exactly, problematizations. (P. Rabinow & Foucault, 1997, p.117)

Thus, a problematisation is a 'work of thought' (P. Rabinow & Foucault, 1997, pp.117). That is to say, a problematisation is a complex social and material construction, articulated in thought. For Foucault, a problematisation has three elements (each being a set of factors), these being power, knowledge and subjectivity, and he contends that no problem exists that does not simultaneously involve all three elements (P. Rabinow, 1997; P. Rabinow & Foucault, 1997). It will be clear from this position that for Foucault, a problematisation is an event of thought.

Foucault took the view that the most profound thought is that which remains on the surface and that, consequently, to analyse problematisations is not to reveal a hidden and suppressed contradiction. Rather, it is to address that which has already become problematic (P. Rabinow & Rose, 2003, p.12). Foucault's view was that for a problematisation to have formed, something prior 'must have happened to have made it uncertain, to have made it lose its familiarity, or to have provoked a certain number of difficulties around it' (P. Rabinow & Foucault, 1997, p.117). In other words, problematisation begins with the identification of a set of difficulties in everyday life where those difficulties are so severe that it is not possible to continue with the activity. For example, medical murder with respect to the medical profession sits well within this rubric and society's management of the medical profession has changed in response to its problematisation. The problematisation of murder of patients by nurses is nascent.

Once a problematisation occurs it generates a response as indicated in relation to the issue of medical murder by medical practitioners. However, for Foucault there are always multiple possible ways of responding to the same constellation of difficulties.

For:

...when thought intervenes, it doesn't assume a unique form that is the direct result or the necessary expression of these difficulties; it is an original or specific response – often taking many forms, sometimes even contradictory in its different aspects – to these difficulties, which are defined for

it by a situation or a context, and which hold true as a possible question. (P. Rabinow & Foucault, 1997, p.118).

The task of the analyst is not to adjudicate between these, but to:

... rediscover at the root of these diverse solutions the general form of problematization that has made them possible – even in their very opposition; or what has made possible the transformations of the difficulties and obstacles into a general problem for which one proposes diverse practical solutions. (P. Rabinow & Foucault, 1997, p.118).

In other words, Foucault would argue that the task of problematisation is to transform these difficulties '... into a general problem for which one proposes diverse solutions...' He illustrates this by identifying mental health as a problematised difficulty and noting the range of solutions proposed for it (P. Rabinow & Foucault, 1997, p.118).

The three dimensions of Foucauldian problematisation, identified above as power, knowledge and subjectivity, are fundamental to his work and I have indicated already the Foucauldian influence on and in this work. It takes the form of an emphasis on these three sets of factors. The three elements of this trinity – power, knowledge and subjectivity – are all re-presented and explicated in this dissertation to a greater or lesser extent.

No pretence is made here that this study is in the same league as *Discipline and Punish*, but through its completion I will initiate a version of the phenomenon or discourse of nurses that murder by beginning a process of drawing linkages among various discourses that constitute the way it appears in society. Put another way, through this study I want to create an ontology of the present with respect to the ways in which the murder of patients by nurses is understood by the addition of a new version.

The approach taken to discourse in this study is essentially realist and discursive, in the truest sense of these words. Realism, in this study, does not itself defer to empirical reality, but to the discursive conventions by which and for which a sense of reality is constructed (Torfing, 1999). Such conventions are in themselves social

constructions and the approach adopted in this study includes a conscious and considered decision to let the data drive the research rather than to constrain the research by subscribing to one theoretical school of discourse analysis instead of another. My approach, as I have indicated, draws on the work of Foucault but discourse analysis has become a large field in its own right with considerable contention around the issue of how it should be approached. Other epistemological stances taken by qualitative methodologies (e.g. interpretivists) assume a social world and then seek to understand it whereas discourse analysis attempts to explore the origins of the socially produced ideas and objects that are found in the world, along with how they are maintained and held in place over time (Phillips & Hardy, 2002). The key element common to those discourse theorists whose work is drawn upon in the development of the methodology of this study is the strong social constructivist framework applied to the social world (Gergen, 1999) that takes the form of the trinity of text, discourse and context. In this constructivist framework, the text is part of the discourse, and the discourse exists within a context. As Wood & Kroger point out, discourse analysis is:

... not only about method; it is also a perspective on the nature of language and its relationship to the central issues of the social sciences. More specifically, we see discourse analysis as a related collection of approaches to discourse, approaches that entail not only practices of data collection and analysis, but also a set of metatheoretical and theoretical assumptions and a body of research claims and studies. (Wood & Kroger, 2000, p.x)

Thus, social constructivism offers a framework of three elements – the trinity of text, discourse and context. Texts are part of discourses and discourses exist in contexts. Texts relate to other texts and contexts, but it is the discourses that constitute roles. Thus, it is essential on this view to attend to all elements of the trinity, and it is the discursive element that is most difficult to attain. The originality of this study lies in an attempt not to merge the frameworks offered by the social constructionists and Foucault – texts, discourse and context on the one hand, and power, knowledge and subjectivity on the other – but in an endeavour to respect and accommodate both in this discursive analysis. By definition, a discursive analysis is rambling, expatiated and digressive but it is also reasoned, reflexive and interpretive (Phillips & Hardy,

2002, p.85) and that is the nature of this work. Fig one is a model used as a reflexive tool during the analysis of the data and the re-presentation of the text.

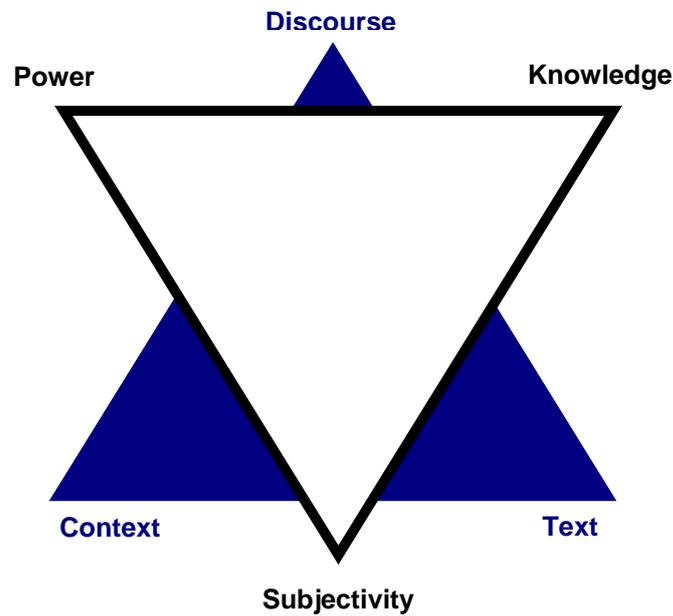


Fig 4.1 Model for reflection.

The relationship between discourse and the discursive is well explained by Torfing (1999). It revolves around the notion of surplus meaning produced as a by product of the partial fixation of meaning achieved through discourses. The discursive is the field of ‘... irreducible meaning ...’ that constitutes a ‘... field of undecidability which constantly overflows and subverts the attempt to fix a stable set of differential positions within a particular discourse. (p.92)’ This discursive study is the very beginnings of a rambling (discursive) journey to surface the meanings surrounding nurses who murder their patients, all the while recognising that the bodies of text constitute sets of beliefs that are and will never become fixed ideas.

Methods

Study methods are the ways in which a researcher approaches the collection of data and its analysis. The time honoured ways of experimental research have served the

positivist tradition very well and that involves a predetermined design for the study and any deviation from that design during the course of the study holds the potential to be considered a fatal flaw. The approach taken in the sort of research being undertaken in this study cannot accommodate that tradition. The need for a reflexive dimension to the research ensures that the method will, to some extent, be iterative.

It has been said that discourse analysis is both a perspective (insofar as it ‘...brings with it a particular view of social phenomena as constituted through structured sets of texts of various kinds...’ (Phillips & Hardy, 2002, pp.59-60)) and a method (to the extent that it is a way of approaching data collection and analysis). However, discourse analysts are yet to develop methods that make discourse analysis truly discursive, and for Phillips & Hardy (2002, p.86) it is the discursive element that is the critical contribution of discourse analysis. The discursive element is the role of the discourse. It is the discursive element that is so difficult to capture but without it, the three dimensional model of text, discourse and context is reduced to two.

The challenge for the discourse analyst is, on this view, to construct a study wherein the method is capable of not merely linking text and context, but of exploring and explicating the roles of the discourses of which the texts are part. There is considerable latitude available to the discourse analyst so far as method is concerned because there is not yet any consensus as to what constitutes the one best way to do it. The complexity of discourse analysis has generated enormous diversity in the methods applied in research intended to achieve discourse analysis. This is likely to remain the case for some time to come. However, diversity should not reduce rigour and in this study every effort has been made to ensure its rigour. The method of data collection and analysis for this study is described in detail in this section.

Data Collection

The study involved a comprehensive search for and retrieval of texts that refer to the field of study. In an endeavour to capture as many as possible of the discourses relating to the specific subject of the murder of patients by nurses, the search strategy was designed to capture a broad range of material rather than to narrow the topic down as is the norm in more traditional searches.

The sources of data govern the voices that are audible in this pursuit. Wetherill (2001) identifies a broad range of possible data sources for discourse analysis. These include interviews, focus groups, documents, newspaper articles, cartoons, novels, political speeches and naturally occurring conversations and to this array, in the context of this project, one might be tempted to separately identify the transcripts of legal cases. Still, as Phillips and Hardy point out, no researcher can study everything (2002, p.19) and conscious decisions have to be made about what data sources will be included in a study. After much reflection, I initially decided to use the data to be mined from the mass media (primarily newspapers) and the professional literature of nursing. After identifying a significant number of biographical books related to individual nurses who had murdered patients, I decided to include those as well because of their readily accessible presence in the public domain.

Conversely, I rejected the idea of including the transcripts of court cases involving defendant nurses who were convicted of the murder of patients. This represented a significant departure from my preconceptions of the shape and outcome of this study so it is appropriate to consider the reasons for this decision. The point of discourse analysis in this research is to get at the particular meanings attaching to the murder of patients by nurses as a mechanism for discerning the conditions that make the murder of patients by nurses possible in our society. The legal transcripts from the cases would certainly reveal discourses at a number of levels because they are verbatim records of the voices of the accused, the witnesses for both prosecution and defence, and the judges. I was, however, swayed by three factors.

The first was the inaccessibility of legal transcripts relating to the murder trials of nurses who were convicted of murder. The inaccessibility lay in the cost of obtaining such documentation; the complexity of the legal proceedings which usually involves a multiplicity of charges, interlocutory processes and hearings, orders, declarations, trials, appeals and so on; and the fact that many of these proceedings occurred in jurisdictions where the language was other than English.

The second factor was more germane to the discursive methodology of the research. It was the argument that the worth of the data to be gleaned from the voices of each

of these participants in the transcripts is outweighed by the potential distortion of the discourses. These voices would be trammelled by the rules of evidence, for example. Thus, evidence may be held to be inadmissible, as would be the case if it was determined to be hearsay or illegally obtained, for example. Comments found to be prejudicial by the judge may be struck from the record and would therefore never constitute an audible element of the discourse and yet they may be central to it. No participant is unconstrained in this context. The language of the law creates a further distortion because many words that have a common meaning become words of art in the lexicon of the discipline. The discourses revealed would be those of the discipline of law, not those of the lay public and to this extent they would not constitute meaningful contributions to an analysis of the discourses around the phenomenon within the public domain.

The third factor was the recognition that the omission of the legal transcripts as a data source does not mean that the voices of the participants are excluded. Rather, the exclusion of the transcripts meant that those voices were admitted via the same route as all other voices in this study. That is to say, it is heard through the mass media, newspapers, professional literature of nursing and biographical books about nurses who murder, some of which are written by lawyers. This approach to the inclusion/exclusion of sources of data was employed in a deliberate attempt to include information from the margins of the field for it is here that the 'silenced'⁴ voices are likely to subsist. These voices may be heard in the court transcripts but only through a legal filter. In the works of Foucault, it is these voices that appear to hold the key to alternate possibilities for as much can be learnt about power and domination from the dominated as from the dominators. For this reason it is important to ensure, to the extent that it is possible, that all voices involved are heard and their influence/power in the field assessed.

My comments about the exclusion of the legal transcripts as a source of data reveal one of the qualities that are inherent in the analysis of discourse. Postmodernists have made explicit the presence of the researcher's voice in the production of texts that

⁴ Margins' and 'silenced' are terms commonly used by a range of postmodernists. Margins refers to the periphery of the distribution of power across a society whilst 'silenced' is used to

articulate the process and outcome of research. Discourse researchers have, of necessity, to make this declaration because the premise of discourse analysis is the construction of social realities through the relationships between texts, discourse and context. It is inconceivable that the discourse researcher could avoid being a part of the construction of a new version of the discourse. By way of respect for this inevitability, I want to declare an assumption on my part that is fundamental to the decisions made about the data sources for this study. My assumption was, and remains, that the meanings presented to the public and developed through discourses – that is to say, those meanings that have general application – are the meanings most likely to hold the key to understanding contemporary social realities relating to the murder of patients by nurses. These discourses are re-presented in the mass media.

Searching

As I have pointed out elsewhere in this dissertation, my search for sources of data on the topic of murder of patients by nurses began accidentally, with cases emerging from searches for other information sought in relation to law and nursing. That triggered my interest but not so much my searching until one afternoon I found myself in an antique and second hand bookstore in an older part of Newtown, Sydney. I had spent much of the day at the University of NSW library looking for material relevant to law and nursing but not particularly on murder in that context. The bookshop was light relief. I was browsing for novels for holiday reading, a good ‘whodunnit’ or two. I stumbled onto a shelf that housed ‘True Crime’. As I looked along the shelf, I came to serial killers. Within the serial killers section was a section on ‘Women that kill’ and among those I found books that were biographical accounts of the murderous exploits of baby killers Genene Jones (Elkind, 1990a) and Beverly Allitt (N. Davies, 1993a), both of whom were nurses. There was also an account of Terri Rachals (Manners, 1995a), another nurse. I was curious. I looked again at the section on male serial killers to see if it included any volumes on male nurses and there was Donald Harvey (Whalen & Martin, 2005). Now I was hooked. Shortly afterwards, I went away and designed this study. My search had begun in earnest.

characterise voices that do not hold the same power as dominant discourses and are therefore unlikely to be heard.

From those books and some preliminary, tentative probes, I identified my principle search terms as 'nurse', 'patient' and 'murder' or 'homicide'. I piloted these three terms on Google[®], and then on a number of databases including CINAHL, LexisNexis, APAIS, PubMed and Medline. I also set up a Google[®] daily search on these terms and continued this throughout the duration of the study as a mechanism for bringing new cases to my attention. Eventually I was satisfied that these search terms were ideal for the purpose of garnering data from the broadest possible array of sources. I might add that I took some convincing on this because the searches of the databases dealing with nursing literature yielded precious little in the way of results. Initially I thought this was due to poor selection of search terms so I consulted with the librarians of two universities but trials of alternative terms such as 'client', 'resident' and 'killer' yielded even less from the professional literature. This is an issue that I comment on extensively in Chapter 8. After running the search ('nurse'+ 'patient') + ('murder' or 'homicide'), I then limited the search to exclude euthanasia or mercy killing. The final search period was 1980 – 2006, a neat quarter of a century. Whilst I stipulate a timeframe here, that was purely for practical purposes of the study; the focus of discourse analysis is more spatial than temporal. This was Stage 1 of a two-part search strategy but I want to talk about the selection of databases before I move on to discuss Stage 2 of the search.

The selection of appropriate databases in which to apply my search strategies of ('nurse'+ 'patient') + ('murder' or 'homicide') and [('nurse'+ 'patient') + ('murder' or 'homicide')] not ('euthanasia' or 'mercy killing') would normally have been straightforward. However, my candidature was part-time and spanned more than 6 years. Libraries change their subscriptions over time and that can impact on one's access to particular databases. I was in the fortunate situation of being a doctoral candidate at La Trobe University whilst employed at The University of Adelaide which doubled my opportunities for access. However, it also doubled the prospects of changes in access. This was compounded by the fact that my circumstances changed so that I was working at La Trobe University where I was also a doctoral candidate. They changed again when I moved to work at James Cook University and transferred my doctoral candidature to The University of Adelaide on account of my supervisor taking up a position there. All of this made the process of conducting my searches a somewhat disrupted process but in the end, it worked to advantage the

process because the databases that I was ultimately able to access were the most appropriate for the purpose.

The databases that I relied on most heavily initially were CINAHL and PubMed for the nursing literature; and LexisNexis for both its legal and its newspaper coverage. In the final searching, I still relied on CINAHL and PubMed for the professional literature, but added to this was Ovid and ProQuest 5000. For the newspapers, for the final searching I had access to Factiva, a specialist newspaper database and this was particularly significant for Stage 2.

It was Stage 2 that proved to be the richest source of data. It was also considerably more time consuming than Stage 1. Fortunately, however, the search terms were a given because this part of the search strategy involved searching all of the databases for the specific name of each and every one of the cases included in the study. It was Factiva that proved invaluable here and in some cases, searching the name of the convicted nurse produced almost 2,000 articles. For other less publicised cases, there was only a handful of articles but this was itself useful information in the context of this study. Where a search produced a massive number of articles, the number of articles was usually inflated by having been picked up by the newswire services. I could have eliminated this in Factiva by simply clicking the box to sift out multiple publication but I chose not to do so because I was seeking to uncover the various voices contributing to the discourses and the gloss (or in contemporary language, the spin) that copywriters and editors place on their version of a newswire article tells us much about the ways in which meanings are constructed in the media.

One of the interesting practical issues that arose in relation to databases involved Factiva. The standard library of import filters for Endnote® bibliographic software that enable the importing of records from databases directly into Endnote® did not include a filter for importing from Factiva. After further consultation with the librarian, I was able to locate an appropriate filter at the University of Queensland and I am very grateful to their open policy on making it available. This filter saved me a great deal of time and distress after I discovered that I would not be able to export my NOTARI® records to Endnote®.

The sources uncovered by these searches yielded the data for this study. That data was then subjected to analysis and the background and process of that analysis warrants careful explication.

The Analysis

This study is heavily influenced by the work of Foucault. His techniques of archaeology and genealogy are techniques that have emerged retrospectively as methods in successive iterations. That is to say, he did the research, published the work, then extracted and explicated his methods in the next work. Arguably the best example of this is the relationship between *The Order of Things: an Archaeology of the Human Sciences* (Foucault, 1986) and *The Archaeology of Knowledge* (Foucault, 1972) In the latter work he reflects on the analysis that formed the substance of *The Order of Things*. His brilliance did not depend on the methods but his capacity to generate discursive analyses that spanned a broad range of disciplines. Given that there is no specific Foucauldian ‘method’ to follow, it is this ability to generate discursive analysis that my study will seek to replicate rather than the actual techniques that he applied. The absence of a specific method creates a difficulty for a researcher aspiring to replicate the work of Foucault but in a work such as this where there is no such aspiration, that absence of method is positively liberating.

The specifics of the analysis, captured in a recorded decision trail as the work progressed, will be critiqued in Chapters 5-8 of this dissertation and re-presented to the reader in the concluding chapter. A free ranging discursive account will be tempered with some rules of research. Whenever possible these were predetermined. For example the literature search was comprehensive and a full search history archived. Criteria for the inclusion and exclusion of material have been provided in the section on data collection and these are refined through explanation as the material is analysed. The means of extracting data for the discursive analysis is transparent and made express in Chapters 5-8 as the material is analysed. The logic and reasoning applied to this analysis reflects my training in these skills in both the legal and nursing disciplines.

In anticipation that this study would generate a large volume of data that would require careful management, I decided to opt for an electronic approach to aid the analysis and cast about for appropriate software for this purpose. Whilst this proved to be absolutely the correct decision, it was not the smoothest of processes.

The Software

Generally speaking, it would be true to say that almost invariably, where a study is being conducted using discourse analysis in Australia, and the study involves the management of data sources and the generation of a significant volume of data, the data will be managed electronically. Almost equally invariably, the software of choice will be QSR-NVivo®. I am familiar with this software and have conducted workshops in its use so I am well aware of its capabilities and its shortcomings. I consider it to be exceptionally good for microanalysis in particular. The nature of the analysis being contemplated for this study did not require the management of the extensive detail of which QSR-NVivo® is capable. I was also aware that the Joanna Briggs Institute was in the process of developing a suite of software for the management of systematic reviews. That suite of software is known as the System for the Unified Management of the Review and Assessment of Information (SUMARI®) (Institute, 2003). Within this system there are a number of modules. The two that were suitable for trialling with this study were Comprehensive Review Management System (known as JBI-CReMS®) (Joanna Briggs Institute, 2003a) and Narrative, Opinion and Text Assessment and Review Instrument (known as JBI-NOTARI®) (Joanna Briggs Institute, 2003b). This was an exciting opportunity to take this software and use it in a way that no one had previously attempted and that is what I opted to do.

NOTARI®, as its name clearly implies, provided the tool for cataloguing the articles, recording the identified discourses and storing the extracts of the texts that exemplified the discourses. CReMS® is designed to take the data extracted and stored in NOTARI® (among a number of other modules that do not require mentioning here) and allow that data to be manipulated however the user requires. Together, they appeared to be ideal for the purpose, even if they were untried in the precise circumstances that I had engineered. I embarked on the project with

considerable enthusiasm knowing that I would be immersed in the software for many, many hours and thus began my electronic travails. I want to discuss the issues that arose with NOTARI® before I move on to CReMS®.

A key difference between QSR-NVivo® and the SUMARI® suite is that the former is stand-alone whereas the latter is web-based. This means access is contingent on the Internet being up and running from desktop to server. That was not always the case during the course of this study. It also meant that speed of data input was contingent on the speed of the internet connection. In the early stages of this study access was via dial-up connection so speeds were incredibly slow and as all users of the Internet know, download speed is inversely proportionate to user frustration levels when online. This was initially an exasperating experience but I am pleased to be able to record dramatic improvements in the technology over the life of the study and it is now a very stable platform that is made viable by the ready availability of affordable, high speed broadband Internet. Having input data from thousands of articles, I can confidently state that a user beginning their study today would be unlikely to find the web-based nature of this software to be a significant inconvenience.

On the other hand, a user may find the absence of adequate navigation tools in the software to be a significant drawback. This was a particular problem for me because of the number of sources that I was using. I provided feedback to the programmers and project managers in relation to all of the deficits that I identified in the software but primarily in relation to CReMS®. On the matter of the navigation, they pointed out that the normal systematic review would involve less than 50 papers so the software, which was intended to deal with systematic reviews, never contemplated having to deal with larger numbers of sources. Like all commercial software, the SUMARI® suite has a schedule of development and revision. Unfortunately, these latter problems could not be rectified during the period of the study. They were scheduled to be remedied for the next release but they remained a constant irritant for me throughout the life of the study. Ironically, that new release was launched during the very week that I was writing up the final draft of this Chapter. For all that, the basic concept of NOTARI® is excellent and in the end it did serve my purposes very well.

The second of the modules that were to make life simple and easy in the management of the data in this study was CReMS® which is the module that provides for the overall management and manipulation of the data entered into the other modules such as NOTARI®. One of the capabilities of CReMS ® is that it is possible to export records directly from CReMS ® to Endnote®, the bibliographic software. It will be obvious that in a study involving thousands of records that would be a major advantage, particularly since NOTARI® is not capable of this. After duly entering the thousands of records into NOTARI® , I then exported them to CReMS® in accordance with the instructions. The CReMS® then promptly froze and locked me out, never to let me log in again. When I consulted the programmers, the explanation was as indicated earlier. It was designed for about 50 records, not 5000. My problem was that I was hearing this at the middle of the study rather than at the beginning when I could have made a decision to use other software. Thus, I can make no evaluation of CReMS® because, effectively, I was unable to use it but like NOTARI®, the new version of CReMS® was launched in August 2007 as I wrote up this Chapter.

The Data

Notwithstanding the problems with the software, NOTARI® facilitated the extraction of the data. It allowed the distillation and categorisation of the discourses which form the framework of the four data chapters (Chapters 5-8) and it enabled the extraction, cataloguing and storage of the data along with its allocation to the particular discourses. Sometimes the same data was allocated to more than one discourse, thereby affording glimpses of the linkages and relationships between texts, discourses and contexts.

I should acknowledge one other feature of my analysis of this material. I want to borrow a concept most commonly discussed in the context of grounded theory and that is the notion of saturation of data (Anells, 2003). In analysing bodies of texts from sometimes many hundreds of reports on a particular occurrence, there is a point at which nothing new emerges either in the texts themselves or the discourses that

they constitute. All of the texts were perused but when I considered that I had gone beyond that point of saturation, I made the decision to terminate the analysis.

Ethics

There was no formal requirement to submit this proposal to an Ethics Committee as it does not involve the collection of data from human beings. This does not absolve the researcher from ethical responsibility, however, so in the process of deconstruction I kept in mind the general ethical principles that surround all human activity and therefore applied to the conduct of this research. Even so, the potential of this research to harm the reputation and standing of the profession of nursing weighed heavily. I perceived a need for additional strategies to monitor the ethical comportment of the study and the emergence of new understandings of the construction of nurses who murder. To this end I maintained discussions with professional peers who provided ethical feedback. This is discursive research so it carries with it some inherent responsibilities to assure the quality of the research both because of its emergent nature and because of its engagement with the subjective. As a discursive researcher I am constantly aware of the injection of my own voice and the creation of my own discourse. This is unavoidable so as a researcher, I can only seek to make it explicit. To this end I have engaged in a reflexive process with the analysis and its reporting at regular intervals throughout the conduct of the study by way of supervision meetings and in numerous presentations to colleagues and peers.

Conclusion

The bodies of texts that were the raw materials for this study were examined to locate the texts within. The texts within were then interrogated to reveal the discourses that they constitute. In the following chapters those discourses are re-presented in an attempt to extrapolate how meaning has come to existence and how the various discourses surrounding murder committed by nurses on their patients in the course of their work shape the meaning of these crimes for our society.

Chapter 5

Nurses as Murderers

Introduction

The public and professional discourses tell us much about the constructions of nurses who murder patients at least during the period of the study. From a postmodern perspective there are multiple realities and multiple truths. Sociologists have exposed the centrality of the media in constructing public perceptions of various phenomena. As most individuals have little or no direct exposure to the phenomenon of murder of patients by nurses so media accounts are pivotal in shaping public perception. Journalistic agency is fundamental to these constructions. Some writers take the view that the journalist is merely an agent in this process. Others attribute much more active responsibility to the journalists because of the choices they make in how the phenomenon is portrayed (Cotter, 2003; Grenz, 1996). Leaving aside the issue of agency and responsibility, it is the bodies of texts that constitute the extant literature that are the concern of this study. There are two key dimensions to constructions of the phenomenon of nurses who murder patients. One is the construction of murder by nurses and the other is the construction of nurses who murder. Both are of central importance to this study but the nature of discursive analysis is the elucidation of the construction of the roles of discourses so I begin this analysis with the constructions of nurses as murderers of patients.

It is possible to identify dominant and competing discourses in the public and professional domains around certain aspects of those individuals convicted of the murder of patients that contribute to identifiable constructions of the nurse who commits the murder or murders. It is possible to locate bodies of texts commenting, for example, on factors such as their age, gender, and background. These factors could be construed as demographic but it is neither a demographic nor even an epidemiological approach that characterises this study. Here the focus is on distilling from the texts the various constructions of nurses who murder. Furthering this process, it is also possible to locate bodies of texts commenting on how and why

these nurses go about killing, including aspects such as motive, victim selection and method of killing. Continuing in the same vein, it is possible to identify bodies of texts that explore how they deal with the post-murder period including the investigation. In this regard it is informative to interrogate these texts for the place of confession and the approach to celebrity (or perhaps notoriety would be a more apt expression here). This study seeks to explore the question of how the various discourses surrounding murder committed by nurses on patients in the course of their work shape the meanings and treatment of these crimes in society; to do so, it is important to generate understandings of the constructions of nurses who murder through identifying the characteristics attributed to them in the literature. The understandings so generated also contribute to understanding how these constructions have come about and thus assist in answering the second of the two research questions contemplated in this study.

The absence of one profile of an individual who is more likely than others to murder patients means that, on present understandings, any nurse is as likely as another to do so. Such a situation holds grave implications for the capacity of organisations and institutions charged with the responsibility of protecting patients from the unwelcome ministrations of nurses intent on killing them. To this extent, any understanding of such nurses generated through my work represents a contribution to the development of strategies related to management of risk. More will be said of this toward the end of this dissertation as a more extensive understanding of nurses who murder is developed. For now it is enough to begin an examination of the features identified earlier. That is: age; gender; motive; method of killing; confession; celebrity status; and the victims.

Age

Media descriptions of people commonly include age as an automatic element of an individual's profile. This is the case when mention is made either of nurses accused of murder or their victims. Stage of life stereotypically gives some meaning to behaviour. For instance, the young can be reckless and inconsiderate or they may be portrayed as innocent. Middle age brings experience and wisdom but it may result in disappointment and bitterness. Conjecture on the relevance of the age of a murderer

to the crime they commit is open to the interpretation of the reader. For instance, those who are the same age as me cause me to reflect on other things that make me different and distance me from their crimes. The media add the age as further evidence of the incredulity of the crime whatever the age of the offender⁵. They accentuate the otherness of the murderer – what thirty five year old mother would do this?

A number of examples extracted from these discursive texts illustrate how age is part of the description. In the case of Roger Andermatt, the Canadian Press put it this way: '...Roger Andermatt, 36, is Switzerland's worst serial killer...' (AP, 2005c); in the case of Christine Ackley, the *Rocky Mountain News* began by saying '...Christine Ackley, 38...' (Rocky Mountain News, 2004b); while Gutis (1987) writing about Richard Angelo in the New York Times, referred to him as 'the 25-year-old registered nurse...' (Gutis, 1987); and in BBC News Online (1994), Stephan Letter was described as '...a 27-year-old nurse...' (p.17). These extracted texts are typical representations from the general media of the disclosure of age as a relevant characteristic of nurses who murder patients. That age is considered relevant is apparent from Table 5.1 which demonstrates, among other things, that for every single case, the literature contains some reference to the offender's age.

⁵ The term 'offender' caused me considerable consternation. I puzzled over whether I should use this term which is the normal term used by law enforcement agencies and the legal system generally in countries such as Australia and the UK or the US-preferred term of 'perpetrator'. The semantics of this distinction are important, given the emphasis here on discourse. The term 'offender' clearly articulates an underlying assumption that the person is offending society by acting outside of the law as laid down by the powerful elite of society. 'Perpetrator' does not of itself convey that sense; but it has come to connote the doing of bad deeds, and in line with the US cultural imperialism enabled by dominance of the mass media, it has come into the Australian psyche, more commonly in its truncated form of 'perp' which epithet constructs the criminal form of the individual. I have opted to use 'offender' in this study and to remain mindful of its power in this context.

AGE RANGE	NAME	AGE AT TIME OF CONVICION
TEENS	RAINEY, Shermika	17
	MARTIN, Justin W.	19
TWENTIES	ALLITT, Beverley	23
	RACHELS, Terri	24
	FALUDI, Timea	25
	GRAHAM, Gwendolyn	25
	ANGELO, Richard	25
	MOHAMMAD, Nureddin	25
	GEEN, Benjamin	25
	LETTER, Stephan	25
	FELTNER, Jeffery	26
	VAN OORT, Christie	26
	GIERSBERG, Michaela	27
	MGWATYU, Luvuyo	27
	NORRIS, Colin	29
GRUBER, Maria	29	
MORI, Daisuke	29	
THIRTIES	LEIDOLF, Irene	30
	ROEDER, Michaela	30
	WAGNER, Waltraud	32
	PAVIA, Daillyn*	32
	MAY, Cheryl	33
	MALEVRE, Christine	33
	GILBERT, Kristen	33
	JONES, Genene	33
	ROSENFELD, Brian K.	34
	TENZER, Heidi	34
	CALEFFI, Sonia	36
	DUDLEY TERRELL, Bobby Sue	35
	AKIN, Joseph Dewey	35
	FIRTH, Alison	36
	MAJORS, Orville Lyn	38
ACKLEY, Christine	38	
FORTIES	JACKSON, Vickie Dawn	40
	DeBERK, Lucy	41
	CULLEN, Charles	41
	DIAZ, Robert	41
	JENKINS, Pamela	42
	GUIMARAES, Edson	42
	WILSON, Gayla Ann	44
	HARVEY, Donald	45
	RACHMAN, Hal Speers	46
	ATKINSON, Kathleen	47
	SALISBURY, Barbara	47
	KANNER, Wanda	49
FIFTIES	MEYER, Stephanija	51
	MULLINS, James	56

Table No 5.1 – Ages of Nurses Convicted of Murder

Examination of the table leads me to no conclusions about a particular age at which a nurse is more or less likely to murder patients.

There is no information as to whether the newly qualified nurse or the older, more senior nurse who has become jaded and embittered over time is more likely to murder patients. The media interest in the age of the offender seems to be directed to the construction of the portrait of the murderer as other rather than establishing any

pattern. The younger the offender, the less typical the murder, or put another way, the more abnormal the murderer appears. It is easier to establish otherness of nurses who murder through this emphasis. The majority of nurses convicted of the murder of patients have committed multiple murders, so is the age at which a nurse first murders a patient significant? For instance, does the age at which the nurse begins killing patients determine the length of their killing trajectory i.e. over how many years do they continue killing? Does age have anything to do with the cessation of killing? There is nothing in the literature to tell us any of these things.

Beyond that, all that can be said is that nurses at all stages of their careers have been known to murder patients. It may be that in trying to come to grips with the phenomenon of nurses who murder patients, and with so little information that can be held to be definite truth, the age of the offender along with gender is a relatively incontestable detail that adds credibility to the construction of the nurse as murderer that is embedded in the text.

Gender

Whenever there is textual reference to a case, the gender of the offender, or alleged offender, if male is always expressly indicated, even if it is obvious from the individual's name. As with age, extracted texts demonstrate this. For example, in the case of Roger Andermatt, *The Guardian* (Black., 2001, p.20) reported that 'The male nurse dubbed Switzerland's 'Angel of Death...'. Similarly, Associated Press (AP, 2005d) reported that 'A criminal court on Friday sentenced a male nurse to life imprisonment ...' and the Canadian Press (2005) reported that a '...criminal court sentenced a male nurse...'.

RN

Name	Sex		Professional Status
	M	F	
ACKLEY, Christine		F	RN
AKIN, Joseph Dewey	M		RN
ANGELO, Richard	M		RN
ATKINSON, Kathleen		F	RN
CALEFFI, Sonia		F	RN
CULLEN, Charles	M		RN
DE BERK, Lucy		F	RN
DIAZ, Robert	M		RN
DUDLEY, Bobby Sue (Terrel)		F	RN
FALUDI, Timea		F	RN
FIRTH, Alison		F	RN
GEEN, Benjamin	M		RN
GILBERT, Kristen		F	RN
JENKINS, Pamela		F	RN
LETTER, Stephan	M		RN
MALEVRE, Christine		F	RN
MAY, Cheryl		F	RN
MGWATYU, Luvuyo	M		RN
MOHAMMAD, Aida		F	RN
MULLINS, James	M		RN
NORRIS, Colin	M		RN
RACHALS, Terri		F	RN
RACHMAN, Hal Speers	M		RN
ROEDER, Michaela		F	RN
ROSENFELD, Brian K.	M		RN
	11	14	

EN

ANDERMATT, Roger	M		EN
ALLITT, Beverley		F	EN
JACKSON, Vickie Dawn		F	LVN
JONES, Genee		F	LVN
MAJORS, Orville Lyn	M		LVN
	2	3	

AIN

CARR, Samantha		F	NA
FELTNER, Jeffery	M		AIN
GIERSBERG, Michaela		F	AIN
GRAHAM, Gwendolyn		F	NA
GRUBER, Maria		F	NA
GUIMARAES, Edson	M		EN
HARVEY, Donald	M		EN
KANNER, Wanda		F	AIN
LEIDOLF, Irene		F	NA
MORI, Daisuke	M		AIN
RAINEY, Shermika		F	AIN
TENZER, Heidi		F	AIN
VAN OORT, Christie		F	AN
WILSON, Gayla Ann		F	AIN
WAGNER, Waltraud		F	NA
	4	11	

Table No. 5.2 Gender of Nurses Convicted of Murder.

The implication in each case is that the fact of being male is relevant to the commission of multiple murders. Put another way, the construction of the nurse as murderer embedded in the texts of media reports of such cases carries with it an inference that being male is a relevant consideration. Given that male Registered Nurses form approximately 10% of the workforce they are over-represented in Table 5.2 just as males are over-represented, as pointed out in Chapter 2, in the general population of murderers. This assists in the construction of otherness as nurses are commonly stereotyped as soft and female. There is even an attempt to construct the male nurse who murders as other than male – with descriptions such as a 'cherub' like face or by references to homosexuality such as in the case of Donald Harvey where it was reported that he '...denied he had killed for kicks, or, as prosecutors said, to gain release from his repressed homosexuality' (Palmer, 1987a, p.3). In each case there is an implication of other forms of deviance in addition to a taste for murder.

This latter point holds true in the case where female nurse murderers are suspected or known to have been in lesbian relationships. Displays of unflattering photographs

and in particular 'mugshots', of nurses around the time of the murder augment the discourse of an unfeminine murderer.

It is not the male nurses who murder patients that capture the imagination of the media, and thus, of the public. That falls to the female nurses who kill patients. There have been books and films about such notorious convicted nurses as Beverley Allitt (N. Davies, 1993a), Genene Jones (Elkind, 1990a) and Terri Rachals (Manners, 1995). These books have been written usually by investigative journalists who have been involved in reporting the initial cases. It is true that there have been books about male nurses who have murdered patients but these are much less common, involve high numbers of victims and are more often written by lawyers than journalists. There is one other important qualification or distinction to be made here however, one further obfuscatory factor. The female nurses who have attracted the greatest notoriety and the greatest literary attention have been those whose victims were infants and children. They have almost always been characterised in the bodies of discursive texts that constitute the media as 'baby-killers'. I found no cases of male nurses who murdered their baby patients – although Daisuki Mori's victims included a number of older children (Hadfield, 2001; Kyodo News, 2001c) – so it is possible that it was their victim selection rather than their gender that drew so much attention. It does appear, however, that it is the age of the victims rather than their number that determines notoriety in the case of female nurses.

Motive

Why would a nurse intentionally and, with malice aforethought, kill a patient? This question is uppermost when people are confronted with a nurse who is convicted of the murder of a patient. It is magnified immeasurably where a nurse has murdered more than one patient. With the exception of the 'babykillers', the motive of a nurse who murders patients will generally be second only to the number of victims as the major focus of media attention in these cases as everyone struggles to understand how such a thing can happen. There is a vast literature on the motives of murderers and in particular, of the motives of serial killers. It must be kept in mind when considering motives that they are truly internal to the actor, and thus can never be known with any certainty. I traversed the matter of motive in a general way in

Chapter 2 of this dissertation. In this study, and thus in this chapter, the focus is on murder in a very narrow domain, that of the practice of nursing. The bodies of discursive texts of the media abound with commentary and speculation on the motives of nurses who murder patients. Nurses are no different to anyone else in the community in terms of their attitude to murder. For most nurses the notion of murdering patients is likely to be the thing furthest from their mind. It flies in the face of all of their professional preparation and conditioning. Nevertheless, this study clearly shows that there are a tiny but significant proportion of nurses who do murder patients and bodies of texts on the phenomenon in the literature almost always speculate about the motivation of the particular offender. These discourses suggest a variety of motives and in this section it is proposed to deal with the motives in order of the most dominant constructions.

The initial tendency is to constitute a discourse around a motive of mercy when a nurse murders a patient. It is perhaps more palatable to think that a nurse would only murder out of compassion. Certainly nurses often offer this as their motive. However, it is rarely the case that a serial murderer kills out of compassion and in this study, the only time mercy killing or euthanasia is involved is where the defendant has argued it as their motive by way of defence or mitigation but the court has rejected it. Otherwise, cases that clearly satisfy the definition of euthanasia have been excluded from the study. For example, Associated Press in reporting on the Roger Andermatt case wrote that:

Claiming he acted out of compassion, a 32-year-old nurse has confessed to killing 27 elderly and ailing patients over a six-year period... (Associated Press, 2001a)

And on another occasion, citing the judge in this case, Associated Press reported that:

'All along, Andermatt insisted his motives were "sympathy, compassion and a desire to end the suffering of the patient" Nieminen said' (Associated Press, 2001b)

However, the motives of sympathy, empathy and compassion claimed by Andermatt, and commonly claimed in such circumstances, were countervailed by admissions of easing the workload and feeling relieved.

Black (2001, p.20) reports the investigating magistrate as saying:

"On the one hand, the accused gave as his motive acting out of sympathy, compassion, empathy and salvation; on the other hand, he also cited total overwork and relief for himself and the team".

There are other examples of nurses claiming to have acted out of compassion. As shown in the case of Andermatt above, where nurses who murder patients and offer mercy as their motive, contention exists about the veracity of the claim. *The Cincinnati Post*, when reporting on the Donald Harvey case, wrote:

... Harvey denied he had killed for kicks, or, as prosecutors said, to gain release from his repressed homosexuality. He said he felt "relief for the patients," whom he said he killed out of mercy. At another point, he said he could not explain how he chose his victims. "I put them out of their misery," he said of some victims, whose cases he described studying beforehand, "like I hope they'd put me out of my misery." Harvey said he would not kill again but that in only two or three cases did he feel he had done wrong. "A lot of people believe in mercy killing, but they never have the nerve to carry it out." (Palmer, 1987a, p.3)

The explanations of motive given by a nurse who has murdered patients will often contain inconsistencies that erode the credibility of their explanation at the same time as offering alternative possibilities.

Local psychiatrists have said that the mercy defense is simply a cover for Harvey's real motive. Ney said he had a compulsion to kill like other people "have a compulsion for malted milk or cold beer." (Palmer, 1987b, p.18)

Agence France-Presse reported similar comments by the court in the Hungarian case of Tímea Faludi where the Court also refused to accept that the motive was euthanasia:

'It [the Court] also said Faludi's actions could not be viewed as euthanasia. "The term euthanasia can only be used at all if a patient expresses a wish to have his or her life terminated. In Faludi's cases, this did not happen," the verdict said.' (Agence France-Presse, 2002b)

However, the reality is that little is known as to why Faludi murdered her patients. There is more speculation than evidence on the matter. As *The Sunday Times* reported:

'Faludi does not appear to have benefited financially. Nor does it seem that any of the patients asked her to put them out of their misery. Observers have speculated that she merely enjoyed having the power of life and death over her victims.' (Vajda, 2001)

The motive in the Faludi case is clearly contentious. Faludi argued it was mercy killing. The court believed it was the sexual thrill that she experienced and this raises another spectre. The media thrives on the sexual so of course this increases the grist offered by the case for the mass media mill. *The Mirror* reported that:

'A nurse who killed up to 35 patients in her care did so because it gave her a sexual thrill, a court heard yesterday. '... 'A psychiatrist told the court in Hungary she was a thrill-killer who was turned on by the ultimate power. Faludi said: "I did this to relieve suffering, not to continue it". (Hall, 2002, p.22)

A number of the nurses convicted of murder have reported a sexual dimension to their homicidal activity and this aspect is explored more extensively elsewhere in this thesis. It seems likely that the more important issue raised here is power. In many of these cases it is evident that power is the critical element.

Another case where the defendant argued that he had been engaged in mercy killing was that of Stephan Letter. The majority of reports on this case evidence the characteristics discussed thus far. However, that was not uniformly the case and the following text shows a rare juxtaposition of the murderer and normality through implying Letter's ordinariness by the account of his attire and his humanness through his remorse. In commenting on this German case, BBC News Online reported that:

'Letter, wearing a dark suit and grey-striped tie, appeared before judges in the Bavarian town of Kempten. He admitted causing the deaths of 12 patients and begged their relatives and his hospital colleagues for forgiveness: "I know that I acted completely contrary to the ethics of my profession," he said. "I wanted to help the patients out of spontaneous feelings of sympathy, although I now realise how catastrophically wrong my actions were," he added.' (Paterson, 2006)

Few people would construe the actions of Waltraud Wagner and her colleagues as merciful. Yet Amiel, writing in *The Times* in 1989 about the Austrian case of Wagner and her three accomplices, accepts their defence in order to make a personal argument against euthanasia:

'It is said that the orderlies explained that the murders began as "mercy killings". This seems to me crucially important. I am prepared to believe that whoever was the ringleader (and there usually is one main perpetrator, although it may not be the most obvious choice) she did initially justify the deaths as a kind way to ease incurable pain. She may have used this to justify her actions to herself or to mask her own murderous instincts and justify them to the others. Whichever, it only proves the deadly dangerous nature of an idea like euthanasia. There is a very, very thin line involved in notions such as euthanasia and that is why I believe it has to be watched so carefully. I have always thought the Church was extremely wise in voicing more than caution in this matter. It is so easy to justify something as being done for a person's own good when in fact it is being done for the convenience of oneself. Killing a person may be done to relieve the agony of the victim, but it can just as easily be to relieve the impatience or intolerance of the killer or for the killer's personal advantage. Euthanasia is such a dangerous business, not because it isn't sometimes exactly what the patient wants, not because it is never true, but because one can so easily slip. The first patient who irritated the ringleader may have been a terminal case in every sense. But when a person who is just about to pop off spends their last hours or days doing nothing but irritating you, there may be mixed motives as you administer the overdose.' (Amiel, 1989)

Whilst the motive of euthanasia claimed by Wagner and her accomplices was rejected, it is the case that some insights into the motives of nurses who murder patients can be gleaned from their comments reported in texts on the subject. The Vienna daily newspaper *Neue Kronen Zeitung* quoted Wagner as telling police after her arrest:

'If someone made me angry, I gave them a free bed in heaven.' ' (Holland, 1989, p.2).

This struck a chord with British reporters also, with *The Globe and Mail* picking it up as their quote of the day on 19th April, 1989 where they wrote:

"The ones who got on my nerves were dispatched directly to a free bed with the good Lord." (The Globe and Mail, 1989, p.1).

The matter of euthanasia in prevailing constructions of murder by nurses needs to be weighed against prevailing trends around the world in relation to euthanasia. It is not proposed to venture very far into the debate as to whether euthanasia should be legal or not. Suffice it to point to legislative developments in Australia, The Netherlands and Belgium along with common law developments in those countries together with the UK and the USA. All of these developments point to increasing acceptance of a right to a peaceful, painless death if one so wishes. There are extensive discourses in

the literature addressing this debate and the associated reforms but in the main it can be said that those discourses and constructions are directed to expanding access to euthanasia. As the acceptability and legalisation of voluntary euthanasia expands in jurisdictions around the world, it seems that the courts are increasingly determined to ensure that where nurses murder patients, if they are unable to demonstrate that it is a clear case of mercy killing, then it will be construed as murder, irrespective of the motive claimed by the nurse. This is intended as a deterrent against nurses getting away with murder. The same is true for all other health professionals including medical practitioners.

There are of course other motives reported in the literature. For example, *The New York Times*, in commenting on the Richard Angelo case, reported that

'...in his second written confession, Mr. Angelo said the reason he injected the drugs was to alleviate his feelings of professional inadequacy and to prove to his nursing colleagues that he was a hero' (Gutis, 1987, p.1).

Ramsland (2006) reports Angelo at another time saying he was,

'motivated more by the idea of saving people than killing them.'

Neither of the above is an example of mercy as a motive. In other cases Angelo's probable motive – the need for attention – is more often expressed overtly. Many of the nurses convicted of murdering patients have had as their motive the need for attention or the adrenalin rush of the emergency situation. In some cases the defendant nurse has themselves admitted this. In the bodies of texts around the subject, this motivation is expressly characterised as the 'super nurse motive'. A good example is the case of Akin reported in the *Atlanta Journal & Constitution*.

"I'm not a super nurse," he was quoted as saying in the interview, an apparent reference to reports that he may have deliberately endangered patients so he could appear to have saved them...The investigator also confirmed that police suspect the "super nurse" motive in the case.' (Yardley, 1991a, p.1)

The media coined the term – the 'super nurse motive' – and not only did the papers run with it but Akin himself used it. This demonstrates the way epithets and labels can rapidly find their way into common parlance through the efforts of the mass media. Beverly Allit and Gene Jones were too early to be accorded this title although they also created emergency situations. Akin's case demonstrates very well

the prevailing construction of the nurse whose victims are casualties of the nurse's need for adrenalin and/or attention. Associated Press reported that

'Prosecutors say Akin got a thrill from listening to the man's heart rate monitor sound an alert and watching hospital workers race to save him.'(1997b, p.3) .

CourtTV took an even more florid approach, headlining their treatment of this case as '*Code Blue Junkie*' and following this with

'Akin had long been suspected of many Code Blue medical emergencies...'
(Ramsland, 1997).

Once again, the motive for killing implied by the title of this article and the texts within is attention.

The mass media thrive on a case of this nature and *Associated Press* reported that:

'Brown [a police investigator] said Akin was doing a "dance of death" in a hallway while Price was dying' (Harwell, 1992a, p.23).

In effect the assertion in these texts was that the motive was excitement around death. The same case was reported with the same attribution of motive in the *Houston Chronicle* where it was said that:

'A jury convicted a nurse [Akin] of murdering a quadriplegic by giving him a fatal dose of a heart medicine for what prosecutors said was the thrill of watching the patient die' (Houston Chronicle, 1992, pp., p.4).

In the case of Joseph Dewey Akin there was much speculation. He was cited as someone who provides an excellent example of a nurse whose motive for killing patients was alleged to be that he '*simply likes to kill people*' for, as Associated Press reported (1992, p.18), that is how the prosecutor described him. The comment is an example both of attribution of motive and characterisation of this nurse.

Another case where the motive of the defendant appeared to be the excitement of the medical crisis was that of British nurse Benjamin Geen and again the media construction dwelt on the need for excitement. Note that the reference to Geen as a 'trainee nurse' was erroneous. *The Straits Times* reported:

'Trainee nurse Benjamin Geen, 25, was a thrill-seeker – one so addicted to drama that he was willing to put the lives of those entrusted to his care at risk. He secretly administered toxic doses of drugs to patients at Horton General Hospital in Banbury, Oxfordshire, causing them to suffer severe breathing difficulties and needing immediate resuscitation. He revelled in the thrill of trying to revive his patients, the BBC reported. His addiction to excitement eventually led him to kill two patients and take 15 others to the edge of death. He poisoned them, causing them to stop breathing, just to enjoy the 'drama' ' (*Straits Times*, 2006).

The discourses of excitement – of the thrill – permeate constructions throughout the media. *The Advertiser* in Adelaide reported

'A British court has heard a male nurse drugged 18 patients so he could enjoy the thrill of reviving them' (*The Advertiser*, 2006a, p.31)

and the *Evening Standard* headed its story

'Nurse who killed for thrills' (Cheston, 2006, p.4).

Denials are even used to press home the point once more. Associated Press Newswire reported that:

'Alleged killer nurse Benjamin Geen today denied his patients were 'bits of flesh' with which to 'satisfy his lust for excitement' (Evans, 2006b).

The motive for nurses who murder patients is in some cases what one prosecutor characterised as 'excitement lust'. There is clearly a public fascination with the notion of medical thrill killing and the form of that fascination is shaped by contemporary understandings of nurses who murder that are themselves shaped by the discourses of the media. The context of these discourses is a key element in determining their strength. The contemporary context of the discourse of thrill-killing by nurses and other health professionals includes graphic representations of the thrill and excitement of emergency work portrayed through TV dramas that make it seem like a part of everyday practice, particularly when they belong to the genre of 'reality television'.

The Independent reported the Geen case in the following way:

'A nurse who craved the excitement of medical emergency has been found guilty of murdering two patients by deliberately injecting them with lethal doses of drugs. Benjamin Geen, 25, waited for vulnerable patients to be admitted to the accident and emergency department of the Horton General

Hospital in Banbury Oxfordshire, and then found a way of becoming involved in their treatment. The result was always the same - the patient's condition rapidly deteriorated and Geen was on hand to help revive them. But in two cases, his intervention proved lethal' (Verkaik, 2006).

The media, however, has a tendency to distort interpretations of the motive of thrill which is more likely to be a manifestation of insecurity that finds expression in the motives either of gaining attention or of exercising power. These discourses involve the vulnerability of the prospective patient; i.e. all of us, and constructions of nurses who murder as thrill-seekers increase our sense of vulnerability because of the associated randomness of victim selection. Discourses constructed in this way will be more real and more influential than objective facts so effectively, objective 'truth' will be no stronger than socially mediated 'truth' which is real in its consequences. Recall the comments of the psychiatrist in the Faludi case. This is but one of many cases where the construction of motive within the body of texts is that of the exercise of power. As the psychiatrist pointed out, the power of life and death is the ultimate power.

It is also of note that a number of the murders committed by nurses occur in Intensive Care and other high dependency units. Nursing staff in these areas generally enjoy considerable technical power over patients who are extremely vulnerable because they rely on those nurses to maintain their breathing and blood pressure through technical means, and may not even be conscious. Power is a recurrent theme in the constructions of nurses who murder.

A sexually-orientated motivation was noted earlier in connection with the Faludi case. A variation on that theme is to be found in the case of Gwendolyn Graham. The Associated Press reported that:

The sensational trial [of Wood and Graham] stunned the nation with its lurid details of the obsessive sexual violence and blind jealousy that led to the slaughter of innocent women.
(Cauffiel, 1992, p.530).

A further variation on this theme can be found in the case of Wanda Kanner who manifested the rarest of motives among nurses who murder patients, that of romantic attachment. It was reported in *The Mirror* that:

'A nurse is accused of killing an MS patient with a bagel so she could carry on an affair with the woman's husband.'

'John Amberik, 52, an electrician, was indicted in May on three charges of theft and two counts of tampering with records. He is accused of working with Kanner to submit false insurance bills, prosecutors said. He is not charged in his wife's death. "If I were to place one word on this case, that word would be greed, the greed of Wanda Kanner," Kasaris said ' (Kropko, 2004a).

There was a strong view permeating the newspaper reports that Kanner was after more than Mrs Amberik's husband. Sometimes the motive for a nurse to murder a patient may be as base as mere greed. Financial gain is a less common motive for murder attributed to nurses but it does occur. In the case of Christine Ackley, the motive was theft. As was reported in the *Denver Post*:

'She [Christine Ackley] has been charged with two counts of first-degree murder, aggravated robbery, robbery of an at-risk adult, theft from an at-risk adult, theft and unauthorized use of a credit card - all felony counts.' (*Denver Post*, 2002b, p.2)

In the case of Edson Guimaraes, greed also played a part. As has been shown, motives vary among nurses who murder patients but in the case of Guimaraes, he apparently was motivated by money and mercy, but probably in that order. As the *Charleston Gazette* reported, in the case of Edson Guimaraes:

'he had ended the patients' lives to ease their suffering. He also admitted, however, to racing to notify the city's highly competitive funeral homes of the deaths, in hopes of earning a \$60 tip if he was the first to report the death and the family signed a contract with the funeral home.' (Goering, 1999b, p.2).

It seems likely that constructions in the bodies of text around nurses who murder nurses out of greed or with theft as the motive are more palatable because the motive – whilst overtly bad and dishonest – is recognisably so and thus allows the public to see the person as a bad person. That is to say, the motive and the conduct are disapproved and condemned but comprehensible because it erodes the fear of the unknown. We may not approve of theft and greed but we can understand them. On this view, the discourses around the motives of nurses who murder enable us to construe the nurse who murders patients as inherently bad and therefore different to 'normal' nurses. The murder of patients by such a person is almost to be expected, and is therefore unremarkable and unlikely to intrude on the trust that we place in

'normal' nurses. Whether that could be said in the case of British nurse Barbara Salisbury is another question. Her motive appeared to be efficiency. She was intent on clearing 'bed-blockers':

'Frank Owen, a 92-year-old great-grandfather who had been on her ward for almost three months, was the type of patient who frustrated her the most, the court heard. Salisbury was constantly pushing for him to be discharged to a nursing home although he needed to be fed through a drip, which could be done only in hospital ... Within minutes of the end of her first shift back, Mr Owen was dead ' (Herbert, 2004b, p.19).

One of the difficult aspects of representing motives is that they are, in the final analysis, truly internal to the actor. There are cases where the offender has offered motives that have been expressly rejected by the Courts. A number of examples were considered in relation to euthanasia but such rejections are not limited to euthanasia. A similar situation prevailed in the Japanese case of Daisuke Mori to the extent that, although Mori offered motives, the prosecution did not accept his explanation of why he murdered his patients. *The Daily Yomiuri* reported that:

'Daisuke Mori, the associate nurse under arrest on suspicion of attempting to murder an 11-year-old girl at Sendai's Hokuryo Clinic by lacing her intravenous drip with a muscle relaxant, has admitted tampering with the drips of at least 10 patients at the clinic, and has started to talk about his motives, according to police. Police quoted Mori as saying, "I did it (laced drips with a fatal dose of muscle relaxant) to a little more than 10 patients," in addition to the 11-year-old girl whose condition suddenly deteriorated after Mori administered a drip, leading to his arrest. Mori reportedly told police he committed the crimes because he had "many causes for frustration," citing his unhappy relationship with a girlfriend who left the apartment he shared with her. He also said he was irritated by his colleagues at the hospital, according to police. Investigators, however, said they were not satisfied with Mori's admissions, saying that they think they were unlikely to be the cause of the grave crimes he allegedly committed. Mori is reported to have been very nervous immediately after his arrest, particularly out of concern over how his father, a police officer, would react to news of his arrest. Police quoted him as saying repeatedly, "I did a horrible thing." But police said Mori calmed down and started admitting details of his crimes Tuesday afternoon. Mori has denied that he mixed muscle relaxant in the 11-year-old girl's drip because he harbored a personal grudge against her, police said. Police do not think Mori committed the crimes because he bore personal grudges against the victims.' (*The Yomiuri Shimbun*, 2001a, p.10)

In such situations, the Courts must obviously substitute their own assessment of motive for the account given by the offender. Mostly this only serves to reject

mitigating circumstances but such decisions nevertheless impact markedly on the media constructions of nurses who murder. The situation is compounded further when an offender offers no motive whatsoever. In those cases the Court and the media are left to conjecture as to why the nurse murdered patients. This means that little can be learned from the case to add to our understanding of the phenomenon but the bodies of texts around such cases are peppered with speculations on the question of motive. Such was the situation in the case of Vickie Dawn Jackson reported by the *Ottawa Citizen*:

'Vickie Dawn Jackson, a former hospital nurse, pleaded no contest yesterday to killing 10 patients nearly six years ago by injecting them with a drug used to temporarily halt breathing. Ms. Jackson, 40, will be sentenced to life in prison, the maximum sentence she faced if she had been convicted by a jury. Authorities in Texas have not offered a motive for the slayings.' (*Citizen News Services*, 2006, p.10)

The case of Orville Lynn Majors, however, was a very different story. Although it is impossible to know with any precision the motive of a murderer if they make no admissions and provide no insights, there was considerable speculation in the media as to his motivation for murdering as many as 26 patients. Many of the texts reporting this case were dogmatic. An example was a report in *Newsweek* (Stone, 1998, p.33) that:

'These weren't mercy killings. To the contrary, police seem to think Majors was motivated by a strange hatred for the elderly and the poor. He allegedly called some patient families "white trash" and "dirt" and reportedly once said that old people "should all be gassed."

I have now identified and considered a range of motives for nurses who murder patients. Some of these motives were those claimed by the defendant, some were imputed by various third parties, and still others were merely inferred from the defendant's conduct. These motives have included mercy, thrills, power, money and love. Cases where the motive was offered by the offender but rejected by the courts have also been considered, as have those situations where no motive is offered and thus can only be surmised. Perhaps most incomprehensible of all in the motive stakes is the sheer inadequacy of motive in some cases. The motive offered by some nurses that murder patients is manifestly inadequate as a justification for their conduct. That was certainly the situation in the case of Justin W. Martin:

'A 19-year-old former nursing home aide told police that he abused a 78-year-old patient to "get a reaction out of her," a Tulsa police detective testified Monday. "I think he just wanted her to look at him, acknowledge his presence," said Anna Cowdrey, a detective in the Sex Crimes Division. Cowdrey testified in a preliminary hearing for Justin W. Martin of Collinsville, who was ordered held for trial on second-degree murder, rape by instrumentation and caretaker abuse charges' (R. Marler, 1997, p.9).

It is true that in the literature there are some attempts to explain the motivation and the underlying psychodynamics of nurses who murder patients. For example, Howard Price cited Beatrice Yorker commenting on the case of Kristen Gilbert in the Washington Times. She notes that victims of killer nurses are not always sick. She points to one nurse believed responsible for the deaths of healthy toddlers who showed up at a doctor's office for immunizations and another nurse accused of killing an ambulatory woman, who visited a hospital for cancer screening. The Georgia nursing scholar says the fact that these crimes are being repeated by people throughout the country who do not know each other and occur with some regularity led her to believe the killings are not coincidental.

The majority of the perpetrators are re-enacting some kind of trauma on someone less powerful than they are," Ms. Yorker said. The widow of Kenneth Cutting, a 41-year-old invalid whom police say was murdered by Kristen Gilbert on Feb. 2, 1992, says she learned of her husband's death through a phone call from Mrs. Gilbert. (Howard Price, 1998, p.1)

No matter who is committing murder on patients, it is important to understand why. A key question on which the discourses in the literature are silent is whether the level of qualification has any bearing on the motivation of the offender. We have seen the variety of motives attributable to nurses at all levels of education. Are the motives for murder the same as for qualified nurses and assistants or do they differ in any material respect? The discourses in the bodies of texts analysed in this study afford no insights or even any hint of an answer to this question. In the constructions contained therein, these seem not to be relevant issues. This matter is explored in Chapter 7.

Method of killing

Constructions in the media of nurses who murder patients often turn on the method of killing used by the nurse. The methods vary from peacefully easing the patient out of this world with a larger than usual dose of morphine through to violently beating the patient to death. It is instructive to see the constructions that emerge from the bodies of texts around each of the various methods and those constructions are the focus of this section.

The most common method of killing among nurses appears to be the use of the lethal injection. This was the method of choice in the case of Beverley Allitt who used insulin most commonly. This was so in the case of Lucinda de Berk too, as was evident at post-mortem examination.

'In each case, De Berk had told colleagues that the children were sicker than doctors thought, and was alone with them shortly before they died. Post-mortem examinations revealed potentially lethal levels of drugs in their blood. (Castle., 2003, p.17).

Another nurse who used lethal injections was Christine Ackley who '...gave Sasser [her victim] a fatal injection of saline and a muscle relaxant at his Denver apartment before dumping his body in Roxborough State Park...' (Anon, 2004, p.2). Akin also allegedly used lethal injection to produce crises:

'...Joseph Dewey Akin, a former Marietta nurse accused of injecting a man at a Birmingham hospital with a lethal dose of medication...' (*Atlanta Journal and Constitution*, 1992a).

and

'...Birmingham police charged Mr. Akin in August 1991 with intentionally injecting Mr. Price with an overdose of lidocaine, causing him to go into cardiac arrest. An autopsy showed that Mr. Price had twice the lethal dose of lidocaine in his body...' (McIntosh, 1992b, p.3).

Angelo, too, used lethal injection, as reported in *The New York Times*:

'Mr. Angelo, law enforcement officials said, would inject the drugs, which he previously diluted with a saline solution, in small amounts, often causing his patients to go into respiratory or cardiac arrest. He would then be among the first to arrive at bedside and work frantically to revive the patient. Often, as in the Kucich incident, the team working on the patient would revive the patient.

Sometimes, authorities charged, they would not be as successful and the patient would die' (Gutis, 1987).

Yet another was Benjamin Geen who used injections of drugs to induce sometimes fatal respiratory arrests. It was a bit of a give-away because when:

'... arrested at the hospital on 9 February, 2004, police found a syringe loaded with a potentially lethal muscle relaxant in his pocket' (BBC Online, 2006).

The evidence against Japanese assistant nurse Daisuke Mori, who also used lethal injections, reveals a highly calculated approach to the murder of patients of a variety of ages. I have included quite a long quote here to clearly identify both the extent to which nurses may be calculating in their approach to the murder of patients and to demonstrate how lethal injections may be used for the purpose. It may be that it is because it is a Japanese text that it is so detailed but it would be unusual to find this level of detail in the reporting of such a crime in many other countries. *The Daily Yomiuri* reported that:

'The Izumi Police Station in Miyagi Prefecture plans to issue a warrant for the 29-year-old Mori's arrest on suspicion of lacing the woman's IV drip with muscle relaxant, causing her death at the Hokuryo Clinic in Sendai on Nov. 24, the sources said. According to the sources, the woman was admitted to the clinic with a fever on Nov. 15, and put on an IV drip. Her condition later improved to the point where she could eat rice porridge and half a banana. However, on Nov. 24, her condition suddenly deteriorated soon after Mori changed her drip. TD Doctors believe she died of a heart attack, the sources said. Muscle relaxant was found in blood samples taken from the woman and a 4-year-old boy whose condition suddenly worsened in mid-November. Police decided to charge Mori with murder as they consider the evidence-such as the rapid deterioration of the patient's condition and the existence of muscle relaxant in the drip administered to the woman-sufficient to charge him. The woman had been hospitalized in a nursing home for the elderly in need of round-the-clock care in Sendai for about 10 years. After being admitted to the clinic, she was reportedly under Mori's care. Mori has denied all the allegations against him. At a hearing held Tuesday at the Sendai District Summary Court to disclose the reason for his detention, Mori read a statement that said, "I do not remember lacing the drips of any of my patients with muscle relaxant."' (*The Daily Yomiuri*, 2001b).

The investigators were able to construct a fairly damning account of the actions of Daisuke Mori (although much of it was circumstantial):

'Police had asked medical institutions to turn in blood samples from patients whose conditions were known to have worsened after Mori gave them IV

drips. The blood samples had been taken in the ambulance on the way from the clinic to other hospitals or after their arrival at other hospitals. Police said they have received four to five samples. The Miyagi investigators had asked the Osaka prefectural police to analyze the blood samples as they had gained experience in dealing with such a case during their investigation of the serial murders of five dog-loving housewives in the prefecture with muscle relaxant in 1992 and 1993. An analysis of a blood sample from the 11-year-old girl in December detected one of three muscle relaxants used at the clinic. The drug's main component is vecuronium bromide, which often remains in the body as residue. It was later learned that components of a muscle relaxant were detected in blood samples from the two other patients. The 5-year-old boy was transferred to another hospital after his condition suddenly deteriorated at the clinic. A doctor at the other hospital kept the boy's blood sample as the sudden deterioration of the boy's condition struck him as suspicious. 4 kids suddenly got sicker. Meanwhile, police learned Wednesday that the conditions of a total of four children, including the 11-year-old girl, suddenly deteriorated after they received IV drips from Mori. Paramedics who transported the children to other hospitals from the clinic reportedly had grown highly suspicious as each month since August had seen a deterioration in the condition of one of the children, police said. It was the condition of a 5-year-old boy that first worsened dramatically and briefly turned serious after Mori gave him an IV drip in August. The boy was transferred from the Hokuryo Clinic to a municipal hospital. Another 5-year-old boy who was admitted to the clinic in September for an asthma attack became seriously ill after a drip and died of respiratory failure after being taken to a hospital by ambulance. In November, one month after the 11-year-old girl fell unconscious after receiving a drip in October, another 5-year-old boy temporarily become slightly sick after a drip. Of the four children, muscle relaxant was detected in the blood samples of the girl and the boy who fell seriously ill in August. Another chemical thought to be a drug less toxic than the muscle relaxant in question was detected in the blood sample of the boy who fell ill in November, according to police. ' (*The Yomiuri Shimbun*, 2001b)

The complexity of the process of detection is also illustrated by this case but those matters I have addressed elsewhere in this dissertation.

A variation on this theme is the case of Hal Speers Rachman who delivered a lethal injection by remote control. The attempt by Rachman to murder Lebowitz was elaborately planned. It relied on his medical knowledge and his knowledge of the hospital's systems, as the *New York Times* reported:

"The police and hospital administrators have concluded that the two nurses attending Mr. Lebowitz acted responsibly in accepting the telephone medication order and in administering the two intramuscular injections. California law allows for verbal drug orders, but does not specify a method of physician identification. The incident began when a nurse in a general medical wing of the hospital received a call about 11:30 P.M. on Sept. 20

from a man identifying himself by name as Mr. Lebowitz's physician. According to several accounts, the caller explained that he wanted to lower the patient's blood sugar in an effort to stimulate the effectiveness of other drugs. A second nurse administered the insulin and noticed about three hours later that Mr. Lebowitz had fallen into a coma. An emergency medical team reversed his condition and an investigation by hospital staff on Sunday morning revealed the hoax. It was then that Mr. Lebowitz's doctor, who asked not to be identified, was called' (*New York Times*, 1986).

Although lethal injection is the method of choice for nurses who murder patients, the bodies of texts around this discourse suggest some creativity among those nurses with respect to the particular agent used.

'All the victims died after being injected with mivacurium chloride, a muscle relaxant that can be deadly in large amounts. If convicted, Jackson could face death - by lethal injection' (*Sunday Herald Sun*, 2002, p.33).

Obviously the irony is not lost on the media. Genevieve Jones was another nurse who favoured muscle relaxants. In her case the agent was succinylcholine. As the *Houston Chronicle* reported,

'Prosecutors contended that Jones, who worked as a nurse for Kerrville pediatrician Dr. Katherine Holland, murdered Chelsea by injecting her with succinylcholine chloride, a muscle relaxant similar in effect to curare. The drug causes respiratory arrest, and eventually, death.' (*Houston Chronicle*, 1986a, p.15).

Another nurse, Christine Ackley, used a lethal injection to make a murder look like suicide.

'A home-care nurse arrested in connection with the death one of her patients told authorities that she drugged him to try to make it look like a suicide...' (Ingold, 2001, p.2).

Other nurses have used lethal injections on some occasions but other methods on other occasions. Beverley Allitt was one such example. According to the Associated Press (1993):

Allitt's weapons of choice were sometimes lethal injections and sometimes suffocation. They reported that ' Allitt killed or injured the children, aged 7 weeks to 11 years old, in 1991 at the Grantham and Kesteven General

Hospital in central England. Some victims were killed by lethal injections or suffocation.' (Associated Press, 1993, p.17).

The same was true of Roger Andermatt who also killed by lethal injection or by suffocation. The judge in the case afforded a concise description of his methods:

'Andermatt gave his victims an overdose of tranquilizers or smothered them with a folded plastic bag or a small piece of cloth over the mouth and nose, Nieminen said. In some instances, the nurse claimed he first sedated the patients before stifling them.' (AP, 2001d)

Suffocation appears to be quite popular among nurses as a method of murdering patients. It is unusual to get a third party's description of the murder of patients, but Wood provided just that with respect to murders she alleged were carried out by Graham:

' Wood told police she witnessed the Jan. 18, 1987, killing of 60-year-old Marguerite Chambers, an Alzheimer's disease patient. She "observed Gwendolyn Gail Graham suffocating (the patient) by pressing a washcloth beneath the chin of Chambers and another washcloth over Chambers' mouth and nose," the warrant said. Wood told police she did not intervene' (Perlman, 1988)

Another nurse who favoured suffocation as his method of killing patients was Jeffrey Feltner.

'Abrams had broken ribs that showed she could have died when someone held her down while suffocating her, prosecutors said.' (AP, 1990)

A variation on this theme of suffocation is that of strangulation. American nurse Bobby Sue Dudley [Terrell] was convicted of strangling some of her victims (Moss, 1988b, p.1)

A particularly interesting case is that of Barbara Salisbury. I cited this case when I discussed motive but it is equally pertinent here. Few people would readily understand why the conduct of Barbara Salisbury in relation to one of her patients was not found to be murder. She used the lethal injection as an adjunct to her other methods:

'...Salisbury...told nurses to lay him on his back so "his lungs will fill with fluid and he will die". She then injected him with diamorphine despite him

showing no signs of pain. Within minutes of the end of her first shift back, Mr Owen was dead' (Herbert., 2004, p.2)

Brian Rosenfeld had a favourite method of killing his patients which involved the use of thioridazine in syrup form. As Tobin (1992, p.3) reported,

'...Rosenfeld, a former nurse, allegedly was seen injecting a suspicious fluid into the woman's feeding tube.'

Associated Press reporting on the Rosenfeld case said:

'One of Rosenfeld's victims, Muriel Watts, 80, a patient at Rosedale Manor Nursing Home, was scheduled for cremation when investigators moved in for an autopsy. She had enough of the drug Mellaril in her system when she died to kill an elephant, officials said. Rosenfeld also pleaded guilty to giving Hazel DeRemer, 81, and Alphonse Silva, 76, lethal doses of the same anti-anxiety drug.'(Associated Press, 1992).

Other nurses have been known to be extremely creative in their approach to the murder of patients. Indeed, some nurses go to elaborate lengths to achieve their end, using creative and cruel methods. The bodies of texts around the murder of patients by nurses make much of the methods of murder as I have shown. Perhaps the brutality of some of these nurses is too much for the public psyche because these aspects do not seem to penetrate constructions of nurses who murder. An alternative explanation may be that these cases are so aberrant that they serve to reinforce the view that only a nurse who is completely abnormal would engage in such conduct. Some extracts from the bodies of texts may help to illustrate the extremes involved, as in the case of Austrian nurse Waltraud Wagner and her accomplices.

'Presiding Judge Peter Straub condemned the "ingenious and malicious methods" used by the defendants. The elderly patients were given intravenous overdoses of drugs or killed by forcing their tongues aside and pouring water down their windpipes' (Jahn, 1991; *Kitchener-Waterloo Record*, 1991, p.4).

Whilst Wagner *et al* seem to be remarkably brutal, few can compare with Gayla Ann Wilson and Shermika Rainey. As Davis (2004, p.13) reported:

' Rainey was accused of holding Ryan in her bed while another nurse's aide, 44-year-old Gayla Ann Wilson, beat Ryan with brass knuckles. Ryan was taken to a hospital in Pine Bluff, where she died Aug. 14. Rainey pleaded guilty to the lesser charge of conspiracy to commit first-degree murder, punishable by six to 30 years in prison. Capital murder is punishable only by life in prison without parole or by death. Rainey was scheduled to go to trial

next week. Under the plea agreement, Rainey agreed to testify against Wilson, who is scheduled for trial Oct. 11. Prosecutors plan to seek the death penalty against Wilson. Rainey was unrestrained and standing with her attorney, Alvin Clay of Little Rock, as she told Anthony she understood the agreement, offered by 13th Judicial District Prosecuting Attorney Jamie Pratt. Asked to relate what happened in the early morning hours of July 30, 2003, Rainey said she held Ryan down and covered Ryan's mouth as Smith beat Ryan with a set of brass knuckles. Wilson told her Ryan was being "disrespectful," and struck Ryan seven or eight times, Rainey said. Rainey said Wilson "pulled the brass knuckles from a blood-pressure measuring bag," describing the weapon as "metal with four holes for fingers." The blows crushed Ryan's facial bone into her sinus cavities and caused bleeding on the brain, bruising, scratches, and swelling on her head and mouth. '

Other nurses have violently assaulted patients but generally those attacks have lacked the element of premeditation. For example, an older patient in a South African psychiatric hospital was fatally assaulted by a nurse who was subsequently charged with and convicted of his murder.

'A former professional nurse at the Fort England psychiatric hospital was sentenced to 12 years imprisonment on Monday for the murder of a patient in July 2001. Grahamstown regional court magistrate Judith Roberson found Luvuyo Mgwatyu guilty of murder for kicking 69-year-old mental patient Mtutuzeli Tshakaza in the abdomen and tramping on him. Tshakaza died in the Settler's hospital four days later after complaining of abdominal pain. '

(AAGM, 2003)

Another approach to killing patients is that of aggravated assault with resultant injuries leading to infections and death. Such was the end that was meted out by Justin W. Martin to Tok Sun Han. As Marler (1997) reports the:

...victim was Tok Sun Han, who died Aug. 22. The medical examiner said her death was caused by pneumonia due to multiple soft-tissue injuries. Cowdrey said she interviewed Martin twice at a Tulsa police station in early August. Both interviews were videotaped, she said. In the second interview, Martin told [Detective] Cowdrey that he burned Han on July 28 with a hot cigarette lighter on her left shoulder and foot. "He would hold the cigarette lighter to her skin," Cowdrey said. There was no flame -- just a hot lighter, she said. "He said he wanted to get a reaction out of her. She wouldn't open her eyes," Cowdrey said. Martin also said he broke Han's wrist while changing her diaper. He did not report the injury to supervisors at the Tulsa Christian Care Center, 6201 E. 36th St., Cowdrey said. Martin also admitted that he stuck a slender plastic bottle into the victim's vagina, Cowdrey said. The water-filled spray bottle is used to bathe and clean patients. Martin also said he flicked Han's ears with his fingers, used his fist to pry her legs apart to change her diaper and forced a water bottle into her mouth "to get her to

drink," Cowdrey said. Another time, Cowdrey said Martin explained that he had tried to rouse Han, whose head had slumped forward toward a wood laptray. He told Cowdrey that he flipped the tray upward several times, with the tray striking Han around the eyes.' (R. Marler, 1997, p.9).

Perhaps one of the most novel approaches to the killing of a patient was that of Wanda Kanner. She used a bagel as a lethal weapon. *The Plain Dealer* reported this in some detail:

'Prosecutors say Wanda Kanner purposely caused Amberik to choke to death three years ago by feeding a bagel to a woman she knew was on a diet of pureed food because of her failing health. Kanner gave the meal to a woman who because she was having an affair with Amberik's husband and the sick woman stood to drag the illicit couple's already precarious finances into wreckage, said Assistant Prosecutor Dan Kasaris.' (M. Levy, 2004, p.1).

Another interesting aspect of the method of killing is timing. Nightshift seems to be a dangerous time for patients and prime time for nurses who want to murder them. Reuters reported that:

'Close observation of the wards by worried doctors revealed that the number of deaths in the [unit] was always higher when certain nurses were doing a night shift (*The Seattle Times*, 1989, p.2).

Whilst the time of day can be a relevant component of a murderer's modus operandi, as has been demonstrated here, it is still a matter that is more appropriately located within the enabling conditions section rather than necessarily in the methods of killing and it will be considered in more detail there.

The constructions of nurses who murder contained within the texts that constitute the mass media place considerable emphasis on the method used. Where the method is lethal injection it is condemned but it is not greeted with the horror accorded to cases of cruelty. Dangerous drugs are 'slipped' into intravenous infusions or the infusions are described as 'laced' with the particular drug. Patients 'lapse' into a coma, as is the case with insulin, or other drugs are used to induce 'sudden' cardiac or respiratory arrest. Arrests are commonly portrayed as exciting events providing opportunities for 'professional heroism'.

This stands in stark contrast to constructions of nurses who violently attack patients or who treat them in other equally cruel ways. Reports of cruelty belong to a world of

otherness where disturbing words such as 'torture', 'violation' and 'grotesque' are more characteristic. In such cases the construction is a nurse who is patently a bad person – brutal, uncaring, abusive, pathological and most appropriately incarcerated for a very long time. In what seems to form a kind of middle ground (e.g. cases such as those where nurses have suffocated patients) the constructions in the particular case will be influenced by other factors such as the motive, mitigating circumstances, and the like. These comments relate to constructions of nurses who murder that emerge from the discourses contained in the bodies of texts around that subject. So far as constructions of murder of patients by nurses are concerned, the method of killing is a critical element.

Confession

A high proportion of nurses who murder patients confess their crimes. So inconceivable to the average person is the notion of a nurse murdering patients that sometimes vital cues are missed that enable these nurses to continue to murder, and a drunken confession by Donald Harvey is an example of just such a missed opportunity. The *Cincinnati Post* reported that Harvey's killing trajectory:

...nearly ended the same year when he got drunk and began babbling about the murders. No one believed him, though, and he soon left town to pursue a career in the Air Force. "I spilled it all," Harvey said. "But they thought I was crazy." Although it never landed him in jail, his drunken confession got him into trouble with the military a year later when his superiors learned police had questioned him about some deaths at the hospital.' (Horn, 1997, p.1)

Some other examples of cases where the offender confessed may assist in setting the context for some further discussion of the discourses embedded in the bodies of texts relating to this phenomenon. In the case of Stephan Letter, it was reported in the *Daily Telegraph* that:

'A male nurse on trial over the deaths of 29 patients in Germany has admitted killing some people in his care. Stephan Letter, 27, told the court in Bavaria that his actions "cannot be justified under any circumstances" but said he had acted out of compassion.' (Cleaver, 2006, p.8)

Confessions are important in obtaining convictions in cases of nurses who murder patients because of the difficulty that often arises in obtaining other evidence of their crimes. They are not always a conventional confession to investigators or the Court,

however, as is evidenced by the case of Brian Rosenfeld. He allegedly told his cellmate about 23 of his murders and admitted to police that he had murdered 3 people.

'Brian K. Rosenfeld, 34, a nurse who police said admitted killing 23 nursing home patients, pleaded guilty Thursday to murdering three elderly patients with drug overdoses' (Associated Press, 1992, p.2).

Unlike many nurses who murder patients, Orville Lynn Majors maintained his innocence although the prosecution alleged that he had confessed his murders to another inmate whilst in prison. As Associated Press Newswire reported:

Majors has maintained his innocence throughout the investigation into deaths that occurred at the hospital from May 1993 to March 1995' (AP, 1997).

The alleged confession of Orville Lynn Majors reported by Associated Press also occurred in prison:

'Prosecutors plan to use a purported jailhouse confession by accused killer Orville Lynn Majors to bolster their case for the admissibility of a study of a series of suspicious deaths at the hospital where Majors worked as a nurse. A fellow inmate of Majors at the Vermillion County Jail gave a deposition in the case this week and is expected to testify that Majors confessed to killing patients at the hospital, according to court documents.

Samuel Compton "is expected to testify that Majors confessed that he murdered patients in his care," prosecutors wrote in a motion filed Thursday with Clay Circuit Judge Ernest E. Yelton, the special judge who will hear Majors' case (AP, 1998b).

However, the issue of indirect confessions can be problematic and the alleged prison-cell confession of Majors illustrates this point well, as Associated Press reports:

Kevin Ridling, a former inmate at the Vermillion County Jail, said in a Sept. 16 letter to Special Judge Ernest Yelton of Clay County that Compton told him "he was going to lie on Orville Lynn Majors to get a lesser sentence." The letter was filed in Vermillion Circuit Court on Friday. "I want you to know that its not right for him to be set up," Ridling wrote Yelton. "If Orville [Majors]is guilty, let the jury find him that way. But not because someone is lying on him to get a lesser sentence." Ridling also wrote a similar letter to Vermillion Circuit Judge Bruce Stengel on Sept. 9. (AP, 1998c)

Jeffery Felton is another nurse who murdered patients and who publicly confessed:

'Feltner, 26, a certified nurse's aide, began confessing to killing elderly patients several weeks ago in a series of calls to WESH-TV in Daytona Beach.' (AP, 1989a, p.1).

As can be seen from the foregoing examples, confession is relatively common among those nurses who murder patients and who are detected. A significant proportion of those nurses who confess to the murder of patients, however, subsequently retract their confessions. This was so in the case of Japanese assistant nurse Daisuke Mori. The *Kyodo News* reported that:

'He [Daisuke Mori] initially admitted to the allegations, but four days after his arrest he began to claim his innocence.' (*Kyodo News*, 2006).

It is possible that Daisuke Mori's confession was coerced, as he argued, but there is no evidence to establish that this was the case.

'During the trial, which lasted two years and eight months, Mori pleaded not guilty to murder and attempted-murder charges, saying he was forced by investigators to confess to the allegations during lengthy and exhausting interrogations.' (Agence France Presse, 2004)

Guimaraes is another example of a nurse convicted of murdering patients who initially confessed but subsequently retracted his confession:

'Guimaraes...initially confessed to five murders, saying he had ended the patients' lives to ease their suffering.' (Goering, 1999b, p.2).

Timea Faludi, too, retracted her confession. In Faludi's case, she confessed then sought to retract her confession. '*Faludi later withdrew a confession to police, and her lawyer claimed she had lied to make herself more interesting*' (Agence France-Presse, 2002b).

The *Toronto Star* reported the inclusion, in this illustrious troupe of retractors, of Waltraud Wagner and her accomplices: '*Wagner and the other three aides have retracted initial confessions*' (*The Toronto Star*, 1991a). These are confessions of behaviours that should be hard to make up, as Associated Press had earlier reported:

The key defendant in Austria's biggest murder trial since World War II testified Friday that she administered drug overdoses and lethal water torture to elderly hospital patients to ease their pain. Waltraud Wagner, one of four nurses' aides accused of killing at least 42 aged patients at the Lainz Hospital, told the court she had virtually unlimited access to drugs at the suburban Vienna hospital. ... She also admitted to later using what she called "mouth care" - a deadly water torture - twice by herself and five times with another defendant, Stefaniya Mayer. It involved holding patients' tongues and pouring water into their lungs... (AP, 1991a, p.32).

In fact, *The Seattle Times* noted that the Wagner case saw confessions from three of the participants, reporting that:

Three orderlies and a nurse dubbed the "angels of death" have confessed to killing at least 49 elderly patients by lethal injection, police said yesterday... (*The Seattle Times*, 1989, p.2).

These extracts from this body of texts show it is not unusual for a nurse accused of murdering patients to confess to having done so. The point was made earlier that such confessions are often crucial to obtain a conviction because of the various difficulties inherent in prosecuting these cases. Thus, some understanding of what leads these nurses to confess is pertinent. Unfortunately, whilst not completely lacking, there are surprisingly few insights to be gleaned from the texts of media reports of these cases. Reports of the Stephan Letter case make it clear that his confession was driven by remorse but it needs to be borne in mind that this was in the face of some compelling evidence against him so in that case it was not going to determine the outcome of the case. The discourses around confession in the mass media warm to those confessions apparently grounded in remorse. More commonly the discourse is either overtly or more quietly rooted in boasting. A significant proportion of these nurses appear to be proud of their achievements possibly because it demonstrates the extent of the power they have wielded. In some cases the opportunity to brag about their achievements is irresistible and in other cases, once exposed, confession and the resultant attention may compensate for the fact of being caught.

The discourses around retracted confessions shed a little light on both constructions of murder by nurses and constructions of nurses who murder. In general, it seems that once a confession is made (or even alleged, as in the case of the 'jailhouse confessions'), then the content of the confession will be presumed by the media and the public to be true. The possibility that a confession may have been made under duress or coercion, or that the existence of a confession may have been fabricated by others, seems not to undermine the attributed truth of the content. Thus, whilst the probative value of the confession may be impaired for the purposes of the prosecution that will not be the case in the media or the minds of the public.

Retraction can be dismissed as the defendant merely having thought better of it in the cold hard light of day (or with the benefit of legal advice to say nothing!).

There are other issues embedded in the discourses around confession. Some of these include inflated numbers of victims or understating the number of victims. The significance of this is probably related to the rationale for confessing but the media also profits from the slow release of information by some nurses such as Charles Cullen who gradually built the number of confessed murders to approximately 40, but suggested that there might have been as many as 80 over 16 years, explaining that he could not remember precisely. There were of course inconsistencies in his accounts of his exploits but the construction that emerges is that no one except the offender can ever really know how many patients a nurse might have killed. This is affirmed by the fact that in most cases these nurses who are serial killers are generally convicted only of one or two murders. This is important in terms of the levels of anxiety that patients in hospitals should have about the possibility of being the next victim of such a nurse. If nurses are only to be convicted of two or three murders (even where they may have murdered many tens of patients), they will be less likely to intrude on the consciousness of the average patient than would be the case if they were convicted of the full number of murders committed. The chance of being murdered as a patient is still slight, but less so.

The relationship between confessions and notoriety leads to a consideration of the place of celebrity in the construction of nurses who murder.

Celebrity Status

One way or another, nurses who murder patients are likely to achieve a degree of celebrity. It is clear that some nurses who have murdered patients and are apprehended for so doing thrive on the resultant attention. This is not surprising in the slightest where the admitted or assumed motive for the murders is attention and power. Many of the nurses who murder patients did so because they craved attention and the perception of the media is that serial killing is definitely newsworthy. Where babies are the victims, nurses who murder patients make for very good television, it seems.

'In 1982, pediatrician Kathleen Holland was setting up practice in Langford, Texas. Needing a nurse, she hired Geneene Jones, with whom she had worked briefly at a hospital in Austin. But when one of Holland's first patients collapsed during an office visit and died, both she and Jones were suspect. Jones, the jury decided, was guilty; she is serving a 99-year sentence. Holland resumed her practice, but is still fighting to reclaim the hospital privileges that were denied her. Their story is told on NBC's "Deadly Medicine" (Monday at 9), starring Veronica Hamel as Holland and Susan Ruttan as Jones. "She was psychopathic, deeply disturbed," said Ruttan. "I had to come with a reason why she did this. The actual character never acknowledged her guilt. She was always in denial." (Brennan, 1991, p.4)

This is a powerful combination, as illustrated by these comments about Donald Harvey:

'Harvey overcame modest beginnings in Owsley County, Ky., to become famous beyond anybody's wildest imagination. Reporters swarmed and courtrooms were packed in 1987 when Harvey pleaded guilty to the killings.'(*The Plain Dealer*, 1991)

The public fascination with serial killers generally subsumes cases of nurses who murder patients and this reinforces the strong element of celebrity status, even after conviction.

'Today, Harvey lives in a protective custody unit at the Warren Correctional Institution in Lebanon, Ohio. He is considered a "model inmate" and works eight hours a day as a clerk in the prison's Health and Safety Department. ... Harvey said he is trying to get used to prison life. He spends his days reading *Newsweek*, watching nature shows on PBS and meeting with doctoral students who want to make him the subject of a thesis. Everyone, he said, is still trying to find out why Donald Harvey became a killer. "I've been trying to figure myself out for 45 years and I'm still no closer to an answer," Harvey said. "Maybe it's in my genes. Maybe they dropped me on my head when I was a baby. Who knows?" (Horn, 1997, p.1)

The discourse around power and attention in media reports of these cases is extensive and it is instructive to examine some examples. Such nurses may become the subject of whole books, as was true of Donald Harvey. In his case one of the authors was his defence attorney:

'Local Author Bruce Martin and Defense Attorney William Whalen will appear at the Western Hills Plaza Media Play store, Saturday, November 5, at 1 p.m., to sign copies of their true-crime book, *Defending Donald Harvey*. The story of America's most-notorious Angel-of-Death serial killer,

Defending Donald Harvey was written by Harvey's court-appointed defense attorney, Whalen, and co-author Martin. The book reveals facts formerly protected by attorney-client privilege and provides frightful insights into the mind of the cherub-faced killer.' (*Business Wire*, 2005)

As *The Republican* indicated in the case of Kristen Gilbert, she too was the subject of a book:

' Convicted murderer Kristen Gilbert was a perfectionist in several ways: She chose perfect victims and used the perfect method to kill them. And now her crimes have made her the perfect subject for a new book, aptly titled "Perfect Poison." Living just down the road in Vernon, Conn., author M. William Phelps was no stranger to Gilbert's deadly saga and resulting conviction. Gilbert, a nurse at the Veterans Affairs Medical Center in Northampton, was convicted of systematically killing patients by using epinephrine, a drug that is used to save patients in cardiac arrest, but which can be deadly to healthy people. (Lenker, 2003, p.4).

The level of publicity accorded cases of nurses who murder patients is sometimes exceptional by any standards. For example, the Lucinda de Berk case enjoyed a much greater amount of publicity than is usual in The Netherlands. *The Globe & Mail* noted that the case:

' ... has been widely publicized in the Netherlands, where serial-murder trials are virtually unknown, and in Canada, since Ms. de Berk lived in Winnipeg and Vancouver during her teenage years, at one time working as a prostitute.'(*The Globe and Mail*, 2003, p.12).

This suggests that familiarity is a key determinant of the extent of coverage. If cases gain most coverage in those geographical areas where the offender is known – irrespective of where they perpetrated their crime – it may be that many cases go unnoticed because the offender is unknown in the area and their antecedents are unknown. This would go some way towards explaining why for some cases included in this study immense amounts of material were available and the case received banner headlines whereas others, equally serious, went almost unnoticed with minimal mention in the media. As *The Globe and Mail* rightly point out, though, the de Berk case was the biggest ever case of a serial killer in The Netherlands and it had some legal complexities too with respect to the admissibility of certain evidence.

'A panel of three judges in The Hague criminal court will decide Ms. de Berk's fate Monday in the biggest serial-murder trial ever in the Netherlands. The case has left court watchers perplexed, wondering whether the judges will

consider the accused's self-incriminating excerpts from her personal diaries as evidence in reaching their verdict.' (Cowan, 2003, p.16).

In the case of Joseph Dewey Akin, while there was some celebrity associated with his case, the media coverage was essentially very objective and gave little airtime to other than relatively objective reporting of the relevant facts, as for example:

'...Thursday, Mr. Akin's first public statements on the investigations in Georgia and Alabama were broadcast in an interview with the syndicated television show, "A Current Affair." He strongly denied that he had killed anyone and described himself as an excellent, caring nurse. "I didn't kill anybody," he said. "I never hurt anybody in my life." '(Yardley, 1991a, p.1).

This makes it all the more ironic that in Akin's case the defence took an interesting approach to celebrity and notoriety by casting the media as an ally, as the *Atlanta Journal and Constitution* reported:

"The trial of a patient's lawsuit against nurse Joseph Dewey Akin should be televised to show the "frailty and shoddiness of the evidence," the nurse's attorney said in court papers Wednesday. In his motion for a televised trial, attorney John Matteson said Mr. Akin "has been the victim of a firestorm of adverse media attention predicated on rumour and innuendo.' (McIntosh, 1991, p.4)

This example implies the possibility that celebrity status could be the key motive for some nurses who kill patients. The *Tulsa Tribune* reported the televised Akin interview in the following way:

' Producers of the television show "A Current Affair" said Akin was interviewed Wednesday in Atlanta for a segment to be broadcast today. "I'm not a super nurse," Akin told producer Leslie Fagan. "I'm just a competent nurse. I didn't kill anybody. I never hurt anybody in my life. I sleep at night because I have nothing to fear. I sleep at night because I know I have done nothing wrong." (AP, 1991b, p.4).

The context of the bodies of text from which the discourse of celebrity emerges is interesting in itself. In the US more than anywhere else, the mass media is clearly a willing partner in this. The United States has progressed much further down the path of televised court trials than perhaps any other western developed nation with a common law system. The media and the legal professions have evolved a coincidence of interests that permits this alliance to work both for and against the interests of justice in any given case. Akin's case could be construed as an abuse of

this process. This engagement of the mass media with the legal domain is evidenced in other ways. For example, the inclusion in catalogues of serial killers of short, sensational accounts of nurses who murder patients adds to the celebrity of such individuals but does little to inform the community of the true nature and significance of their conduct. An example of this is the following extract from an article in *Psychology Today*:

'Angel of Death Waltraud Wagner used lethal injections, strangulation or drowning to kill between 49 and 300 elderly patients in an Austrian hospital in the mid 1980s. Wagner's motive, as one of her three conspirators put it: "The ones who got on my nerves were dispatched directly to a free bed with the good Lord." All four were sent to prison. (Blustain, 1999, p.57)

That is it. That is the whole entry for Wagner – just another serial killer in a list of them. This agglomerates all the bad people together but it tells us nothing about them. It does nothing to assist understanding. Neither can the contagion of celebrity be ignored. A story in *The Mirror* epitomises this by generating spin-off stories with headlines like 'I survived the 'kill for kicks' nurse' (Box, 2006). In a very real sense this trivialises the horror of a nurse who murders patients. It diminishes the fear by building confidence that such nurses do not always succeed in despatching their victims. The same is true in the case of some other publications. For example, this brief snippet relating to the case of Charles Cullen is drawn from the *Reader's Digest* which works hard to glean matters of public interest, however trite:

'Charles Cullen claimed that he murdered 40 patients during his 16-year career as a nurse. Investigators are reviewing patient records at many of the facilities where Cullen worked, including the Liberty Nursing and Rehabilitation Center and Sacred Heart Hospital, both in Allentown PA.'(Alexander, 2004, p.162)

The mass media play a critical role in constructing the perceptions of the offenders along with their actions. For example, the texts of the mass media can construct the persona of the players in these cases by the use of language. This is an example of how the bodies of texts of the media affect perceptions and the process can be seen clearly at work in a report of the Akin case in the *Atlanta Journal and Constitution*:

'Tanned and smiling, Cobb County nurse Joseph Dewey Akin surrendered at the Jefferson County Jail Thursday, a day after he was charged with killing a patient by lethal injection. Mr. Akin, 34, stepped out of a black Saab at 3:45

p.m. CDT wearing a dark suit, lime-green shirt and paisley tie. He only smiled and blushed slightly as reporters shouted questions about the murder charge.' (Yardley, 1991b, p.1).

The mass media is able in this way to construct an image of the specific nurse and this is dealt with at greater length in the treatment of characterisations of nurses who murder patients in Chapter 7.

Another form of celebrity afforded nurses who kill patients, along with other serial killers, is that of being the object of study by various disciplines and even some charlatans. As the *Hamilton Spectator* pointed out:

'... compared to Ohio mass murderer Donald Harvey, Hannibal Lecter -- played by Anthony Hopkins in the movie *The Silence Of The Lambs* -- is a really nice guy. So says D. Glenn Foster, dubbed by some in American law enforcement as the human lie detector. ...Of Donald Harvey, dubbed the Death Angel in Ohio, Mr. Foster says: "He admitted to 87 grotesque homicides, including 17 in one week. He is an extremely complex creature, the ultimate monster.'" (Prokaska, 1992, p.3)

Conversion to an object of study is a facet of all presentations of the convicted serial killer as society seeks to obtain better understandings of this phenomenon. Nevertheless, this close scrutiny amounts to yet another form of attention and thus is often likely to be perceived as a reward by those motivated by craving attention.

Whatever form the celebrity takes, all nurses who murder patients will come to experience it. Put another way, the texts of the mass media contain discourses that construct celebrities out of nurses who murder patients. A key determinant of the resultant constructions is the victims of the nurses.

The Victims

One approach to understanding the place of victims in constructions of nurses who murder is to identify the victims as individual people. In most cases, the media seeks to give a human face to the victims of these murderers but quite apart from the need to accord the victims their humanity, it is important to recognise that the victims of a nurse who murders patients can give some insights into both the modus operandi and motivations of that nurse. The victims of nurses who murder patients also

demonstrate the vulnerability of all patients due to the opportunistic and random selection of victims. As the *Boston Herald* reported,

'Kristen Gilbert's victims, known to her jury during her trial only as helpless, bedridden patients, were brought to life as beloved sons, husbands and fathers in emotional testimony last week. One by one, relatives of Henry Hudon, Kenneth Cutting and Edward Skwira took the stand to describe the lives of the men Gilbert killed to the jury that is considering the death penalty.' (J. Crittenden, 2001, p.18)

There has been a propensity within the mass media to adopt this approach in the form of catalogues of victims. Here I propose to provide something of a catalogue of catalogues in a series of several quite long extracts. No apology is offered for this because of the importance I attach to this matter of the victims. I have included each of these extracts in full primarily to demonstrate the extent to which the bodies of text around this issue contribute to a discourse that could reasonably be expected to elevate the murder of patients by nurses to the level of an everyday concern for the consumers of health care. I have also included them because of the need to acknowledge the humanity of the victims and because these catalogues reveal the vulnerability of all of us who might present at our local hospital in the hope of receiving treatment. The first example is a report in relation to the case of British nurse Benjamin Geen. The Press Association Newswire provided the report which, via a catalogue of his victims (including a majority that might be regarded as 'near misses'), indicates the role he played and how easily a nurse can murder patients.

'He (Geen) gave the doses to his mostly-elderly victims shortly after they were admitted to hospital.

DAVID LONG, 53 - Mr Long arrived at A&E at 2pm on December 4, 2003, suffering from a suspected lithium overdose. Geen inserted a tube into his arm to allow drugs to be administered. A doctor who checked him over found him alert and responsive with a clear chest and steady pulse. But no sooner had he left the room, he heard Geen shout out that Mr Long had stopped breathing. Mr Long was injected with an anaesthetic drug by Geen for no medical reason.

DAVID NELSON, 77 - Five days after Mr Long, Mr Nelson came into the Horton with a chest infection. Again, as the doctor went out to write his notes, Geen came running out to say the patient was 'getting worse'. The doctor said later: "This abrupt change in his circumstances was inexplicable to me at the time." The patient was taken to the resuscitation room where he stopped breathing. Doctors suspected a stroke and that death was imminent. But to

everyone's surprise, Mr Nelson gradually came round. His urine would later test positive for a sedative also found in trace form on Geen's fleece.

ROBERT ROBINSON, 51 - Mr Robertson was admitted on December 13 after he drank a bottle of gin and took painkillers. But he stopped breathing when he was given an anaesthetic which he did not need.

HILDA WIGRAM, 89 - Mrs Wigram was admitted with a possible brain haemorrhage on December 22. A nurse who stood with Geen as he administered a painkiller said she was perturbed when he injected it rapidly, instead of by the prescribed method of little by little. She too stopped breathing and had to be revived. Experts pointed to a muscle relaxant.

WALTER COATES, 61 - Mr Coates was admitted on December 29 with a suspected stomach ulcer and suffered the ordeal doctors describe as 'dry drowning'. A doctor saw him at 6am and described him as fully alert. But when he was called back at 6.20am, he found two nurses including Geen in the room and the patient 'in a state of total distress'. Mr Coates was conscious and trying to speak, gasping 'as if he was being strangled', while members of his family looked on. He was poisoned with the muscle relaxant vecuronium - a drug normally used by anaesthetists to ensure patients remain absolutely still for a CT brain scan or during operations. Mr Coates was transferred to the nearby John Radcliffe Hospital. By 10.30am his breathing was back to normal and he later left hospital.

JOHN MONCUR THORBURN, 73 - Admitted on December 30 with chest pains, Mr Thorburn was a life-long asthmatic who suffered from chronic obstructive pulmonary disorder and emphysema. He was seen by a 'very abrupt' male nurse, known to be Geen, who put a needle in his hand. His wife recalled Geen coming into the room before her husband was taken to X-ray. Experts said there was 'no natural reason' why Mr Thorburn should have stopped breathing. He was not a diabetic but his blood sugar levels were dangerously low, which pointed to the admission (sic) of insulin. He also could have been given a sedative or painkiller.

SHEILA GRAY-SNOOK, 73 - Mrs Gray-Snook was admitted to the Horton at 8am on January 2, 2004, with an irregular heartbeat. She had a cardioversion - a short, sharp electric shock to restart the heart - which went without incident. At 8.25pm, she collapsed and stopped breathing. By 10pm she had recovered. Baffled doctors suggested an investigation into whether they had a 'dodgy batch of drugs'. Experts concluded she must have been given a muscle relaxant.

ANTHONY BATEMAN, 66 - The first of the fatal victims, Mr Bateman, from Banbury, was already 'really very unwell', suffering from asthma, arthritis and a heart condition, when he was admitted to the Horton on January 6 for a suspected cancer. Doctors said he was conscious but after Geen had taken a blood sample and set up a saline drip his condition deteriorated and he stopped breathing. Doctors tried to resuscitate him but decided that because of his poor state of health and, believing his illnesses were causing the

respiratory arrest, he should not be kept alive artificially. Experts said Mr Bateman's arrest was 'highly unlikely' to have been caused by his underlying illnesses and his life would have been prolonged by resuscitation. They concluded he had been given a muscle relaxant, probably through his saline drip.

JONATHAN FELTHAM, 22 - Geen's youngest victim Mr Feltham came to the Horton A&E after he accidentally smoked a cannabis joint believing it to be a cigarette and became unwell. He went to hospital just after 7pm on January 7 and within half an hour he had collapsed. Geen alerted staff to the emergency and after attempts to resuscitate him, he spontaneously recovered. Experts pointed to the unauthorised administration of a sedative or pain killer.

HAROLD BOSS, 66 - An emphysema sufferer, Mr Boss was admitted on January 15. Emphysema sufferers can struggle to breathe if given too much oxygen, meaning that carbon dioxide builds up in their bodies. At one point Geen asked the doctor: 'Can someone have a respiratory arrest from carbon dioxide retention?' Within a short time, Mr Boss was confused and turning blue. He sank into a deep coma and stopped breathing. The doctor noticed that the setting on the machine delivering oxygen to the patient had been turned up, and said Geen told him it must have been done while the patient was being x-rayed. The oxygen level was righted and the patient quickly recovered. He has since died.

NOREEN BROOKS, 55 - Mrs Brooks also suffered a 'totally unexplained' respiratory arrest when she was admitted at 6.45pm on January 19 for uncontrolled diabetes. When Geen set up her drip she was alert and was given a number of drugs. By 8.30pm she had stopped breathing, but had recovered by the next day. Experts said she was given a muscle relaxant.

DAVID ONLEY, 75 - Geen's second murder victim. Mr Onley, from Deddington, Oxfordshire, was like Mr Bateman seriously ill when he was admitted in the early hours of January 21. He had a heart condition, was diabetic and due to a triple bypass operation three weeks earlier, had a wound that was thought to be infected. Nevertheless, doctors said he was alert and responsive and the night passed without incident. Geen came on duty at 7am and Mr Onley was handed over to his care. By 8.30am Mr Onley had stopped breathing. By 9.50am he was awake and talking to staff. At lunchtime he suffered a heart attack and was revived but then just before 4pm he suffered another and his organs failed. He was put on a ventilator but was dead by the evening of the following day. Experts said Mr Onley had dropped breathing because he was given a muscle relaxant. This episode, they said, would have had a 'significant affect' on his heart and weakened his body's ability to fight.

ARTHUR MARLOW, 79 - Mr Marlow was admitted to the Horton on January 26 with a stomach ulcer and suffered a respiratory arrest, Mr Marlow's daughter, June Taylor, who worked at the Horton as a nurse, recalled how she had left her father for 15-20 minutes. When she returned, she said, the situation had gone downhill. 'Ben (Geen) was in the cubicle with my dad,' she said in a witness statement. 'He was stood next to the bed, he was

just standing looking at my dad, then he turned round and saw me and used words to the effect of: 'Does your dad normally go off in a deep sleep like this?'" The prosecution suggested that in fact he was waiting and watching to see what effect the drug he administered to Mr Marlow would have so that he could, at the right moment, call out for help and start to do 'his hero's act'. Experts concluded he had been given a sedative. He has since died.

GRACE Vera FOX, 88 - Mrs Fox collapsed twice and stopped breathing while she was in hospital on January 27. Her daughter told police she had popped out and when she returned, her mother's eyes were shut and her body was jerking. She fell deeper and deeper into a coma and her blood sugar levels dropped dramatically. Insulin, of which she had no need, had been administered. Mrs Fox has since died.

ESTHER JORDAN, 79 - Mrs Jordan was taken to the A&E in a stable condition on January 31 but after being alone in a cubicle with Geen she rapidly went downhill. As she stopped breathing she was rushed to a resuscitation room and doctors warned her relatives that she could die at any time, fearing she had suffered a stroke. But she recovered and was eventually transferred to a ward. Experts suggested she had been given insulin or a sedative. Mrs Jordan died shortly before Geen's trial began.

HERLINE PROBERT, 67 - Mrs Probert was a nurse who previously worked at the Horton hospital but was admitted on February 5 following a fall at home. She described how Geen had taken her pulse, temperature and blood pressure then inserted a tube to administer drugs. She told police she saw a syringe attached to the tube with a cloudy liquid in it but remembered nothing after this. Another nurse said she remembered Geen coming into the treatment room on this occasion and squirting the contents of a syringe down the sink. She said he said something like: 'My patients always go off on me.'" Experts said Mrs Probert had been given a large dose of morphine, possibly combined with a sedative.

TIMOTHY STUBBS, 42 - Mr Stubbs was Geen's last victim and his case set alarm bells ringing. He was admitted the same evening as Mrs Probert suffering from stomach pains. Mr Stubbs said Geen told him his blood pressure was high and injected a drug which he said would bring it down. He said he got off the bed to try and arrange his gown but within half a minute was soaked in sweat and his body felt heavy. Mr Stubbs said someone was saying 'keep the head up', and the next thing he remembered was waking up the next day. A junior doctor said that as Mr Stubbs struggled to breathe, Geen went to put a tube down his throat to create an airway. She told him not to but he did it anyway, she said. The patient gagged and the airway was removed. After recovering from his collapse, Mr Stubbs was transferred to intensive care where doctors continued to monitor him. The drugs midazolam, a sedative, and vecuronium, a muscle relaxant, were found in his urine sample but doctors knew they had not prescribed them.

Geen was cleared of committing grievous bodily harm against

HEINRICH ZINRAM, 93. Mr Zinram arrived at the Horton by ambulance on February 1 suffering a suspected chest infection. He was settled in by Geen and within an hour he was suffering breathing failure. He was transferred to intensive care but by the next morning was breathing easily and recovered enough to go back to his nursing home in nearby Chipping Norton. Experts concluded he had been given a dose of a sedative or painkiller.' (Simpson, 2006b)

Geen's victims – including those who survived – ranged in age from 22 years of age to 93. The victims included males and females, young and old, very sick and not very sick. One could almost say they were a convenience sample opportunistically subjected to Geen's ministrations designed to maximise his adrenalin rush. Whether this extends to pushing the boundaries until he was caught is a question often asked with respect to serial killers in general but what is eminently clear is that anyone who received Geen's ministrations was placed at risk.

Another extensive catalogue of victims constituted part of the reporting of the case of Donald Harvey. In the *St Petersburg Times* this was presented as follows, and in this case, not all were patients:

Former hospital orderly Donald Harvey pleaded guilty Tuesday to the aggravated murder of 24 people, the attempted aggravated murder of four people and the felonious assault of one person. Here is a list of his victims, provided by the medical examiner's office:

Aggravated murder

1. Helen Metzger, a neighbor of Harvey's, died April 10, 1983, after arsenic was placed in her pie.
2. Henry Hoeweler, 82, the father of Harvey's roommate, died May 1, 1983, after arsenic was placed in his pudding.
3. James Peluso, an acquaintance of Harvey's, died Nov. 10, 1984, after arsenic was placed in his pudding.
4. Leon Nelson, 64, a Drake Hospital patient, died April 12, 1986, by suffocation.
5. Virgil Weddle, 81, a Drake Hospital patient, died April 19, 1986, after rat poison was placed in his dessert.
6. Edward Schreiber, a Drake Hospital patient, died June 20, 1986, of cyanide-laced orange juice.
7. Robert Crockett, 80, a Drake Hospital patient, died June 29, 1986, after cyanide was injected in his intravenous tube.
8. Donald Barney, 61, a Drake Hospital patient, died July 7, 1986, after cyanide was injected in a gastric tube and injected into his buttocks.
9. James Woods, a Drake Hospital patient, died July 25, 1986, after cyanide was injected in a gastric tube.

10. Ernst Frey, a Drake Hospital patient, died Aug. 16, 1986, after cyanide was injected in a gastric tube.
11. Milton Canter, 85, a Drake Hospital patient, died Aug. 29, 1986, after cyanide was injected in a gastric tube.
12. Roger Evans, 74, a Drake Hospital patient, died Sept. 17, 1986, after cyanide was injected in a gastric tube.
13. Claborn Kendrick, 69, a Drake Hospital patient, died Sept. 20, 1986, after cyanide was injected in a gastric tube.
14. Albert Buehlmann, a Drake Hospital patient, died Oct. 29, 1986, after drinking a cup of cyanide-laced water.
15. William Collins, 85, a Drake Hospital patient, died Oct. 30, 1986, after drinking cyanide-laced orange juice.
16. Mose Thompson, 65, a Drake Hospital patient, died Nov. 22, 1986, after cyanide was injected in a gastric tube.
17. Cleo Fish, 67, a Drake Hospital patient, died Dec. 10, 1986, after drinking cyanide-laced orange juice.
18. Odas Day, 72, a Drake Hospital patient, died Dec. 10, 1986, after cyanide was injected in a gastric tube.
19. Leo Parker, 47, a Drake Hospital patient, died Jan. 10, 1987, after cyanide was injected in a feeding bag.
20. Margaret Kuckro, a Drake Hospital patient, died Feb. 15, 1987, after drinking cyanide-laced orange juice.
21. Joseph Pike, a Drake Hospital patient, died March 6, 1987, after being poisoned with cleaning fluid.
22. Hilda Leitz, 82, a Drake Hospital patient, died March 7, 1987, after being poisoned with cleaning fluid.
23. John Powell, 44, a Drake Hospital patient, died March 7, after cyanide was put in a feeding tube.
24. Stella Lemon, 87, a Drake Hospital patient, died March 16, 1987, after being given cyanide three or four weeks before.

Attempted aggravated murder

1. Margaret Hoeweler, mother of Harvey's roommate, was given arsenic periodically between 1983 and 1985.
2. Diana Alexander, a friend of Harvey's, had hepatitis serum placed in her iced tea in January 1984. She later suffered hepatitis.
3. Harold White, a Drake Hospital patient, was given arsenic in June and July of 1986. He later died at another hospital, but the death could not be directly attributed to the arsenic.
4. John Oldendick, a Drake Hospital patient, was given arsenic in the late summer of 1986. He later died at another hospital, but the death again could not be tied to the poisoning.

Felonious assault

Carl Hoeweler, Harvey's roommate of six years, was given arsenic periodically and became very ill in 1986. Prosecutor Arthur Ney said Harvey testified he didn't want to kill Hoeweler, but wanted to cause him 'pain and suffering.' (*St. Petersburg Times*, 1987, p.6)

Another example of a wide range of age groups, again with a preponderance of elderly people, was the large group of victims of Charles Cullen who numbered possibly more than 40. As the Associated Press reported:

'Matthew Mattern, 22, of Shamokin, Pa., died Aug. 31, 1999, at Lehigh Valley Hospital in Salisbury Township, Pa. One of Cullen's youngest victims who was in the hospital after being severely burned in a car accident.' (The Associated Press, 2006b)

In keeping with an emphasis on the elderly victim, Roger Andermatt's victims were all post-retirement age. As the Canadian Press reported,

'His victims were between 66 and 95 years old and were suffering from Alzheimer's disease or were in need of high levels of care' (AP, 2005d)

Either way, they were fairly vulnerable people.

So too with Stephan Letter whose case provides another example of this approach:

Regina Endress, 83, was in a coma when she was transferred to Sonthofen from a hospital in Regensburg. Within five hours Letter had killed her, according to the indictment. The last victim, a 73-year-old Spanish woman, Pilar del Rio Peinador, had been admitted to hospital with breathing problems but was already well enough to be planning a holiday in her homeland when Letter fatally injected her in July 2004. He eavesdropped on doctors discussing survival chances or the pain threshold of patients before selecting his victims. On the first night inspection, he would inject the tranquilliser Diazepam and the muscle relaxant Lysthenon. On the second round of the wards, he would announce that the patient had stopped breathing. The defence case will centre on a psychological analysis of Letter to establish a motive for his killings. Two factors come into play: first, he was the child of a neurotic, controlling mother, who was convinced (despite evidence to the contrary) that he was mentally handicapped.' (Boyes, 2006, p.39).

'Most of Mr Letter's alleged victims were more than 75 years old, and their deaths raised no suspicions at the time, the court heard.'(BBC News Online, 2006).

In the Letter case, he did not have any involvement with the patient other than killing them, a point made in the *Daily Telegraph*:

'Not all of the patients were seriously ill, and he had no contact at all with some of them.' (Cleaver, 2006, p.8)

This of course means that any vulnerable person to whom Letter could gain access was at risk of being murdered by him. This issue of vulnerability is compounded by that of randomness: victims of nurses who murder patients are often selected randomly. As the Associated Press Newswires (2001) reported, the following list identifies:

'... the patients at the veterans hospital in Northampton, Mass., who prosecutors said died when Kristen Gilbert gave them overdoses of the heart stimulant epinephrine. Gilbert was found guilty of first-degree murder of three veterans:

Henry Hudon, 35, of Westfield, suffered a series of heart attacks and died Dec. 8, 1995, hours after being admitted to the hospital. His family said Hudon, a diagnosed schizophrenic whom they believed was suffering from the flu, had begged not to be left in the ward the night he died. They said he feared patients were being killed.

Kenneth Cutting, 41, of Leominster, was remembered by witnesses for his charm and sunny disposition despite being hospitalized for 20 years with multiple sclerosis. An infection had prompted his transfer to the intensive care unit at the VA. Shortly before his death on Feb. 2, 1996, witnesses said Gilbert asked to leave work early if he died.

Edward Skwira, 69, of Haydenville, died Feb. 18, 1996, after being transferred to the VA hospital from an alcohol treatment facility in Worcester. He also had a history of heart problems. A nurse testified she found three used ampules of epinephrine by his bedside that she had noticed missing from the ward supply earlier in the evening.

Gilbert was found guilty of the second-degree murder and assault with intent to commit bodily harm of one veteran:

Stanley Jagadowski, 66, of Holyoke, was transferred to the hospital in July 1995 after having his right leg amputated above the knee. A diabetic with an enlarged heart, Jagadowski went into cardiac arrest 20 minutes after another nurse said she saw Gilbert enter his room with a needle and heard him cry out "Ow, you're killing me." He died a day later on Aug. 21, 1995. Other nurses testified he often said "You're killing me" when he was complaining. In addition, Gilbert was found guilty of assault with intent to kill the following patients between Jan. 20, 1996 and Feb. 4, 1996:

Thomas Callahan, who suffered from lung disease and had a long history of schizophrenia and bouts of homelessness, was 60 when he went into cardiac arrest after being admitted to the hospital with severe respiratory problems on Jan. 22, 1996. Two nurses said they found broken vials of adrenaline in a wastebasket by his bed. Minutes before, Callahan - who often burst into song - had been singing "Ave Maria." He survived, but died several months later.

Angelo Vella, a former firefighter from Westfield, was 68 when he suffered sudden cardiac arrest after being admitted on Feb. 3, 1996, for treatment of a chronic respiratory problem. His daughter testified that

Vella told her he was stricken after Gilbert, who was his nurse, "put something in my arm." He died a year later of respiratory disease.

Gilbert was found innocent of one count of assault with intent to kill in the case of Francis Marier.

Marier, a 72-year-old diabetic with no history of heart disease, was admitted Dec. 19, 1995, for an infected toe. He went into cardiac arrest when given an injection for his diabetes by Gilbert. Marier, an Army veteran of the Battle of the Bulge, died last year of unrelated causes. '

It does seem however, that some nurses have a system for the selection of their victims. In *USA Today* (Leavitt, 1988, p.3), a report claimed that in one case, selection was according to the first letter of the name in an attempt to spell out 'M.U.R.D.E.R'. The report was later found to be untrue but it does give some insight into the need to build some certainty and predictability into constructions of murder by nurses.

Vulnerability of victims is a recurrent issue in the mass media and that was certainly so in the case of American nurse Bobby Sue Dudley [Terrell]:

'They charged her with attempted murder in the case of a 94-year-old woman who suffered a near fatal insulin overdose. A month later, a Pinellas County grand jury indicted Dudley on murder charges in the deaths of North Horizon patients Mary Carter, 79; Aggie Marsh, 97; and Leathy McKnight and Stella Bradham, both 85. Dudley was charged with killing the patients either by strangling them or injecting them with fatal doses of insulin.' (Moss, 1988b, p.1)

According to *The Evening Post*, the same pattern is evident in the case of Scottish staff nurse Colin Norris whose alleged victims were aged between 79 and 90' (Bruce, 2005). The nurse in this case was charged with the murder in two Leeds hospitals of four elderly patients and the attempted murder of a fifth. The deaths resulted from overdoses of insulin but the nurse denies all charges and the case is yet to be heard.

It will be obvious from this discussion that elderly hospital patients are a prime risk group for nurses who murder patients:

'She [Vicki Dawn Jackson] was arrested this week in connection with the deaths of people aged between 65 and 91 at a hospital 100km north of Dallas, where she worked until last year.' (*Sunday Herald Sun*, 2002, p.33)

Another nurse who targeted the elderly is Gayla Ann Wilson. The Associated Press Newswires reported on the selection of a jury that:

'will hear the capital-murder case against Gayla Ann Wilson, accused of fatally beating an 81-year-old Dallas County Nursing Home resident.' (AP, 2004c)

American nurse Jeffrey Feltner also selected elderly people for his victims, according to Associated Press (AP, 1990), who reported that:

'The trial will look only at the death of Sara Abrams, 75, at New Life Acres nursing home in Melrose on Feb. 10, 1988. Feltner also faces a murder charge in Volusia County for the July 11, 1989, death of Doris Moriarty, 83, at Clyatt Memorial Center in Daytona Beach. Prosecutors say they are continuing their investigation of the remaining five deaths: four at New Life Acres from Feb. 7 to April 6, 1988; and one at Bowman's Nursing Center in Ormond Beach on July 27, 1989.'

Likewise, the victims of Graham and Woods were all elderly. As the *Houston Chronicle* reported, the '...victims were Belle Burkhard, 74, Marguerite Chambers, 60, Edith Cook, 97, Myrtle Luce, 95, and Mae Mason, 79. Most suffered from Alzheimer's disease (Perlman, 1989c, p.21).

There are of course many more examples that could be cited here. However, as has been shown in earlier chapters, it would be a mistake to think that all nurses who murder patients focus on the elderly. At the other end of the spectrum there are the likes of Beverley Allitt, Lucinda de Berk and Genene Jones, who have from time to time been referred to as the 'baby-killers'. Their victims are babies and young children, another group over whom it can be reasonably easy to wield power. There is much greater horror and notoriety in the discourses associated with nurses who murder children.

In the cases of English nurse Beverley Allitt and Dutch nurse Lucinda de Berk, it could be said that they bridged the gap because each was also accused or suspected of the murder of an elderly patient or two as well the babies. In the case of de Berk,

'The prosecutor said she attacked very young children and elderly people. A judge for the International Criminal Tribunal for the former Yugoslavia (ICTY), 91-year-old Chinese national Haopei Li is believed to have been among her victims.' (de Hemptinne, 2004).

The victims of Genene Jones, on the other hand, were exclusively babies. As the *Dallas Morning News* reported,

'The dead had very little in common. They were small children with severe or largely routine ailments. They then suffered massive hemorrhages as their blood failed to clot or they had unexplained heart failures. They turned blue from poor blood circulation or had violent seizures' (P.L. Robertson, 1989, p.8).

In the case of Joseph Dewey Akin, he was investigated and implicated in the precipitation of many 'Code Blue' emergencies but charged and convicted on only one count of murder:

'Mr. Akin, 35, is charged with murder in the death of Robert J. Price, 32, a quadriplegic who died at Cooper Green Hospital on March 27, 1991.' (McIntosh, 1992a, p.1)

The emphasis in another report of the Akin case in *The Dallas Morning News* (1992, p.5) was on the fact that his victim was disabled. This attracted considerable disapprobation. I will say no more about the victims for now but it is appropriate to reflect on this Chapter as a whole.

Conclusion

At the outset of this Chapter, I indicated that it would be about the nurse as murderer. In exploring that notion I have considered elements of the bodies of texts that say something about those individuals. In so doing, I have identified discourses around the murderers that included their age, gender, motives, methods, attitude to confessions, celebrity and finally, their victims. This study so far has been a journey into aspects of being that are completely at odds with all the values and principles the profession of nursing espouses. It has been a journey that is at once confronting and intriguing. In the methods Chapter I committed to accommodating the six elements of discourse theory. They included the text, discourse, context, power, knowledge and subjectivity. The end of each of the four chapters of analysis – chapters Five to Eight - will constitute waypoints on the journey to Chapter Nine, the conclusion of this study. Upon reaching those waypoints, I will engage in the reflexive process adumbrated in Chapter Four and take stock of how I am faring in the pursuit of that accommodation. When I reach Chapter Nine, I will confront these elements again in a final assessment of the extent to which I succeed in achieving that end.

The texts, discourses and contexts of murder by nurses have been carefully laid bare in this Chapter. The extant knowledges have been explored through a heavy reliance on printed media extracts. There is some evidence of additional sources such as radio and television news reports. Where these were encountered in written form, they were included. It may be that there could be other discourses confined to the television and radio but these have not been explored specifically. Power has been explored consistently through the Chapter in the behaviours of the nurses towards vulnerable patients together with their manipulations of the health and legal systems. There is a discourse around killing as an exercise of power that permeates the entire sphere of murder. In the case of murder of patients by nurses, how could it be otherwise? It is the ultimate exploitation of vulnerability. However, that is not the only power embedded in the texts explored in this Chapter. There is the power of the media which lies in its capacity to so deeply influence the construction of meanings held by the public. Of itself this contributes to the attention paid to context in this Chapter. Finally, there is the element of subjectivity in the Foucauldian sense. It too is woven through the interstices of the texts. It can be seen in this chapter in the evolution of otherness as these nurses are cast in the role of murderer in any of the characterisations described herein. The commitment to the six elements of discourse is intact and this journey of exploration is well under way.

Chapter 6

Being Able, Being Caught & Being Judged

Introduction

The cases that have been identified in this study are outlined in Chapter 3 and from the bodies of text surrounding those cases discourses that emphasised the characteristics of the nurses involved have been identified and examined in Chapter 5. Those discourses dwelt on aspects of the nurses such as their age, gender, motive, method, and victims. These were considered along with the place of celebrity or notoriety. Here I consider what the bodies of texts revealed about the conditions that make it possible for nurses to murder patients; about the apprehension, investigation and prosecution of these nurses; and about the judgement and punishment of these nurses. The texts relating to each of these aspects are considered against their contexts, and the discourses which they constitute. As with all of the data gathered in this study, the most prolific source has been the mass media and primarily, the written media in the form of newspapers. It is true that other sources have been drawn upon such as the professional literature but, as is the case in Chapter 5, they have proven to be a much more finite resource.

Enabling conditions

Trust in Nurses

There is necessarily within western developed countries a high level of trust in nurses. Vulnerable people either place themselves in the care of nurses or are placed by others into the care of nurses. Either way, these people who are sometimes referred to as patients are generally highly vulnerable and have no option but to trust those charged with their care. Not only do we, as members of society, generally trust nurses but we do so implicitly and naively. When the public is polled on which

profession they consider to be most ethical, almost invariably nurses will be at the top of the list – and if not, they will certainly be up there in the top five. The discourse of trust in the bodies of texts relating to nurses who murder patients is an important background consideration so a number of examples are provided here. For instance, in the USA, in a Gallup poll conducted in December, Bender reports that

‘...nurses were ranked the most ethical professionals, with 84 percent of those polled rating nurses' ethical standards as "high" or "very high," and pharmacists ranked second (73 percent)... Nurses have held the top position on the survey for all but one of the eight years they have been included in the survey. According to Gallup trend data, the one exception was 2001, when firefighters were included on the list shortly after the September 11 terrorist attacks and held the top position.’ (Bender, 2007, p.18)

The situation is no different in the UK where Ferriman reported that

‘A new poll by the independent research agency MORI of almost 2000 adults, commissioned by the BMA, shows that ... satisfaction with doctors remains high. The same proportion of the public (89%) said they were either very satisfied (36%) or fairly satisfied (53%) with the way doctors did their jobs. Only nurses scored more highly, with 95% of respondents saying that they were either very satisfied (54%) or fairly satisfied (41%).’ (Ferriman, 2001)

In Australia, *Readers Digest* conducts an annual poll to determine who the general public considers to be most trustworthy among the professionals. They currently have nurses in fourth place behind ambulance officers, firefighters and pilots, reporting that:

‘Ambulance officers topped our list for the third year in a row with an average score of 8.45 out of 10. They're followed by firefighters, pilots, nurses and pharmacists, who leap-frogged doctors from last year’ (Australian Readers Digest, 2007a, 2007b)

However, nurses in Australia should not be concerned at this aberrant result. Roy Morgan Research, who conduct the well known Morgan Polls, had this to say about nurses in 1995:

‘The Nursing profession (down 1% to 89%) was still seen as the most ethical and honest profession, as it has been every year since being included on the

survey in 1994. Pharmacists (down 2% to 84%) and Doctors (down 1% to 79%) have been consistently named in second and third place, with School Teachers (down 3 % to 74%), Engineers (down 1% to 68%) and Dentists (down 4% to 67%) also regularly rating highly. Police (up 1% to 65%), State Supreme Court Judges (unchanged on 65%), High Court Judges (up 1% to 64% and University Lecturers (down 2% to 64%) made up the top ten professions for perceived high levels of ethics and honesty in 2005. '(Morgan, 2007)

A further point to be made here is that the nursing profession itself contributes much to bodies of texts that construct the discourse of trust. In capitalizing on its showing in the polls, nursing bodies frequently refer to nursing as the most trusted profession. A quick scan of the Internet will bring up many examples of this. For instance, in a submission to the Human Rights and Equal Opportunity Commission Inquiry into Discrimination in Employment on the Basis of Criminal Record, the Nurses Board of Western Australia said:

The community's expectation of a nurse and the level of trust placed in a nurse by the community continues to increase. Nurses are consistently reported in surveys as being the most trusted professional and in fulfilling its obligations under the Act, the Board is cognisant of its responsibility in ensuring that view is not damaged. (Nurses Board of Western Australia, 2005)

These discourses of trust in, and of, the profession of nursing are central to the ethos of nursing and may go some way toward explaining the difficulty for nurses in acknowledging that there could be nurses who are willfully killing patients. Equally, however, they compound the issues surrounding the murder of patients by nurses and for this, if for no other reason, they need to be problematised in the Foucauldian sense. They are in need of, and in their own right, deserving of a deep consideration.

The part played by trust in enabling the murder of patients by nurses is exacerbated by the fact that in recent years nurses have become increasingly autonomous in their care of patients. They are often entrusted with a wide range of drugs, such as was the case with Waltraud Wagner:

'During the trial, Wagner testified that she had almost unlimited access to drugs in an unlocked medicine cabinet and that she began administering them on night shifts when doctors were absent. She said overworked nurses paid no attention. ' (Porubcansky, 1991, p.10)

Nurses are the people who provide care around the clock. This commitment reinforces the sense of trust but the texts constituting the discourses around the murder of patients by nurses reveal that this level of trust may itself be problematic, particularly with respect to the nightshift. Experienced nurses know that most deaths seem to occur on the night shift. This is some evidence that this is attributable to nature's ways. However, there can be no denying that it provides an ideal opportunity for those nurses bent on killing patients. An example may serve to illustrate this point:

[Vickie Dawn] 'Jackson is accused of injecting the victims with mivacurium chloride, used to temporarily halt breathing to insert a breathing tube. Authorities say all 10 patients died during Jackson's night shifts at the 38-bed hospital in late 2000 and early 2001' (Brown, 2005a).

The night shift can be a dangerous time for patients. Indeed, an entire book was written about the case of Genene Jones who worked the night shift and it was entitled *The Death Shift* (Elkind, 1990c). The case of Daisuke Mori in Japan provides another example – although less direct – of the preference for night shifts among those nurses who murder patients:

'Mori worked on the busy night shifts about eight times a month, two more than usually required, during which a nurse and nursing assistant team up to take care of some 10 in-patients. Mori would be in charge of drip infusions, according to sources at the clinic. Some nurses, including Mori, frequently used the operating room to prepare medicines. Mori was always happy to have direct or indirect involvement in operations, the sources said.' (Kyodo News, 2001b)

There is a connection between trust and the night shift in as much as there is generally less supervision on night duty. Anecdotally, nurses will say they enjoy the freedom of night duty – not least because it takes them away from the constraints of working with senior staff who are present during the day. With so much trust placed in nurses generally, it is difficult for most people to contemplate, much less actually believe, that medical murderers have been the most prolific serial killers in a number of countries. This was inferred in relation to the Letter case.

'Yesterday, however, the 27-year-old German went on trial in connection with the deaths of 29 patients in the biggest case of alleged serial killing in Germany since the second world war.' (Harding, 2006, p.18)

The bodies of texts construct a number of discourses here. There is the issue of the number of victims which usually will shock the public. Equally, however, that same public will buy more newspapers if the story involves more victims. The need for attention that characterises a high proportion of serial killers is fed by the publicity and the publicity is fed by the scale of the crimes. It is almost as if the media is hoping to set a record – the most murders by a nurse for this country or that country; the most prolific female or male serial murderer; and so it goes. It is difficult to ascertain which does more damage but both are powerful discourses. The literature on serial killers suggests at least the possibility that this encourages the serial murderer to be even more active. This is exacerbated by the employment mobility of these nurses.

Employment mobility of nurses

The bodies of texts relating to particular cases of nurses who murder patients suggest that employment mobility is a key factor enhancing and facilitating the seriality of nurses who murder. The texts construct a discourse around the ease with which it seems nurses are able to find new jobs no matter how poor their performance in the current or previous job. Within the bodies of texts there are many examples that support this proposition. For example Joseph Dewey Akin had allegedly been sacked no fewer than five times for falsification of qualifications:

'Barber said the suspect [Akin] had been fired from at least five hospitals and surrendered his licenses to authorities in the two states this month.' (*Chicago Sun-Times*, 1991, p.37)

This matter attracted considerable attention from the media. The texts relating to the case of Akin illustrates the extensive discourse in the media around mobility:

'Akin has been fired from at least five Georgia hospitals, usually for falsifying his educational background. He was suspended last week from his job as a research nurse at an AIDS clinic in Atlanta.' (AP, 1991b, p.4)

It was argued that the ability of nurses to hide behind their professional regulation, and the failure of regulators and employers to cooperate to safeguard the public, has made it easy for nurses who kill patients to move on before suspicion attaches to them and for them to escape detection.

Another factor exacerbating the situation is that of multiple jurisdictions which also enable nurses who are serial killers to move around to avoid the creation of patterns of killings or other conduct that might lead to suspicion.

'At North Fulton Regional, as many as 15 deaths accompanied suspicious code-blue incidents during Mr. Akin's employment. The GBI [Georgia Bureau of Investigation] has said it plans to inspect the records of all nine hospitals where Mr. Akin worked in the metro area.' (McIntosh 1992b, p.1)

One of the most disturbing aspects for the public in all of this was the repeated assertion in the media that a key factor enabling dangerous nurses to move from job to job is the fact that 'local hospitals and a state regulatory agency routinely will not discuss a nurse's employment record.' (Perl, 1991, p.1).

As with most matters of this nature, it is not confined to any one jurisdiction. As *The Sun's* banner headline reported,

'Nurse 'murdered' 13 in 3 hospitals' (Sullivan, 2002, p.18)

This was a reference to the de Berk case in The Netherlands which showed the capacity of dangerous nurses to move from one job to another in that country. In fact, in de Berk's case, she had also moved from one country to another. That was also true in the case of Roger Andermatt who moved between Germany and Switzerland (McDermid, 2005, p.13).

The case of Jeffrey Feltner is another that demonstrates the mobility of nurses who murder patients.

'In Ormond Beach, police Sgt. Ron Morgan said investigators plan to obtain an arrest warrant for Feltner in the death of Ruby Swisher, 81, who died June 21 at Bowman's Care Nursing Home, where Feltner worked for only one day. Bowman's administrator, Steve Moser, said Feltner was hired through Health Force, a national firm that arranges workers in the health care field. ' (AP, 1989a, p.1).

I have shown here that nurses who kill patients are able to continue doing so because of their mobility in employment, and this in spite of complaints, dismissals and general suspicions. Few can match the work history of Charles Cullen however. As Associated Press reported:

'Charles Cullen worked at 10 facilities over his 16-year career' (The Associated Press, 2004b).

Now, of itself, ten jobs in 16 years is probably not all that exceptional. However, it becomes little short of extraordinary when his performance is taken into account, as Associated Press highlighted in 2004:

'June 1987 to January 1992 -- Cullen works at St. Barnabas Medical Center in Livingston, N.J. The hospital said it fired Cullen, but declined to say why.
February 1992 to December 1993 -- Cullen employed at Warren Hospital in Phillipsburg, N.J. Cullen quits two months after he and other nurses are questioned in the death of a 91-year-old patient.
April 1994 to October 1996 -- Cullen works at Hunterdon Medical Center in Flemington, N.J.
November 1996 to August 1997 -- Cullen employed at Morristown Memorial Hospital in Morristown, N.J. The hospital says it fired Cullen for "poor performance.'" (The Associated Press, 2004b)

The texts reveal that nurses who murder patients are able to move from job to job, hospital to hospital, and it is clear that unsatisfactory performance – or even situations where a nurse is suspected of involvement in the deaths of patients – causes no impediment to the nurse's ability to move on and successfully obtain further employment as a nurse. The discourses relating to this mobility reveal much about the priorities of health care services. Even where a nurse is specifically suspected of involvement in death(s) of patients it may make no difference, as can be seen in commentary on the Akin case:

'Some key events in the case of former nurse Joseph Dewey Akin: 1990 - While Akin works as a nurse at North Fulton Regional Hospital in Roswell, Ga., 17 patients die. An investigation is begun, but no charges are filed. After seven months, he is fired for undisclosed reasons.' (The Associated Press, 1998)

There are of course many other examples. The case of Rosenfeld is another where a nurse who murders patients was able to freely move from one job to the next after being sacked.

'In five years, Rosenfeld was fired from 14 nursing homes. Some of his past employers said they received complaints from other staff members about his mistreatment of patients.' (Leisner, 1992)

Those complaints were evidently not communicated to prospective employers. It is clear from the discourses in the bodies of texts relating to these cases that the first instinct of health care agencies is to keep such incidents quiet. Little indication of such problems is provided to future potential employers – even when character and professional references are sought. However it is possible that new employers simply do not want to know. Beverley Allitt is a case in point:

In her behaviour as a student nurse, she had littered the hospital with warning signs – the faeces and fire in the nurses' home, the thefts from Ward Four, her history of imaginary illness – and even without knowing of these, other wards and other hospitals turned her away simply because she was not up to standard. She was hired on Ward Four, the parents and the nurses now knew, because they were desperate for staff. Once there she was left alone with children. No one had the time to supervise her (N. Davies, 1993a, p.345).

Employment mobility and the killing trajectory?

If, as argued above, the suspect nurses are unimpeded by employers from moving on then a countervailing discourse suggests that this is a more serious issue than it might otherwise be and organisations may have a greater culpability than they realise. Within the literature pertaining to serial murderers in general, there is a school of thought that maintains that serial killers who go undetected into their middle years – perhaps into their 50s – will burn out and simply stop killing because it loses its thrill. It is no longer satisfying (Alvarez & Bachman, 2003b; D. J. Sears, 1991). Against this, there is a more prevalent discourse that implies that nurses who are serial killers of patients will only stop killing when they are stopped. They will not stop of their own volition. Put another way, nurses who murder multiple patients usually will only stop if apprehended.

'Had Geen not been stopped, he would have gone on to kill again, said the senior investigating officer in the case, Det Sup Andy Taylor.' (BBC, 2006).

In this context, the discussion of age of nurses who murder in Chapter 5 becomes even more relevant. Moreover, within this discourse some voices – particularly those of the prosecutors – express the need to be alert to the possible existence of nurses who kill patients, and to resource investigations adequately even if those

investigations may be huge undertakings simply because of the scope of inquiry and investigation required. Of course, if such cases were detected earlier by more appropriate actions by employers, the investigations may assume a more modest scale. Discharging the burden of proof in such cases is an enormous challenge. There is a need to qualify this commentary by noting that it is the voice of the investigators, the police, who most vociferously articulate this perspective. No doubt they are as interested as any other party in achieving resolution of such cases but equally they have a vested interest in exploiting public fear to secure additional resourcing.

Failure to act on clues and cues

That nurses might murder patients is so far beyond the pale that most people, including the colleagues of those nurses who would murder patients, simply reject the possibility. At least, that is the impression given by the many discourses contained in mass media reports. This seems to have been the situation in the case of Waltraud Wagner:

'Max Edelbacher, a senior police investigator, said Tuesday that questioning of nursing personnel substantiated the assumption of "knowledge and suspicion" about the crimes committed at the hospital's First Medical Department. He said police got the impression staff members did not take rumors about the deaths seriously' (Prinz, 1989b).

The failure to take such threats seriously means that those nurses who do murder patients have an advantage from the outset in terms of their apprehension. There is a recurrent theme in the many accounts of particular cases that there were almost always cues that something was wrong with the particular nurse but these clues were usually not acted upon until the evidence was overwhelming – or in other words, until there had been a number of murders or related incidents that ruled out the possibility of chance or accident. One clear example of such a case was that of Beverley Allitt. This was a relatively early case in the life of this study that occurred in the UK and it was also a case involving the murder of babies. It therefore attracted huge coverage in the media. The body of texts relating to this case is vast and it reveals the consternation of the public that it could take so long to notice that babies were being murdered in a hospital. The question as to why the situation had not been resolved much sooner was the focus of a Commission of Inquiry. As *The Guardian* reported:

"The first point at which she might have been stopped was at her interview for selection for nurse training at Grantham and Kesteven hospital, where she had regularly attended casualty with apparently self-inflicted wounds. At the end of training, the head of the nursing school would have been required to sign an "evidence of good character" form. Without this a student nurse cannot automatically register to practise with the United Kingdom Central Council for Nursing, Midwifery and Health Visiting. Some heads of schools do withhold these forms and, in such cases, the council seeks further references and considers candidates individually. Apart from checking the nurse's registration status, a personnel officer would typically confirm a candidate's references and also ask for completion of a medical questionnaire. If this revealed evidence of concern, an occupational health specialist would be asked to vet the candidate. However, this would depend on the recruit volunteering such evidence. Employers are also required to check with the police on all staff who are to work with children, although such checks pick up only criminal convictions. Keith Johnston, spokesman for the National Association of Health Service Personnel Officers, said yesterday: "What we rely upon is individuals being honest. If they are not being honest, it comes down to picking up perhaps a gap in dates or something that doesn't seem quite right in the application or the medical questionnaire. "Philip Hunt, director of the National Association of Health Authorities and Trusts, said on BBC Radio: "The whole of the NHS has been absolutely shocked by this; all of us want to look at our procedures to make sure they are as tight as possible." (Brindle, 1993, p.4).

The Allitt and Wagner cases, of course, are by no means the only examples. The case of Joseph Dewey Akin should have set alarm bells ringing long before it did. There were plenty of cues that signalled that all was not as it should be and in this case it was the nurses who pointed out the aberrant number of emergencies:

'The six-month average code-blue number at North Fulton Regional was 12, but during the six months Mr. Akin worked at the hospital, 32 incidents were reported, the nurses told state investigators. Nurses at the hospital suspected that Mr. Akin was injecting patients in the critical care ward with drugs that manipulated heart rhythms. At least four types of heart drugs were stolen from the hospital while Mr. Akin worked there. The thefts stopped after he was fired in December 1990. While the GBI investigated the allegations, Mr. Akin moved back to the Birmingham area, where he grew up, and continued nursing. He was hired by Augmentation Inc., an agency that supplied hospitals with temporary nursing staff.' (McIntosh 1992b, p.1).

So far, the discourses considered here and constructed by the texts have been largely around failures of nursing staff to address suspicions about colleagues. The discourses around this failure are so strong as to clamour for examination and re-examination to seek an understanding as to how this could be so. Nurses are

professionals with professional responsibilities and a regulatory framework that could not possibly brook failures of those responsibilities. The responsibilities include reporting colleagues whose conduct falls below the accepted standards of practice. Nevertheless, it is clear from the bodies of texts and from the cases cited in the texts that failures do occur so it is reassuring that when it comes to apprehension, it is almost always other nurses who blow the whistle – albeit much too late – that leads to apprehension. This aspect, and the related discourses are discussed later in this Chapter.

Suspicious of Colleagues

Earlier it was noted that nurses themselves have trouble with the notion that colleagues could be murderers. This is so even where clues are present and where colleagues of the offender have their suspicions. No matter how deep their suspicions may be, however, nurses and other co-workers are profoundly reluctant to report their suspicions of a colleague. For example, even in the presence of considerable gossip, innuendo and rumour it took a long while for any action to occur with respect to the Akin case. The unacceptability of his conduct was minimised.

'He has his own ideas of how nursing should be practiced, and it's antagonized a lot of people everywhere he's been," Mr.Matteson said.'
(McIntosh & Montgomery, 1991, p.1)

Another factor in this reticence is what the professional nursing literature refers to as 'a code of silence'. Some commentators claim that there is a code of silence within all health professions – and nursing is not exempt – with respect to malpractice in all its forms. Writing an editorial in a nursing journal shortly after the Cullen case, Mason (2004) shares a personal example of the code at work:

One day, I arrived at work to find Rita's bed empty. Joan, the charge nurse for that shift, said Rita had choked to death on her secretions. [Rita suffered from amyotrophic lateral sclerosis and thus could move nothing but feel everything.] "She'd been through enough so I didn't suction her. She and her sister [who cared deeply and actively for her sister] are both better off this way." ...Haunted by my failure to report Joan, I struggled with why I had not done so. I was complicit in a code of silence well known among physicians but less recognized among nurses.' (Mason, 2004, p.11)

There are, of course, often real or perceived barriers to individual nurses voicing their suspicions about colleagues. That was so in the case of Waltraud Wagner and her accomplices:

'Edelbacher said she [Dorah Eugenie Ferrada-Avendano] knew of killings at the hospital two or three years before she first mentioned her suspicion last year. He said that as a single woman coming from abroad and having to look after a son, she was under constraint that made it hard for her to approach authorities' (Prinz, 1989b).

Relationships between Staff

The bodies of texts reveal a discourse relating to the significance of relationships between staff. The texts disclose that there are cases where relationships between staff – both professional and personal - have played a role in determining whether a nurse murders a patient. In some cases it is a personal relationship that plays a determining role. In other cases it is a professional relationship. The case of Genevieve Jones provides an example where both personal and professional relationships played a pivotal role in bringing about the murder of patients and in her case, the victims were infants or young children.

'Dr. Lawrence Hooghuis, who was a pediatric intern at Medical Center Hospital when Ms. Jones worked in the pediatric intensive care unit there, said he also felt his patients fared worse when he and Ms. Jones were not getting along. ... "The babies would more often have a downhill course if we (he and Ms. Jones) had a bad relationship.' (Allee, 1984)

In some cases, the safety of the patient is more contingent on the doctor/nurse relationship than might be expected. Sometimes this seems to amount to awareness without suspicion, or at least without intervention. That appeared to be so in the Japanese case of Daisuke Mori. It appears that the relationship between doctors and nurses in Japan clearly enabled problems to arise and to be swept under the carpet rather than addressed, if *The Daily Yomiuri* is correct (Kurita, 2005b; *The Daily Yomiuri*, 2001a)

Another example where the relationship between staff was influential in the murder of patients was that of Genevieve Jones and her relationship with Dr Holland (Elkind, 1990c).

Complicity or Culpability of other staff

As I have shown, both the public and nurses have difficulty accepting that a nurse could murder one or more patients. However, there are bodies of texts that reveal a discourse of complicity where other nurses are complicit either by omission or by commission. This may seem at odds with the discourse of whistleblowing discussed earlier but there is no inconsistency – it takes nurses a long time to blow that whistle and it is not all nurses who do so. There are occasions when nurses actively or passively contribute to the murder by patients by another nurse. One such case was the killing of William Neff by Heidi Tenzer. Other staff members, including a registered nurse, did nothing to prevent the patient's death. As the media reported:

'Three former workers at an assisted living center pleaded guilty Monday to neglecting a dying 83-year-old Alzheimer's patient who police say was kicked and stomped by one of their co-workers. Prosecutors said the three women failed to get help for William Neff for days after he was severely beaten by a frustrated nurse's aide at the Alterra Clare Bridge personal care home in Lower Makefield in 2000. (Caruso, 2003)

Tenzer had a diagnosed mental illness. For the others, it is much harder to establish why they did nothing to save the man at least some time in the days following Tenzer's assault on him. There are other examples of such conduct that both shocks and seems incomprehensible in all the circumstances. In this connection it seems appropriate to draw from the texts reporting the case of Tok Sun Han.

'Han was partially paralyzed as a result of a 1994 stroke, said her daughter, Micha Ko. Her mother spoke only Korean but could not speak that language often other than short sentences, Ko said. Ko said she first noted injuries to her mother on July 28. She noticed that her mother's bed was stained with blood when she picked up her mother to give her a bath. Her mother was bleeding from the vagina, she said. The nursing home staff could not explain the injuries, other than to suggest that the bleeding was caused by hemorrhoids, the daughter said. Three days later, the daughter said she noticed more bruises on her mother's face and body. The mother's neck was swollen, with a lump slightly smaller than the size of a golf ball, she said. She also noticed that the inside of her mother's mouth was cut and swollen. The daughter ordered her mother taken to St. John Medical Center, where she was treated in the emergency room and later admitted. A doctor and nurse testified that the woman's injuries were among the worst they had encountered. ' (R. W. Marler, 1997, p.9)

That these injuries were wilfully inflicted over a protracted period of days means that they could not have passed unnoticed but they certainly went unreported by staff of

the facility. It was left to the daughter to act on the obvious. This is a powerful and recurrent discourse and one that raises many questions that cry out for answers. Among these is how do health service organisations react to such occurrences in their midst. However, the question that is most strident in my mind is what keeps these nurses and other staff so quiet, and how do they reconcile that silence and inactivity first with their own conscience, and secondly with their professional commitment.

Organisational response to suspicions

The bodies of texts relating to the murder of patients by nurses reveal a discourse of denial and avoidance on the part of organisations, as illustrated by the issue of employment mobility of nurses who murder patients. The texts constructing this discourse show that often health care organisations are reluctant to believe or accept that a member of their staff could possibly be murdering patients or residents and consequently, the response of the organisation to reports of suspicions of such activity may be inadequate. Investigations conducted in-house appear to be an inadequate response to allegations, rumours, gossip or the like that raise questions of patient safety, given the frequency of examples of such investigations never going beyond the organisation. McIntosh and Montgomery in commenting on the Akin case, wrote:

'Georgia Baptist completed its investigation of death rates or emergency "codes" during the time Mr. Akin worked there and found no unusual patterns, a spokeswoman said. And a Grady spokeswoman said the hospital is not planning any investigation into Mr. Akin's activities there. Frederick Bailey, North Fulton Hospital's chief executive officer, said the investigators have pinpointed 18 patients who suffered mysterious code blues and said five deaths resulted from the codes. "It's possible some of those five can be attributed to the nurse, but there's no evidence to indicate he did anything," Mr. Bailey said. In the Birmingham case, nurses were suspicious about the patient's death, according to a statement from Cooper Green on Wednesday. "The nurses immediately reported [Akin] to hospital administration, and an investigation ensued," the statement said.' (McIntosh & Montgomery, 1991, p.1)

There is a perennial discourse revealed by the bodies of texts around the conditions that enable this form of homicidal activity to continue undetected for long periods, and it may be that the facilities themselves are complicit in this:

'Investigators suspected Akin in over one hundred deaths in the area over the past decade in twenty different facilities where he worked. However, many of those facilities had thwarted investigations.' (Ramsland, 1997)

There is revealed by the texts a strident discourse of dissatisfaction with organisational responses to suspicions about individual nurses. The case of Richard Angelo provoked considerable coverage in the media and much of that coverage focused on the adequacy or otherwise of the hospital's response to complaints and suspicions about Angelo. As the following extract shows, the family of at least one victim was dissatisfied with the organisational response. The family attorney points to the failings of the hospital that enabled Angelo to murder patients in his care:

'...Scollo of Lindenhurst, L.I., also charges in her complaint that the hospital was aware of the earlier death of another patient, John Stanley Fischer, on Sept. 8, 1987, who died of Pavulon poisoning and that her father's death could have been prevented had Good Samaritan Hospital conducted a proper investigation into Fischer's death. "This tragic case involving the wrongful death of Milton Poultney and the anguish inflicted on his daughter Carole and other members of his family is just part of the shocking pattern of neglect that has been countenanced by the medical establishment and Good Samaritan Hospital," declares Baron. "We are demanding that the hospital turn over to us any writings, letters and memoranda resulting from any investigation of Angelo concerning his hiring, his work at the hospital, and what efforts were made to check out his professional and personal credentials prior to his hiring," said Baron. "This hospital had a responsibility to properly monitor its mortality rate in the ICU/CCU unit," contends Baron. "But they failed to report the high number of these unusual deaths to the State Department of Health for investigation and they failed to take note of the death rate during the hours Angelo worked." (PR Newswire, 1988)

The organisation's conduct in the Angelo case may well have been a major contributing factor enabling Angelo's homicidal activity to continue. The texts suggest that the media seemed to think so and this served to keep it alive as current news. As the *New York Times* reported:

'Good Samaritan, a 415-bed hospital in West Islip, has come under scrutiny from the State Department of Health, which is investigating whether the hospital followed proper procedures in reporting unusual incidents involving its patients. (Gutis, 1987)

Such is the faith in nurses, and so incomprehensible is the notion of a nurse murdering patients, that patients may be disbelieved if reporting attempts on their

lives by nurses. That was the situation of one young German soldier when she tried to report an attempt on her life by Stephan Letter:

"The nurse also is charged with two counts of attempted manslaughter. In one of those cases, Letter allegedly injected an unauthorized anesthetic into a 22-year-old German soldier hospitalized after she was lightly injured in a fall. She recovered and was able to leave the hospital after briefly losing consciousness. Letter avoided arrest at the time only because the doctor did not believe the soldier's story, Koch said. ' (Pohl, 2006)

Although Barbara Salisbury was ultimately convicted of attempted rather than completed murder, the intent was the same. For this reason, it is relevant to consider commentary on that case in the British press. For instance, it has been suggested that the state of the health system and in particular the Leighton Trust may have been a key factor in enabling Salisbury to behave in the way that she did:

"The chief executive of Crewe's Leighton Hospital has been suspended as part of an investigation into hospital practices following the conviction of nurse Barbara Salisbury for attempted murder...Alan White, chairman of Mid Cheshire Hospitals Trust board, said in a statement: "In a confidential draft report the Healthcare Commission has made the board aware of its concerns relating to certain management systems and processes in the trust. As a precautionary measure the trust has suspended its chief executive Simon Yates whilst these issues are further investigated." ' (N. Irwin & Alison Barbuti, 2005, p.18)

These examples of texts clearly show that there is a perennial discourse in the media at least that may best be described as 'accountability'; there is a need to make someone responsible for failures to detect nurses who murder patients. When a nurse succeeds in murdering a patient, then apart from all the other sequelae, it may constitute a *prima facie* failure of the nurse regulatory authority in that jurisdiction.

Flaws in the Regulatory Framework

When a nurse murders a patient, the bodies of texts relating to such events reveal a discourse around a sense of betrayal that the public feels because of the trust relationship with nurses. They also feel that their government has failed them because the government sets in place the policy decisions and the regulatory framework that at least in theory, reflects social and political values. When a nurse can murder multiple patients in the face of that regulatory framework, the public understandably feels the government has failed them badly. This thinking seems to

inform discourses around the response of the employing organisations and the failure of regulation. That is to say, at least in some cases, the inadequacy of the organisational response has been attributed to the weak regulatory framework in the particular jurisdiction. This was so in Akin's case where the *New York Times*, citing state bureaucrats, reported that:

'Mr. Osten, who is responsible for enforcing the state's Hospital Code, said hospitals are required to report to the state any "unexpected death," or a death that occurs" outside the normal course of a patient's treatment or illness." The classic example, health officials said, would be if a patient dies after a tonsillectomy, a common operation that should not put a patient at risk of death. If that were to happen, hospital officials are required to investigate the incident and decide whether it should be reported to the state.' (Gutis, 1987, p.1)

Although this case occurred quite a while back, contemporary developments in clinical governance make it seem almost inconceivable that as recently as 1987 it should have been within the hospital's discretion to determine what constituted a reportable case. This discourse of perceived jurisdictional failures is not confined to the cases from the USA. It was argued that the Wagner case was a symptom of problems in the Austrian medical health care system (Porubcansky, 1991). Understaffing may be an issue for the specific organisation but in public health systems it tends to be an issue for government. In this case, the regulatory framework has failed to ensure that facilities comply with the law with respect to drug administration.

The discourses relating to the regulation of nurses emerge from an extensive body of texts which suggests that the issue has attracted a lot of attention from the media. The texts show this very clearly. For example, it was expressly argued in the press following the Akin case that the ability of nurses to hide behind their professional regulation, and the failure of regulators and employers to cooperate to safeguard the public (Perl, 1991, p.1), had made it easy for nurses who murder patients to escape detection and to move on before suspicion attached to them. Given my earlier comments on employment mobility, there would appear to be some justification for the media's stance on this issue. Moreover, the investigative authorities were reticent to identify Akin as a suspect even though the '*...police files have identified him as a*

suspect in more than 30 code blue emergencies at North Fulton Regional Hospital..' in a six month period (*Atlanta Journal and Constitution*, 1992b, p.2).

For the uninitiated, '*Code blue is the medical term for an emergency during which a patient's heart stops*' (McIntosh 1992b, p.1). The jargon of health professionals is indicative of the drama associated with medical emergencies and health professions. Nevertheless, the apparent protection of nurses by the regulatory authority appears to come at a cost to those patients who are consequently killed by these nurses. As the *Atlanta Journal & Constitution* went on to say:

'While everyone agrees on the need for a better system that allows hospitals to track nurses, the Georgia Board of Nursing says it takes no role in following employment histories. Nor will the board make public complaints about a nurse unless they result in a board action, such as revoking a nurse's license. "Our practice is not to confirm or deny an ongoing investigation," said Jack Sinks, a spokesman for the licensing board. So, no prospective employer could find out about Georgia's investigation into the deaths, nor would they know that Georgia Baptist Medical Center complained to the board in March 1990 that Mr. Akin had falsified his credentials.' (Perl, 1991, p.1)

Much has been said about the issue of the regulation of nurses. However, Brindle (1993, p.4) makes the point that no matter how effective the registration system for health professionals might be, it will not succeed in protecting patients against those who are bad. He writes that '*...the Allitt case shows how a registration system can be no guard against a professional who sets out to perform acts of wickedness - however many clues may be left along the way.*'

The foregoing discussion implies that there may be a range of factors that make it more possible for nurses to murder patients than it might otherwise be in the absence of those factors. They include the trust placed in nurses; the privileged relationship between nurses and patients; the authorisation of nurses to administer drugs to patients; the failures of health service organisation administrations; failures of legislative bodies; reticence of nurses to acknowledge the possibility of nurses murdering patients; and reticence of staff to report suspicions about other staff. The bodies of texts from the media contain texts that constitute discourses of the media that concentrate in a general sense on the breach of trust but outweighing this is the discourse of concern with an emphasis on failures on the part of administration and

regulation in allowing a situation to develop where a nurse can murder patients and not be apprehended until they have racked up a significant number of victims. The number of victims is a recurrent theme at a number of levels, most of which are subsumed by what I have chosen to refer to as seriality.

Seriality and Apprehension

Seriality, in the context of this analysis of the discourses and the texts that constitute them around the murder of patients by nurses, refers to the proclivity of those nurses for killing more than one patient. The discourse of seriality emerges strongly from the bodies of texts which dwell extensively on the serial nature of murder by nurses. As was clearly shown in Chapter 5, almost all cases of nurses who are apprehended for the murder of patients involve multiple victims. It seems that nurses are usually only detected when they have committed sufficient murders to create a visible pattern and this may take many murders. In the case of Charles Cullen, for example, the number was somewhere between 40 and 80 victims. The notion of a need for a pattern of murders before recognition or detection can occur is capable of sustaining alternate theories. It may be that nurses who murder never murder just one patient. That would be reassuring because it would mean that eventually a pattern would be detected in the case of every nurse who murdered patients and thus they would all be apprehended, although at considerable cost in terms of lives lost. However, the existence of cases where the nurse appears to have murdered just one patient may rule out this theory. If so, it may leave open the possibility of a second and alternative explanation – i.e. that nurses commonly murder just a single patient but are never detected because one victim does not a pattern make. By definition, there can be little evidence for this theory because it contends that where a nurse murders just one patient, that murder is unlikely to ever be noticed except where the method of murder lies well outside the scope of nursing practice and no plausible alternate explanation exists, as in the case where a nurse bashes a patient to death.

The detection of murder committed by nurses is inherently difficult because so much of the work of nurses involves a risk to the patient. Moreover, patients are vulnerable

to the extent that they are dependent upon nursing care and often they are seriously ill and the death of the particular individual may not be entirely unexpected. That nurses have ready access to a multiplicity of means of killing people compounds the problem. This is discussed extensively in Chapters 2 and 5. Thus, in a situation where nurses have abundance both of opportunity and of means, motive becomes critical because not all nurses who have opportunity and means choose to murder patients. As was discussed earlier in this Chapter, patients place their faith in nursing staff because their situation dictates that they must and they do so with confidence because they can, relying on the experience, reputation, integrity and regulation of the nursing profession. Clearly, not all nurses warrant this level of confidence. Motive, as was shown in Chapter 5, varies among the nurses who murder, but the range of motives is not appreciably different for nurses to those of any other group of serial murderers.

Characterisation as Serial Killers

The bodies of texts relating to the murder of patients by nurses contain many texts that construct a discourse of express seriality in the sense that I have earlier defined that term. It is not unknown for nurses who have been accused of murdering patients to be labelled as serial killers and for this to happen very early in an investigation or at least, early in the media coverage of the investigation.

In the case of Kristen Gilbert which occurred in Massachusetts, USA, Price wrote in the *Washington Times*:

'Kristen Gilbert, a former registered nurse at a veterans hospital in Northampton, Mass., stands accused of being a serial killer. The case of Mrs. Gilbert, charged Nov. 25 with killing three patients and trying to kill two others, is just the latest in a string of cases over the past two decades of multiple slayings involving nurses.' (Price, 1998, p.1).

In the case of Richard Angelo also, the Court was conscious early in the case, as the initial bail hearing showed, that Angelo may have been a serial killer although insufficient evidence had been gathered to sustain even a single murder charge at that stage.

'Judge Alfred C. Tisch of the Criminal Court denied Mr. Naiburg's first request that bail for the assault charges be set at \$5,000 and ordered Mr. Angelo held without bail, saying that Mr. Angelo "may well have perpetrated the largest series of mass murders in the metropolitan region, if not the nation.' (Gutis, 1987, p.1)

The seriality of Letter's crimes is indicated in the charges laid.

'Letter is charged with 16 counts of murder, 12 of manslaughter, and one of mercy killing, as well as two counts of attempted manslaughter. ' (Harding, 2006, p.18)

There is an awareness of homicidal nurses within some sectors of law enforcement.

"I have no doubt that there were more murders than these three," said Pinellas County Medical Examiner Joan Wood. No one thinks twice when a sick, old person dies in a nursing home, she said. Homicidal nurses can escape undetected for years, Wood said. ... Through exhumation and autopsy, authorities pinned one 1987 murder on Rosenfeld and two more in 1990. But there were probably other murders in between, said Wood. (Nohlgren, 1992b, p.1)

Perhaps Nohlgren's most significant comment in the context of this discussion is the following:

"It would be most bizarre to find a serial nurse murderer after he has only killed three people." (Nohlgren, 1992b, p.1)

This tells us a number of things, such as that we should expect substantial numbers of victims when a nurse is discovered who appears to murder patients. Just as importantly, at least from the perspective of detection, it tells us that statistics might play a very significant role in the detection of these nurses. The pattern is critical to detection. It is interesting that, even though the stereotypical nurse is female, Wood uses the male gender even though it is a generic reference.

The Role of Statistics

A recurrent discourse in the bodies of text revolves around the detection of these nurses who murder patients and in many cases attributes detection to the emergence of an unusual pattern of deaths in a hospital or among patients in the care of the offender. The literature contains many allusions to the part played by mostly very crude statistics in identifying these patterns. For example, a key indicator of whether a nurse is murdering patients in a particular facility might be an otherwise inexplicably high mortality rate. Although it is not common in the literature for

commentators to explicitly draw this conclusion, the discourses constituted by the texts within any particular article may point to such a situation within the case under discussion. This was evident in the Brazilian case of Edson Guimaraes where an inexplicably high deathrate in ICU attracted attention:

'Alerted, administrators as a test transferred Guimaraes to an outpatient unit on his next shift. The death rate in intensive care fell to zero. When Guimaraes returned three days later, on May 4, four patients died, even as police waited in a nearby office to make an arrest. A check of hospital records since has revealed that the unit's death rate doubled during Guimaraes' 12-hour shifts, from an average of just under two deaths to four or more, Silveira said. (Goering, 1999a, p.2).

A similar situation prevailed in the case of Genene Jones, where statistics were again an important pointer to her activities.

'Dr. Greg Istre, an investigator for the U.S. Centers for Disease Control, told the court that more children died or had recurring needs for cardiopulmonary resuscitation when Ms. Jones was working than when she was off-duty. Istre said 19 infants who required CPR died while Ms. Jones was attending them between January 1979 to June 1982. An additional 37 had CPR but survived, He also told the court he found an increased incidence of deaths in the pediatric intensive care unit during the evening shift when Ms. Jones was on duty. "We associated Nurse 32 (Ms. Jones) with increases in deaths and CPRs during the epidemic period,' he said.' (Allee, 1984, p.54)

There are many other examples of this recurrent theme. Statistics played an important part in the detection of Benjamin Geen, for example:

'Suspicion fell on Geen when it emerged they [respiratory arrests] had all taken place while he was on duty.' (BBC, 2006)

Statistics also played an important role in securing the conviction of Lucinda de Berk, although it needs to be borne in mind that the statistics played no part in the detection of her murders and attempted murders, which was based on a single case of a baby dying unexpectedly. However, this does not erode the importance of statistics in identifying any departures from the norm and as such, they are an indicator that health services should bear in mind and monitor. The statistics will sometimes find their way into court in other guises, as in the case of de Berk:

'An expert told the initial hearing that statistically the chances of one nurse being involved with so many incidents of sudden unexplained death or resuscitation was "one in 342 million".'. (de Hemptinne, 2004)

In the Austrian case of Waltraud Wagner and her group, statistics were again an important factor in pointing to the nurses involved in murdering patients:

Close observation of the wards by worried doctors revealed that the number of deaths in the internal medicine clinic was always higher when certain nurses were doing a night shift. (The Seattle Times, 1989, p.2)

The case of Orville Lynn Majors is another example of the statistics demonstrating that something other than natural causes is killing patients.

'They also commissioned a study by a Washington, D.C.-based epidemiologist, who found that patients were 42.96 times more likely to die while Majors was on duty.' (Stone, 1998, p.33).

The same case was reported by Kelly (1999) who noted that:

'A study by a nursing supervisor that prompted the state's \$1.5 million criminal investigation won't be admitted as evidence in the trial. It showed Majors had been on duty for 130 of 147 deaths in the intensive care unit from May 1993 to March 1995. (Kelly, 1999a).

The body of texts constituting this discourse of patterns and statistics is loud and perhaps indicates the need to resort to science not merely to detect nurses who murder patients but also to convince people that this can happen. However, statistics rely on the power of numbers and it is unacceptable that so many people have to die before the numbers are considered 'significant' or to constitute a pattern. The language of science may not be sensitive to the individual but it does need to be more sensitive to the murder of patients by nurses.

There are many texts that report aspects of the case of Joseph Dewey Akin and concentrate the discourse in terms of numbers of victims. Reports of Akin's case have been used extensively here to demonstrate the nature of this discourse but there is no suggestion that his is an isolated or unusual case. It is true that there were fewer reports located in relation to the case of Edson Guimaraes but this is likely to have had more to do with the fact that this study was limited to reports in the English language and Guimaraes was a Brazilian. There were other nurses that would have served as well as Akin in this connection. For example, *The Times* reported that four nurses:

'...are accused of murdering at least 44 patients aged between 73 and 82 who were in their care at Vienna's Lainz Hospital. The murders are said to have taken place over several years and the real number of dead may be as high as four hundred' (Amiel, 1989).

There were, of course, many other reports in English in relation to this extraordinary case which centred on Waltraud Wagner, and frequently the emphasis of the texts was on the numbers. Much more of the commentary in the literature on this case would have been in languages other than English of course. Similarly, Swiss nurse Roger Andermatt's case was widely reported and again, at least in the English language commentary, numbers of victims was a prominent discourse within the reports. For example, (Associated Press, 2001b) reported that:

'Under interrogation, Andermatt confessed to 18 other killings, including 12 in a home for invalids in the central Swiss town of Sarnen, investigating magistrate Orvo Nieminen told a news conference in Lucerne.'

The discourses imply that a pattern emerges in the absence of statistical analysis. Intuitively, experienced staff know when more people are dying than is usual, and whether there is anything suspicious about spikes in the number of deaths, cardiac or respiratory arrests, or other medical emergencies. They also know if anyone is associated with such spikes, whether legitimately or otherwise. A key factor here is numbers because numbers add up to patterns and these are more convincing than suspicions.

Donald Harvey's case is typical insofar as he claims many more victims than just those for whose murders he was convicted.

Although he now claims as many as 87 victims, mostly at hospitals in Cincinnati and Kentucky, prosecutors and his own attorneys doubt the figure is so high. Still, they acknowledge it may be higher than the 37 murders Harvey confessed to a decade ago as part of a plea bargain. (Horn, 1997, p.1)

The texts that constitute the discourse around inflating the numbers is consistent with that of the discourse of the need for attention. Stephan Letter, too, was involved in multiple deaths.

'Stephan Letter is accused of murdering 16 elderly patients in his care at a clinic in Sonthofen, Bavaria, and causing the deaths of 13 others by injecting them with lethal drugs..' (BBC News Online, 2006)

The final number of murders for which de Berk was convicted was seven completed and three attempted. (GDH, 2006).'

There is clear evidence that Graham and Wood intended to kill many more patients.

'...former nurse's aide Catherine Wood, pleaded guilty to one count each of second-degree murder and conspiracy to commit murder...said during the hearing that she and Graham discussed killing up to 20 patients during their overnight shifts at the nursing home' (Perlman, 1989e).

There is little doubt that Timea Faludi was involved in causing or hastening the deaths of as many as 40 elderly patients.

'Timea Faludi was arrested in February 2001 and admitted to helping up to 40 terminally ill patients die during the previous year by administering lethal overdoses of morphine and other painkillers.' (Reuters News, 2002)

The story is similar in the case of Richard Angelo who almost certainly would have continued killing patients until he was detected. He was ultimately detected, but not by his colleagues. It fell to a patient – an intended victim – to catch Angelo.

'It was that 73-year-old patient, Gerolamo Kucich, who first caused concern at Good Samaritan, when he reported to another nurse that a man fitting Mr. Angelo's description had entered his room and injected a substance into his intravenous tubing, bringing about an almost immediate feeling of paralysis and eventually causing him to go into respiratory arrest. Mr. Kucich survived the incident and testified before a Suffolk grand jury, which voted to indict Mr. Angelo, who lives in Lindenhurst, on three assault charges.' (Gutis, 1987, p.1)

There were suspicions of additional deaths attributable to Van Oort too but no evidence was tendered to support the suspicions (Pitt, 2003).

The patterns that emerge are varied as the patterns in snowflakes. The disruption of a pattern when a murderer leaves a place of work may not be lost for the pattern may resume. However if the information is not accessible and shared then the information is lost and the pattern has to slowly develop again before it is recognised. Unfortunately the hapless constituents in this pattern making game are patients.

Charges/Convictions vs Actual Number of Murders

There is a discrepancy between the number of deaths of which the nurses in this study are accused, or at least suspected, compared with the number for which they are eventually convicted or even charged. In most cases involving nurses who murder patients, the defendants are suspected of more murders than those for which they are charged and convicted because it is notoriously difficult to obtain sufficient evidence to secure a conviction with respect to any given death. The bodies of texts constitute a discourse of cataloguing the number of charges and comparing this with the number of suspected murders. What is interesting about this is that the texts are relatively silent as to whether it is satisfactory that so many murders committed by these nurses are not the subject of conviction and penalty.

Catherine May Wood and Gwendolyn Graham are a good example of the difficulty of gaining evidence to secure convictions and the reports of their respective cases are riven with texts related to this discourse.

'Both bodies were exhumed last week, but autopsies have proven inconclusive. Both aides had received good marks from patients and neither was fired, nursing home officials said. Walker Police Chief Walt investigated and that more charges against the two women were likely. He said he did not know if any other bodies would be exhumed.' (Perlman, 1988)

The cases of Wood and Graham makes it very clear that there is a disjuncture between perceptions and suspicions around the numbers of victims, and the number of deaths for which convictions can be secured. The reality is that nurses who murder patients are rarely charged, tried and convicted on all of the murders they have committed:

"There will be no additional indictments of Gene Jones," Bexar County District Attorney Sam Millsap said. "No useful purpose will be served. I think [she] will spend the rest of her life in jail." Jones, 34, was found guilty Wednesday of injuring 4-week-old Rolando Santos with heparin, a powerful blood-thinning drug, and was sentenced to 60 years in prison. Jones was convicted in February of murdering a 15-month-old girl with a drug injection and sentenced to 99 years in prison.' (*The Washington Post*, 1984).

The investigation was drawn to a close and the community were left feeling abandoned (Elkind, 1990c). Although Gene Jones has not been granted parole on the occasions she has requested it she is due for release in 2017. As with these other

cases, it is possible that in the van Oort case, there should have been at least one more conviction but again there was a lack of evidence.

'A second murder charge against a former nursing home worker was dismissed Wednesday after the Sioux County Sheriff didn't provide evidence requested by the county attorney. Christie Van Oort, 26, of Rock Valley, is charged with first-degree murder in the choking death of Dick Post, 87, who died at Valley Manor Nursing Home in April 2002... (AP, 2003h).

Daisuke Mori, too, was charged with fewer murders than he was suspected of having committed. In the case of Joseph Dewey Akin, at the time he was charged in Alabama, he was under investigation for other matters by the authorities in Georgia.

'At the time , Mr. Akin was under investigation by the GBI in medical emergency incidents at North Fulton Regional Hospital in Roswell. During the investigation of Mr. Price's death, Birmingham investigators said they suspected Mr. Akin might have injected other patients, but he was charged and indicted on only one count of murder. (McIntosh 1992b, p.1).

When the charges are limited, then reports of those charges can carry with them an implication that the crimes with which the person is charged are the extent of their crimes and can thus make the offender seem much less dangerous.

'Joseph Dewey Akin...is charged with murdering one patient in spring 1991 at hospital in Birmingham' (*New York Times Abstracts*, 1991, p.12).

This remains the case even where the offender is suspected of involvement in multiple deaths and the discourse of being convicted of only some of their actual tally of murders is pervasive:

Privately, however, sources familiar with the case say that - especially given the fact that investigators have already been working on the case for two years. "It's a critical care unit and not everyone who died there died at the hand of Kristen Gilbert," one source said.' (Ranalli, 1998, p.25).

Even if deaths are to be expected in a critical care unit, those that are unwarranted need to be exposed. The following comment adds perspective:

'Although she was charged with just four murders, investigators believe Gilbert was responsible for dozens of other deaths on the ward, which would make her one of the most prolific female serial killers in U.S. history.' (Contrada, 2003, p.1)

There are a number of issues that flow from this undeniable pattern of under-conviction. It means, for one thing, that many families never obtain closure on the death of a loved one. The discourses suggest that those families where convictions are not secured with respect to their family member are likely to harbour suspicions and to feel that the offender has not been adequately punished. Davies in an admittedly dramatic account describes the reactions of family members at the trial of Beverly Allitt, and the reactions illustrate this point:

On the charge of murdering Liam Taylor? "No verdict." Joanne Taylor hangs her head. On the charge of murdering Tim Hardwick? "No Verdict". It is becoming hard to breathe in court number one. On the charge of attempting to murder Kayley Desmond? "Not guilty". This room is now poised on a knife edge. On the alternative charge of causing grievous bodily harm to Kayley Desmond: Everything hangs on the next word. "Guilty". Now the whole room gasps as one. She's guilty – the word the parents have waited two years to hear. The jury believe she did it. And she did: Bev Allitt did it. The parents faces are set in stone as the clerk of the court reads on. No verdict on Paul Crampton, nor on Brad Gibson – then guilty again of causing grievous bodily harm to Henry Chan.

And now another murder charge – the death of Becky Phillips. The clerk reads the charge, the foreman looks once at his notebook and says 'Guilty'. This time, it is a strangled cheer which leaps up from the public gallery ...' (N. Davies, 1993a, p.349).

The bodies of text constituting the discourses around murder of patients by nurses do not suggest complacency on the part of anyone in relation to this phenomenon and the texts constitute a consistent discourse around the numbers of victims. For example, it is clear in the case of Donald Harvey that law enforcement officers and lawyers are no less shocked by serial killers than are the general public:

'After listening to Harvey's casual, concise description of the crime, attorney William Whalen put down his legal pad and leaned forward. "I have to ask you, Donald," he said. "Have you done this before?" Harvey fixed his eyes on his lawyer and nodded. "How many times?" "I could only estimate," Harvey told him. Whalen hesitated a moment and took a deep breath. Then he asked his client to pick a number. "Seventy," Harvey said' (Horn, 1997, p.1).

Apprehension

Apprehension is used here to refer to the arrest and detention of the nurse until their trial or release. Elsewhere in this Chapter, I have made the point that nurses who murder patients tend to be apprehended almost always when a pattern of deaths is identified. There are of course some exceptions. There is the example of Dutch nurse Lucy Quirinda de Berk who was apprehended after suspicion was triggered by just one sudden and unexpected death.

'Suspicion was first aroused when a five-month-old baby died unexpectedly in September 2001, just after de Berk had gone off-duty' (de Hemptinne, 2004).

Even acknowledging the exceptions, it does seem that apprehension usually is precipitated by a realisation of abnormally high numbers of unexpected and inexplicable adverse incidents with poor outcomes. Put another way, there seems to be a pattern of deaths that is either abnormally high or unusual in some other respect such as there being no obvious explanation (BBC, 2006).

The discourses around the apprehension of nurses who murder patients are interesting but it is the cases that are exceptional that provide the most fertile bodies of text in this regard. Some examples of those cases may assist in explicating this. There can be no doubt that cases of nurses who murder patients are difficult to detect and in the case of Wagner *et al*, it was a chance conversation that triggered an investigation.

"Austrian police said Monday that a conversation between a doctor and a nurse at Vienna's Lainz alerted the doctor to what has been described as the biggest case of its kind in European history." (*The Seattle Times*, 1989, p.2)

The case of Wagner *et al* is unusual in many respects, including the way the nefarious activities of the nurses came to light.

'...The case broke in April 1989 after an elderly patient nearly died from an overdose of insulin although not suffering from diabetes. That case and earlier unexplained deaths or near-deaths led to the arrests.' (Jahn, 1991)

In the case of Gwendolyn Graham, it was the ex-husband who brought the matter to police attention, and it was his actions that ultimately led to investigation, charges and conviction.

'For 14 months, Wood, an unemployed auto worker, had kept his ex-wife's secret. Finally, he went to the Walker police and told them what Catherine Wood had told him: Mrs. Wood and Graham, Alpine Manor employees who had become lovers, had done "terrible things together." They had suffocated elderly patients in their sleep. Mostly they did it for fun. In one case, they sought to put a 98-year-old patient out of her misery (Reed, 1989, p.1).

Sometimes the apprehension of a nurse who murders patients is completely serendipitous. In the case of Donald Harvey it was the work of a very alert assistant coroner.

A short time later, Harvey's career as a serial killer was over. His undoing was an assistant coroner who noticed the faint scent of almonds – the tell-tale sign of cyanide – while performing an autopsy on Drake patient John Powell (Horn, 1997, p.1).

The murder of Willie May Ryan could have passed unnoticed, her significant injuries passed off as the consequences of falling out of bed, were it not for a physician.

Afterward, Ryan was left alone in her room for nearly 2 1/2 hours before Rainey reported that she was bleeding and having problems breathing, according to court records. A police officer initially thought Ryan sustained her injuries in a fall from her bed, but an emergency room physician later determined they were caused by a beating.' (Bowers, 2004, p.15).

The van Oort case is unusual because it is a case where the nurse would have gotten away with the murder of a patient except for her own admissions of guilt.

An investigation at the 95-bed community-owned center found that nothing appeared improper about his death. The death certificate listed cause of death as unknown. Van Oort was arrested in December 2002 after she made a statement to investigators that she deliberately killed Post. In January 2003, Post's body was exhumed and autopsy results indicated he died from airway obstruction, probably with food. Van Oort was recently charged in the death of Rolena Vande Vegte, 91, also a Valley Manor resident. That charge was dismissed but may be refiled.' (AP, 2003d)

In Akin's case it was reportedly nurses who brought the matter to the attention of authorities when they began to piece together suspicious events.

'Akin came under suspicion when other nurses at North Fulton Regional Hospital in the Atlanta suburb of Roswell began noticing that an unusual number of patients suffered unexplained and life-threatening heart

complications while under Akin's care, according to a copyright story in the Atlanta Constitution.' 'Nurses at the hospital reported several kinds of heart medications were stolen from drug supply areas at the hospital. (*The Toronto Star*, 1991b, p.3)

The case of Orville Lynn Majors is another example where it was the actions of nurses that brought the murders to light.

'A study by a nursing supervisor that prompted the state's \$1.5 million criminal investigation won't be admitted as evidence in the trial. It showed Majors had been on duty for 130 of 147 deaths in the intensive care unit from May 1993 to March 1995' (Kelly, 1999a).

On the basis of these and many other examples that could have been included, I find it difficult not to draw a conclusion that, in the overwhelming majority of cases, nurses who murder currently only come to light as a consequence of serendipity. One likely corollary of this is that there may be many more nurses engaging in the same kinds of activity who go undetected and unapprehended.

The Killing Trajectory

Concern with apprehension is a key component of the bodies of text that constitute much of the discourse around nurses who murder patients. The main emphasis is on the length of time that a nurse is able to continue killing patients, a period that I have elsewhere in this dissertation referred to as the killing trajectory. Commentators are often concerned with the length of the trajectory. For example in the case of Charles Cullen that trajectory was some sixteen years. There was a clamouring in the texts reporting this case for an explanation of how this could be so. This capacity for nurses to continue murdering patients over protracted periods of time is exemplified time and again, as in Gilbert's case.

' Even Phelps was surprised by certain aspects as he researched the macabre series of killings. "What surprised me was that this went on for seven years and she got away with it for so long," he said. "No one noticed until the end and someone should have" (Lenker, 2003, p.4).

The case of Jeffery Feltner, too, involved the deaths of several elderly patients over a protracted period of time. When it looked like no one was going to catch him,

'...he made anonymous phone calls to officials saying the seven patients did not die of natural causes but were strangled, some people didn't believe his tale. Although investigators were initially skeptical, authorities now say they

believe Feltner asphyxiated the seven patients over an 18-month period to ease their suffering' (AP, 1990).

As will be obvious from the discussion thus far, there are many more examples of these nurses having long killing trajectories. The bodies of texts construct little in the way of discourses directly on this point. It tends to be subsumed as a subset of the other more extensive discourses such as the failure of the profession and the health services that I have mentioned previously.

Nurses as Whistleblowers

The need for a pattern to emerge before detection is possible may hold a clue to the answer to the question of how could these nurses have such long killing trajectories, but what is of more interest in the current context are the discourses around how these nurses come to be detected. For instance, what role do other nurses play in the detection and apprehension of nurses who murder patients? The answer to this appears to be that it is a vitally important role. How can this be so if it takes so long to detect these nurses? The discourses tell us that nurses are almost always involved in the exposure of a nurse who is killing patients. This was certainly true in the case of the detection of Brian Rosenfeld whose apprehension came about expressly as a consequence of intervention by nursing colleagues:

'Rosenfeld was arrested in August 1990, after two nursing aides saw him inject a strange substance down the feeding tube of an 80-year-old Muriel Watts, a comatose resident of Rosedale Manor. An autopsy revealed that her stomach and blood contained lethal amounts of a powerful, unprescribed tranquilizer - Mellaril. ' (Nohlgren, 1992a, p.1)

German nurse, Stephan Letter, also came to notice as a result of reports by his nursing colleagues that drugs were missing (Pohl, 2006). Letter was subsequently charged and convicted, thus becoming Germany's worst serial killer since World War II. There are of course many more examples of this discourse constructed by the texts from reports of such cases. The place of nursing colleagues in the apprehension of nurses who are murdering patients is clearly critical but it might be more reassuring if it did not take so long. It is clear from the accounts of the cases that nurses who murder patients will not be detected until their colleagues not only

become suspicious but are prepared to 'blow the whistle'. That was so in the case of Akin:

"It's one of those things where we have suspected homicide since March 28," Captain Gaut said. "It came to our attention through a nurse there in the hospital who raised a red flag." He said the nurse would be a key witness in the prosecution. (Yardley, 1991a, p.1)

Evidence was provided by nurses as to the conduct of Akin and their suspicions. This, however, tells us little about what those nurses thought in terms of the impact of the actions of this nurse on patients, their profession and their employer. Within the texts the preoccupation is with the murderer. It was nurses who drew attention to the increased levels of emergency situations on Akin's shifts. The nurses in this case illustrate very well the bind of suspecting a colleague but not quite believing that anyone could be capable of it. It takes time for even suspicion to emerge and consolidate into the confidence to articulate it, and this will usually happen first with colleagues then with officialdom.

Akin's colleagues at North Fulton told hospital administrators that in the months Akin worked there, there were significantly more "code blue" incidents of sudden coronary distress (*Houston Chronicle*, 1991, p.8).

and

'His nursing colleagues at that hospital presented evidence to officials of North Fulton Regional Hospital that there had been more than twice as many "code blue" cardiac emergencies when Akin was on duty as during other periods (*Chicago Sun-Times*, 1991, p.37).

The Akin case demonstrates the vital role of other nurses and health professionals in the early apprehension of nurses who murder patients. There are a number of examples of cases where nursing colleagues have become suspicious and begun a process of gathering data in the form of ward statistics that eventually show a pattern of deaths on the shifts worked by the suspected nurse.

'Four nurses at North Fulton Regional Hospital, suspicious of an extraordinary number of intensive-care patients who developed sudden heart failure, compiled medical records that led to a GBI investigation of a fellow nurse.' (McIntosh & Montgomery, 1991, p.1)

There were obvious indications that the code blues involving Joseph Dewey Akin were excessive. Experienced nurses know that such distortions in the absence of obvious explanations are usually not accidental. However, the distortions will usually have to be fairly significant before they will provoke colleagues into action.

'There seemed to be no pattern to the code blue emergencies that Joseph Dewey Akin kept becoming involved in. The patients, all of whom suffered from sudden, severe, heart problems, ranged in age from 17 to 66. They were both sexes and all colors.'

'When the hospital had [nine deaths] in as many days last December, the nurses in the critical care unit went to state officials with their suspicions.' (McIntosh 1991a, p.8).

When nurses do blow the whistle, there is unlikely to be a lot of support for them. There is always the possibility that an abnormal number of codes is occurring for legitimate reasons and blowing the whistle could be a life-destroying mistake. Examples of such mistakes are discussed later. The bodies of texts around the murder of patients by nurses illustrates a significant awareness of this possibility. The number of prosecutions that fail for lack of evidence may also be a deterrent. The circumstances in which nurses are likely to expose a suspected colleague are not readily apparent from the texts that constitute this discourse. The examples considered so far in this section share little in common besides the large numbers of murders or attempted murders that are required to reveal an apparent pattern.

So far in this section I have focused on a few cases involving the exposure of the murderer by their colleagues. Akin, Letter, Majors and Rosenfeld were exposed by colleagues. A perusal of Chapter 3 will demonstrate just how many of these nurses who murder patients are exposed by their nursing colleagues.

It is clear that these extracted texts constitute a powerful discourse around the colleagues of a nurse who is murdering patients being the most likely individuals to first notice a pattern of behaviour or unexpected adverse outcomes and to bring the matter to the attention of authorities. It may be that this discourse is one of reassurance. The actions of the nurses in such circumstances restore the faith and confidence of the public in the 'normal' nurse. It seems likely that it is for this reason that the characteristically long periods during which suspicions are harboured, but no

action is taken, manage to escape the attention of that very same public. It may also be difficult to risk making an enemy of someone that you regard as a murderer when there is an element of the roulette wheel about the relationship.

Embedded in the texts there is a discourse around the failure of legal proceedings to achieve the necessary outcome following the exposure of a colleague and around the potential sequelae of such situations. Along with this is a discourse of more general failure of organisations to react that is canvassed extensively in Chapter 8. At a unit level the staff can be split as in the case of Genene Jones. Half the staff supported her and believed that she was being treated unfairly; these nurses put considerable pressure on the staff that were suspicious and voiced their concerns. This discourse is also evident in Letter's case where one of his prospective victims was simply not believed when she raised the alarm.

It is equally evident in the procedural failures in investigations such as the the lack of an autopsy in one case that would have revealed the activities of Brian Rosenfeld (Nohlgren, 1992b, p.1). It will be evident from the shape of these discourses that there are many barriers to the apprehension of nurses who murder patients. It is demonstrated in the Rosenfeld case.

The Giving of Evidence

If the detection and identification of the offender in cases of medical murder by nurses almost always requires nursing colleagues to become whistleblowers, then the bodies of texts indicate that the conviction of those nurses will almost certainly require testimony from those same nursing colleagues.

'At Akin's trial, Marion Albright, [the victim's] assigned nurse, testified that when she came back from lunch she saw Akin walking out of [the victim's]room' (Ramsland, 1997).

As I have shown here, the discourse around exposing suspected colleagues asserts that it is crucial to the identification of killers within their profession. Akin's case exemplifies this. However, there is a subsidiary discourse that reveals that nurses can also be a liability in such cases; for example in Akin's case it was the nurses who brought the prosecution case undone by giving conflicting evidence.

'Nurses have given conflicting testimony on where Mr. Akin was and what he was doing before the code blue incidents in question.' (McIntosh 1992a, p.2).

Notwithstanding the jeopardy that nurses can sometimes create for the prosecution, it is clear that they assist more successful prosecutions of nurses who murder than does any other section of the health service. This does begin to assuage the damage done by nurses who murder to the reputation of the profession and perhaps contributes to the maintenance of the confidence of the public in the nursing profession. Notwithstanding the value of nurses giving evidence, the most damning evidence will be that which comes from the mouth of the offender in the form of confession.

The Role of Confessions

Confession generally comes after detection so it is more properly, and more extensively, considered under the heading of Evidence. However, its relevance here lies in the fact that there have been cases of nurses who have confessed to murdering patients but, because it is such a far fetched notion, they simply have not been believed. Thus, even a confession may not be enough to immediately result in the apprehension of a nurse who murders patients.

In June 1988, Feltner anonymously called a Gainesville television station and a mental health crisis center and told them he had killed five patients. But when questioned by detectives, Feltner denied it. He eventually pleaded guilty to making harassing phone calls, trespassing and making a false statement. He served a 127-day sentence and was freed Nov. 19, 1988. Feltner followed a similar pattern last summer. He told a Daytona Beach TV station, a mental health unit and his roommate about the most recent death. This time, when Daytona Beach detectives questioned him, Feltner told them about all seven killings, explaining that he did it to relieve the victims' suffering. But now he denies the killings. (AP, 1990)

Feltner was convicted on corroborating evidence but he was not the only one to endure the frustration of being disbelieved. The texts around numbers have been discussed elsewhere. It is not just the health service facilities that value the statistics. Those nurses who are serial murderers, like most other serial murderers, are prone to maintaining their own statistics too. Other nurses who have confessed their murders and not been believed include Charles Cullen (perceived to be inflating the numbers) and Donald Harvey (who confessed once to drinking mates who did not believe him,

and later after he had been convicted primarily because, like Cullen, he was inflating the numbers). The bodies of texts around confession are extensive and the discourses constituted by the texts within are complex and multi-layered. I explore them more fully elsewhere in this work.

The Nurse who only kills once

Although the emphasis thus far has been squarely on those discourses concerned with nurses who are serial killers of patients, there are a minority of cases where the offenders are likely to have killed only one patient. These rare cases are usually qualitatively different to the serial killer in terms of motive, method and post-murder conduct. The apprehension of a nurse who murders only one patient is likely to come about only in the presence of other circumstances and generally where there is collusion with another person. In the Kanner case it was the involvement with the patient's husband together with the commission of other crimes that led to her apprehension.

' Cuyahoga County Coroner Elizabeth Balraj, MD, initially ruled the death accidental, but about a year later the coroner later classified the death a homicide after North Royalton police came forward with new information. Kanner had come to police to report theft of rings John Amberik had purchased for her while Darlene Amberik was still alive. Synenberg said Kanner and John Amberik developed a relationship that grew initially from common concern for Amberik's wife. ' (*Health & Medicine Week*, 2004, p.523)

The body of texts relating to nurses who murder only once is relatively very slim. This is not the stuff of news headlines, especially in countries where murder is rife, as is the case in the USA for example. The discourses constructed by this body of texts are weak but we need to consider whether this is because nurses either murder serially or not at all, or more likely, the nurse who murders once is not detected and thus does not make the news. Nevertheless, a small number of cases involving only one victim emerged in this study.

When Nurses Conspire to Murder Patients

In other cases where there is more than one defendant, such as those of co-accused Wilson and Rainey, co-accused Graham and May, and Wagner et al, there are multiple murders and there is almost always other criminal activity involved; there may be a sexual relationship between the co-conspirators, and there appears to be a leader and the led i.e. there appears to be skewed power relationships. The bodies of texts relating to the murders of patients where there is a conspiracy receive a more detailed treatment elsewhere in this Chapter.

Legal Complexities

A range of factors complicate the process of investigating murder of patients by nurses. These factors include the scale of the investigation which increases with the number of victims (AP, 1991c, p.4); potential legal complexity; the criminal/civil law divide; and the place of evidence. The texts constitute discourses around each of these considerations.

There are many elements in both criminal prosecutions and any civil processes that may proceed against a nurse who murders patients. To demonstrate the complexity of these proceedings, the case of Joseph Dewey Akin serves admirably. Akin's final guilty plea to manslaughter in 1998 was the consequence of proceedings lasting seven years involving a trial at which he was convicted of murder, a successful appeal leading to a new trial, an unsuccessful appeal against the successful appeal, the new trial that resulted in a hung jury (no decision) necessitating a third trial. Akin pleaded guilty to the lesser charge rather than chance a third trial. Ironically, Akin was freed a few months later due to the benefit of some new legislation.

Little if anything is straightforward in the law which constitutes an overt exercise of power. The body of texts in relation to the van Oort case constitute a discourse relating to the place of politics and procedure, revealing how the politics and procedure of the law may be a greater determinant of outcome than the crime itself. It may also be an example of the difficulty for a low income nurse's aide to secure appropriate legal representation " (AP, 2003d, 2003h; Pitt, 2003)

An additional layer of complexity in the legal proceedings flows from the institution of civil suits by families of victims and survivors of murder attempts. The discourse around the potential for civil suits against these nurses is extensive and actions typically include, for example, wrongful death, negligence, assault. From the opposite perspective, Susan Nelles – against whom all charges were eventually dropped – mounted a successful action for malicious prosecution. The object of civil litigation is compensation. This discourse is interesting because it potentially places personal enrichment ahead of the punishment of the offender as the key outcome. Relatives of those who are murdered by nurses see it as an opportunity for what they would construe as ‘just compensation’.

The Charge

Within the bodies of texts there are constituted significant discourses concerned with the charge or charges laid against the nurse who is accused of murdering patients. In Chapter 2 the legal dimension of homicide is explored. The requirements for a conviction on a charge of murder are considered, along with some of the equally serious but lesser charges such as manslaughter. The laying of a charge of murder, manslaughter, unlawful homicide or any other criminal activity is a serious matter. It is considered to be so by police, courts and related law enforcement agencies. As such it receives considerable thought, care and attention. It is rarely a simple process and in the case of nurses who are accused of killing patients, it is more complex than usual. In considering the discourses around the charging of nurses in such circumstances, I will categorise them as follows:

- Charges v Suspicions: the problem of evidence
- Range of Charges
- Appropriateness of Charges
- Adequacy of Charges
- Plea Bargains and Charges
- Other Charges
- Charging Multiple Defendants

All of the discourses concerned with the charges laid against nurses accused of murdering patients that were encountered in the texts are subsumed by these several categories.

Charges vs Suspicions: the problem of evidence

A major hurdle for those who have responsibility for detecting and investigating allegations of murder of patients by nurses is to reach a point where it is possible to charge the nurse. There is an extensive array of texts constituting this discourse. Charging anyone with murder requires evidence. Evidence is the subject of a subsequent section in this Chapter but it must nevertheless be introduced here as a relevant consideration. As the latter section will show, it is notoriously difficult to obtain the evidence needed to firstly charge the offender, and *a fortiori*, to then achieve the conviction of the nurse. Almost always, the texts reveal that the investigators and others will have suspicions and beliefs about the involvement of the offender in other deaths. While those suspicions and beliefs may be valid, it is only where there is clear evidence that a nurse was involved in the murder of a specific patient that charges can be laid. It is for this reason that, as we have already seen, that nurses who are serial killers of patients are rarely charged with involvement in the deaths of more than just a few of their victims. A number of examples will serve to demonstrate this point whilst simultaneously unfurling the discourses involved here. A landmark case that almost established the genre in the public mind in the United Kingdom was that of Beverley Allitt (N. Davies, 1993a) who was convicted of the murder of four children but was suspected of perhaps another ten attempts. Genevieve Jones (Elkind, 1990a) was also only convicted of one murder, but suspected of many others.

The key consideration is being able to at least lay a charge of murder. Although investigators and others suspected Joseph Dewey Akin of involvement in the deaths of many other patients, he was charged with only one count of murder, as was reported in the *Houston Chronicle* (1991, p.8).

'Joseph Dewey Akin, 35, of Marietta, Ga., was charged Wednesday with murder in the death of Robert Price, 32, who died March 27 at Cooper Green Hospital in Birmingham (*Houston Chronicle*, 1991, p.8).

Even then, the police had cause to suspect Akin for some time before but had no evidence that would sustain any charge, much less a charge of murder. Once one charge is laid, it is easier for the investigators to build a case.

'Police said this week that Mr. Akin has been a prime suspect in Mr. Price's death since the day the Birmingham resident died. And a police captain said this week that he has widened the investigation to include three suspicious deaths at Birmingham hospitals where Mr. Akin worked as a nurse in the early 1980s' (Yardley, 1991b, p.1).

This is by no means unusual. Another example of a nurse who was charged with just one murder was Jeffery Feltner. The irony of his case is that he publicly confessed to several murders prior to his arrest but he was not taken seriously. As reported in the *St Petersburg Times* (1989),

'He is charged with the murder of Doris Moriarty, 83, a retired registered nurse who died July 11' (AP, 1989a, p.1).

Lawyers prefer to lay one charge on which they are confident of securing a conviction than a whole raft of charges for which they may have insufficient evidence. Thus, a nurse who is murdering patients usually will be arrested and charged only with those cases where the prosecution has sufficient evidence to mount a sound case.

Investigators are able to ramp up their investigation once charges have been laid which will usually produce further evidence so it not unusual for additional charges to be laid during the period between charges being first laid and the case coming to trial. This is exactly what happened in the case of Charles Cullen. He was charged initially with the murder of just one patient but this number grew to around 30 charges of murder (Hepp, 2004, p.1).

For families who hold suspicions about the death of their loved ones, the periods between suspicion and charging, then charging and conviction, can be an intolerable time. This is made very clear in the comments of family members of victims of Charles Cullen. For these families there is often no real sense of closure. Often times, they neither know nor care about the legal complexities and subtleties of getting the charge right and when they see the lawyers struggling around this, their reaction is

one of incredulity and frustration. This emerges again in the discourses around the reaction of families in Chapter 8. Leaving aside the pain it causes the families, those complexities and subtleties have to be addressed and that is the concern of the next section.

The Range of Charges

The charge may be straightforward and relatively simple. It might be an open and shut case of murder. This certainly happens, but more commonly the evidence is scant, the circumstances murky and the prospects of success just the faintest hope. For this reason, the charges against nurses who murder patients can be diverse. Harvey's case provides a good example of this. It was a little unusual because he actually confessed and pleaded guilty 'to the aggravated murder of 24 people, the attempted aggravated murder of four people and the felonious assault of one person'. The charges that can be laid in such cases include murder (in its various degrees and manifestations), attempted murder, manslaughter, gross negligence and others, with a significant degree of variation among jurisdictions. Just which charge should be laid is a question for skilled public prosecutors or district attorneys. The critical issue is that the charge should be appropriate firstly for the evidence and secondly, for the nature of the crime. Unfortunately, the texts related to the murder of nurses constitute a discourse of dissatisfaction with the order of priority for these requirements because they often run counter to the priorities of the families (and sometimes the colleagues, investigators and others whose voices are represented in the texts). The discourses point to the frailty and the bureaucracy of the contemporary link between law and justice.

Appropriateness of Charges

The texts relating to a specific case contribute to broader discourses. For example, those relating to the case of Hal Speers Rachman contribute to a discourse around the complexity of laying the appropriate charges. Hal Speers Rachman would have been charged and convicted of murder but for the fact that the 48 year old victim, Edward Lebowitz, died of the complications of AIDS, rather than from the unprescribed insulin that Rachman caused to be administered to him. As the following description makes clear, it is all in the timing. It is obvious that Rachman's intent was to kill Lebowitz.

'A private nurse who cared for an AIDS patient who died Wednesday has been arrested on murder and other charges, with the authorities saying that he had posed as a physician and ordered insulin injections for the patient. Although doctors believe that the insulin was not the direct cause of the patient's death, which came four days later, a Deputy District Attorney recommended that the arrested man be charged with the more serious violation, rather than attempted homicide, pending autopsy results' (*New York Times*, 1986).

In the result Rachman was convicted of attempted murder so in the eyes of most commentators a satisfactory outcome was achieved but that is not always the case. The legal requisites demand that certain elements be provable to secure a conviction, and the process of determining the level is illustrated in the murder of Willie May Ryan.

'Prosecuting Attorney Jamie Pratt of Camden said Friday that he plans to file murder charges against Rainey and Wilson. The degree of the charge remains uncertain, although Pratt said he is considering the most severe charge available. He said "the question" is whether the use of brass knuckles constitutes premeditation, a requirement of capital murder, which is punishable by either life in prison or death....The two employees were arrested Aug. 7 on charges of adult abuse, a Class B felony that carries a possible sentence of five to 20 years in prison. Each is being held in lieu of \$100,000 bail...Bradford said he believes investigators shouldn't have to prove the brass knuckles were brought to the nursing home with the intent of killing Ryan. "If it's true that this woman [Wilson] put the brass knuckles on, that's obviously a premeditated act," he said.' (Bowers, 2003).

It will be apparent that the charge of adult abuse was simply a mechanism to take Rainey and Wilson into custody (though of itself it could attract a penalty of up to 20 years in prison if the offender is convicted). Although in such circumstances there can be no doubt that the most serious charge available should be laid, how one answers the question of whether the possession of 'brass knuckles' amounts to premeditation will be the determining factor. In a practical sense, this is a question of anticipating the view of the Court. The significance in the discourses surrounding this case lay in the fact that, in the particular jurisdiction, it is a requirement for capital murder that premeditation be proven. Capital murder is murder for which the offender may be executed. This case demonstrates well the way in which the language of the charges can convey much about the process. It illustrates the legal discourse which is predicated on contest. It is an adversarial process, a competitive game for creative players. It is the arena – the context – in which the actions of all

parties are weighed and the consequences of the offender's conduct are meted out. For all this, the discourses imply that the experience of the system for families and others affected by the sequelae of nurses who murder, is detached, remote and often, unbearably frustrating.

Given the foregoing discussion, a brief consideration of the case of Daillyn Pavia may be helpful here. Throughout this dissertation I have drawn a distinction between those nurses who have murdered patients with malice aforethought and those nurses who have allegedly engaged in authentic euthanasia or mercy killing. In this brief departure from that practice of exclusion, these two cases throw into sharp relief the use of charging strategies to either advantage or disadvantage a potential defendant. In the case of Pavia, no one was in any doubt that Pavia had killed the victim by administration of a lethal dose of drugs. Neither was anyone in any doubt that she had done so purely as mercy killing to end the woman's suffering.

' Pavia "admitted that without authorization and within a half an hour of taking charge of Julia Dawson as her patient, she intentionally gave Ms. Dawson 15 times the maximum dosage of morphine that had been prescribed." "When this was insufficient in producing the victim's death, the accused admitted she intentionally gave Ms. Dawson Propofol, a sedative for which no prescription had been ordered. Within 10 minutes of the administering of the Propofol, Ms. Dawson was dead. "Dr. Michael Graham, the St. Louis medical examiner, stated that the drugs given to Ms. Dawson were likely to cause death." ... she made the statements because she heard an autopsy had been requested by Dawson's son, and she feared it would disclose the unprescribed drug in the woman's system...Graham arranged for tests after Pavia's remarks were relayed to his office, sources said. ..."All I know is she (Pavia) was going to give her some pain medicine," Dawson [the victim's son] said. "I'm sad they charged her with murder" (Bryant, 2003, p.1) .

The problem was that, under the laws of Minnesota and almost every other jurisdiction including Australia and its states, the conduct involved amounted to murder. Moreover, the law of Minnesota imposed a substantial mandatory custodial sentence for murder.

'A nurse [Pavia] was charged Monday with first-degree murder for allegedly an elderly, dying woman. The victim's son criticized the decision to file charges and said he believed the nurse acted out of mercy' (Salter, 2001).

The Court was seriously troubled by its strictures and obligations in this case and that is reflected both in the charges that were laid, the Court's treatment of those charges and the sentence imposed. As a result of a plea bargain, Pavia was able to plead guilty to a charge of voluntary manslaughter and was sentenced to five years probation. A condition was that she surrender her nursing license and stay out of health work (Bryant, 2003, p.1).

Some nurses may not intend to kill their patient but act with such reckless indifference to human life that it is still sufficient to ground a charge and conviction for murder. This seems to have been the situation in the case of African nurse Luvuyo Mgwatyu where the charge was simple and concise. It was a charge of murder.

'Annexure A of the charge sheet simply states "the accused did upon or about 10 July 2001 and at or near Fort England Hospital, York Street, Grahamstown ... wrongfully and intentionally kill one Mthuthuzeli Beacham Tshakaza." ' (Mientjies, 2001).

Whilst the charge asserts intent, it is unlikely that the intent was to kill here but it certainly involved reckless indifference to human life. When reporting on legal matters, the texts of media reports often contain the language of the law. This is not necessarily because it injects any greater precision into the report because only rarely are the legal subtleties of the particular language explained or explored. It seems more likely to be an affectation of the language of power, and in the case of Mgwatyu, the skewed power relationship between the nurse and the State was readily apparent. Nevertheless, he did murder the patient.

In this case, '...other nurses tried to intervene but were too late. He said according to eyewitnesses Mgwatyu had "stamped on him"' (Meintjies, 2001). This description seems calculated to convey either this nurse's disregard for the patient or his loss of control. Either way it points to the justification for the charge of murder although it is masked with the stamp of objectivity because the account is attributed to an eyewitness. An appearance of objectivity also characterises the *The Sentinel's* account of the accusation against English Nurse Barbara Salisbury:

'Barbara Salisbury is accused of: the attempted murder of James Byrne, aged 76, on May 18, 1999, by the excessive use of a syringe to administer

diamorphine. It is alleged that as she did so Salisbury said "give in, it's time to go". The attempted murder of (The Sentinel, 2004b), aged 81, between February 3 and March 14, 2002, by removing his oxygen supply and lying him flat so he was choking. The attempted murder of Frances May Taylor, aged 88, on March 21, 2002, by the inappropriate administration of diamorphine by the syringe. It is alleged she explained her actions by saying "why prolong the inevitable" The attempted murder of Frank Owen, aged 92, on March 31, 2002, by the administration of diamorphine by injection. ' (*The Sentinel*, 2004a, p.5)

These examples of the charges involved illustrate the importance to both the prosecution and the defence of ensuring that the most appropriate charges are laid. The implications for the career of the defendant are serious indeed and if the nurse is wrongly accused, the injustice is grave. Equally, however, if the nurse is guilty, it is imperative that the charge that is laid is sustainable in the sense of being able to secure a conviction. This will sometimes involve erring on the side of caution and preferring a lesser charge than that which is actually warranted. This raises the question of the adequacy of the charges laid, a notion that produces considerable disquiet particularly among the relatives of victims. Just as importantly, in recent years there has been an increasing frequency of charges laid then dropped. This raises the matter of charges being laid inappropriately or at the very least, precipitately, and there is an increasing number of texts constituting this growing discourse. There are peaks and troughs in this phenomenon and in the period immediately post Allitt and similarly after Shipton, there were many more suspicions, investigations, and charges in the UK. There was no corresponding increase in the number of convictions though, so this may have more to do with health services and governments feeling the need to 'do something'. This may be a good point at which to remember the message that the British Secretary of State for Health, Mrs Virginia Bottomley, extracted from the report of Sir Cecil Clothier QC into his inquiry into the Beverley Allitt case, when delivering the report to the House of Commons. She quoted Clothier's main conclusion '...a determined and secret criminal may defeat the best regulated organisation in the pursuit of his or her purpose...' and Clothier goes on to say '...no measure can afford complete protection against a determined miscreant...' (Clothier, 1994).

Adequacy of Charges

A key principle of a just legal system is that for any crime, the severity of the charge should match the heinousness of the alleged crime because it is the charge on which an offender is convicted that determines the penalties that are available to be imposed. The bodies of texts relating to the murder of patients by nurses constructs this discourse very clearly. One way of developing insights into this discourse of adequacy is to look first at the texts relating to the most heinous cases to see what is said there about the charges. One of the more brutal examples of a nurse who murders a patient is that of Gayla Ann Wilson so I will begin with her case. The point here is not to shock but to assess whether the charges laid match the seriousness of the crime; whether those charges allow sufficient latitude to ensure an appropriate punishment; and to determine whose views are available on these matters.

The Associated Press reported the case of Wilson in 2003 in the following way:

"Two nursing home employees accused of beating an elderly woman with brass knuckles for "being disrespectful" were each ordered held on \$100,000 bond Friday. Nursing assistants Shermika Rainey, 17, and Gayla Wilson, 44, were each charged with a felony count of adult abuse. They work at Dallas County Nursing Home. ' (AP, 2003g; The Associated Press, 2003, p.5).

These two female nursing assistants were working in a nursing home and one of them produced a set of 'brass knuckles' (in fact they were made of lead); while the 17 year old held down the 83 year old resident, the 44 year old proceeded to smash her face. For this they were charged with felony adult abuse. This was a brutal killing. The quietly objective tone of the report fails to capture the horror of their actions, the vulnerability of this elderly woman or the fear of vulnerability that the actions of these 'carers' might otherwise evoke. The texts relating to this could be interpreted as generating a discourse of protection of the public psyche.

In 2004, Associated Press again reported on the case:

Wilson is accused of beating Willie Mae Ryan, 81, with brass knuckles on July 30, 2003. Ryan died at a Pine Bluff hospital two weeks later....Rainey said in court that she held the elderly woman down while Wilson struck her with brass knuckles seven or eight times...the beating was administered in retaliation for Ryan being "disrespectful." (AP, 2004c).

What this tells us about the quiescence of the public on the subject of homicidal health workers generally and nurses in particular – especially against a background of rhetoric of ‘elder abuse’ - requires further elucidation. If this was an isolated example, it might not carry such significance. There are however, other cases. I will consider just one more here, that of Justin W. Martin who was charged with offences against nursing home patient Tok Sun Han who died in hospital from injuries inflicted by nursing home staff.

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"The third count against Justin W. Martin, 18, was filed four days after a medical examiner ruled that Tok Sun Han's death on Aug. 22 was a homicide caused by "pneumonia due to multiple blunt soft tissue injuries," with a contributing cause of hardening of the arteries. ' (Bill Braun, 1997, p.19)

Here, the charge of murder was added to other charges of rape and abuse against Justin W. Martin which had been laid prior to the patient’s death. More will be said of this case a little later when it is discussed in the context of charges other than murder that may be laid against nurses who murder patients. In all of these charges power is a key issue, but in the present context the concern is whether the charges are adequate to fit the crime. The texts relating to this crime are steeped in the formal language of the law and the cataloguing of the victim’s injuries but there is effectively no affective domain to the reporting. This is a vacancy that I will return to often in my encounters with this case.

Plea Bargains and Charges

The difficulty of obtaining sufficient evidence to secure a conviction is significant because one consequence is that it leads to trade-offs in charges. This usually takes the form of either the prosecution making an offer to lay either lesser charges or to seek more lenient sentences in return for confessions, admissions or even pleas of guilt that certainly reduce the need for investigation and evidence and may even obviate the need for a trial. It may mean that all that is required is a sentencing hearing. These trade-offs may secure a conviction but may not necessarily satisfy the families of victims. Akin’s case is an example of this process at work. He ultimately pleaded guilty to a charge of manslaughter and was sentenced to 15 years - of which he served only a fraction (The Associated Press, 1998).

There are of course many other examples but the practice does not attract any overt disapprobation within the discourses of the media because it is usually better than getting no conviction at all. In this case it can be perceived as a contest in the exercise of power. On the one hand, there is the law with all its might seeking to restrain from future killing this individual who has clearly murdered patients. On the other is an individual who has exercised his own power in the murder of patients and is now challenging the legal system with its own power. There are of course many other examples even within this study. They include the cases of Rosenfeld, Dudley Terrell, May, Harvey, Kanner, and Rainey to mention but a few.

Other Charges

The media reports will generally contain information about any other charges that may have been laid against an alleged offender. Often, as has been explained earlier, a charge other than murder may be laid although it is a case of murder. However, in other cases, the other charges may be ancillary to a principal charge of murder. This could include charges such as abuse or gross negligence, drug offences such as unlawful administration of a restricted substance, and the like. Some charges, however, will be unrelated to murder per se, but may be related by the circumstances of the case. For example, within some of the cases informing this study, there are examples of fraud and theft. The inclusion of other charges in the reporting of these cases may be for the sake of completeness. However, the texts may be included because it contributes to a discourse portraying a nurse who murders patients as a bad person who is aberrant in ways other than just being homicidal.

Some examples will serve to illustrate the point. In the case of Christine Ackley, she had engaged in generic criminal activity in relation to the murder of a person in her care. Accordingly, she was charged with, (and convicted of) '*...murder with deliberation, felony murder, aggravated robbery of an at-risk adult, robbery, theft and fraudulent use of a credit card...*' (Denver Post, 2004, p.2).

Another who falls into this category, and whose details can be found in Chapter 3, is Wanda Kanna who is widely remembered for using a bagel as her weapon of choice to murder her patient.

Rachman's case provides an example of a case that is unusual for the fact that charges that could have been laid were not. He was charged with attempted murder and forgery. There is no suggestion either in the charges levelled against Rachman or in the commentary around his case, that the action of impersonating a doctor also constituted a crime (*Houston Chronicle*, 1986b, p.2). These examples illustrate the relative priorities accorded unlawful homicide and crimes such as forgery. The texts around the two classes of crime in the reports of these cases, and the interplay between them, are also instructive. They constitute a discourse around aberrance and otherness with the lesser crimes reinforcing the perception that the nurse charged with murder is a bad person anyway. Even if they did not kill people, they would commit other crimes, but because they would commit these other crimes, we should not be surprised that they would murder patients. The apparent aberrance consolidates the discourse of otherness – they are not like 'normal' nurses and they are not like us.

Charging Multiple Defendants

Where there exists more than one defendant in a case of a nurse and accomplices murdering patients, the process and choice of charge becomes particularly revealing. The discourses become competitive in relation to the various defendants. An excellent example of this is the case of Wilson and Rainey, mentioned earlier in this Chapter. In this case Rainey became the prosecution's best weapon because she gave evidence against Wilson in exchange for a lesser charge of conspiracy to commit first-degree murder, to which Rainey pleaded guilty. She was still sentenced to thirty years in prison.

Another example of multiple defendants is the case of co-defendants Gwendoline Graham and Catherine May Wood. Very early in this case it was reported by Leavitt (1988, p.3) that the two nurses aides were charged with multiple murders in a nursing home and this was reinforced by Perlman (1989c, p.21).

The number of suspected victims rose to eight and ultimately the charges reflected that number of alleged murders. What was especially interesting about the case, and became the focus of a book about these murders entitled *Forever and Five Days* (Cauffiel, 1997), was the dynamics between the two women. The defence team for

each one tried to paint the other as the brains behind the outfit, the mastermind behind the murders, as it were. There is an air of mystery about this because no one seems certain of the real situation. Associated with this is a discourse of sociopathic behaviour – indeed, a sociopathic lifestyle. This is evident in a number of other cases but it is particularly evident where individual nurses have combined to conspire to murder patients. The texts that constitute this discourse further affirm the aberrant nature of the offenders, distancing them still further from the ‘normal’ nurse who can be trusted not to murder the patients.

Another striking example of multiple defendants is the Austrian case involving Waltraud Wagner (aged 23) , Maria Gruber (aged 19), Irene Leidolf (aged 21), and Stephanija Meyer (aged 43). These four women collectively brought about the deaths of many in their care – perhaps as many as two hundred patients. The charges laid against them varied however. Once again it was a question of what charges the evidence would sustain. Gruber was charged with two counts of attempted murder; Leidolf was charged with five murders and two of attempted murder; Meyer was charged with murder (one charge, 2nd degree) and seven charges of attempted murder; and Wagner was charged with 15 murders and 17 attempted murders. The challenge for investigators in such cases is to establish which defendant is involved in what deaths and to do so beyond reasonable doubt.

Where there are multiple defendants who have colluded in the murder of patients it immediately tells us much about the premeditated nature of the crime or crimes, about the wilfulness and the malice aforethought of the individuals involved, and the dangerousness of those individuals. The discourses around who was the mastermind, the ringleader, the dominant partner in crime all serve to point to the culpability of the individuals, but at the same time they reinforce the place of power and its exercise. The texts related to these cases constitute discourses around a need to cast one person as the strong leader who cowed others into submissive collaboration. To do otherwise may mean admitting that there could be whole gangs of nurses who are prepared to unite in the pursuit of the murder of patients.

The Evidence

The crucial place of evidence in obtaining convictions of nurses who murder patients is commented upon in a number of places in this work. There are several dimensions to evidence. There is the difficulty of obtaining the evidence required for conviction; there is the matter of how that evidence is obtained; the cost of obtaining that evidence; and the complexity of the rules of evidence. Within the bodies of texts commenting on the phenomenon of nurses who murder, the texts constitute discourses that, so far as they concern evidence, typically reflect the specific interests of the participants. Thus, for the prosecutors, they concern the accretion of evidence to obtain a conviction, the quality of available evidence (especially in terms of the charges that the evidence will support); and the cost of that evidence in terms of the scale of the required investigation and in terms of having to trade off convictions and sentences in return for confessions or testimony. The voices of the accused (usually mediated through defence lawyers) are often heard denying the veracity or the probative value of evidence – even when that evidence is compelling. Family and friends of the victims are also frequent commentators in the discourse of evidence but usually in the context of their difficulty in understanding how it could be so hard to get a case to trial when there is clear evidence of guilt. This usually reflects a lay interpretation of evidence as against a legal interpretation.

The difficulty in obtaining evidence

Once there is a suspicion that a nurse has been involved in the killing of a patient, several processes need to be triggered if anything is to happen. Most commonly, that suspicion will arise among the colleagues of a nurse. At this point, the nurse or nurses have a choice. They can say and do nothing – in which case that is likely to be an end to the matter. Alternatively they can take their suspicions to the health service management. Then they have the same choice as the nurse: say and do nothing, in which case the matter will go no further unless the nurse pursues it outside the organisation of her own initiative. Alternatively, they may handle it in-house, which may mean the nurse is sacked on some pretext, and as we have seen, will thus be enabled to continue their killing trajectory elsewhere. If the matter is immediately referred to the police, an investigation will begin immediately and that will trigger the commencement of the gathering of evidence.

This raises the question of what evidence and from where will it come. The body of texts around murder of patients by nurses reveals a strong discourse of delay. The investigators are often confronted with a cold trail or with a mountain of data that has to be sifted. This makes the task of evidence gathering much more difficult. What evidence will it be? Will it be evidence from an autopsy? The likelihood is that the body will have been cremated and that avenue will be closed off. However, there are quite a number of cases that have turned on the exhumation of multiple bodies. This was true in the case of Jenkins (Cadzow, 1991) in Charters Towers, Qld where five bodies were exhumed. Ultimately, the case was dismissed for lack of evidence and delay. Other forms of material evidence e.g. the possession of drugs that have been found in the bodies of dead patients for whom the particular drug had not been prescribed have been useful. Examples include the cases of Geen and Majors. . Again, such evidence can be difficult to obtain and even when it is, it will still constitute only circumstantial evidence in the absence of a confession.

Impediments abound in the texts related to the investigation of nurses who murder. With respect to cremation, the following extract from the texts relating to Brian Rosenfeld is indicative of its impact. The investigation into murders of patients by Brian Rosenfeld was clearly hampered by the fact that a high percentage of patients who died at the nursing homes involved were cremated.

'Unfortunately for investigators, most Pinellas nursing home patients are cremated after their deaths, Wood said. That prohibits autopsy. But authorities did identify 29 people who had died under Rosenfeld's care and who were subsequently buried. Four were buried in Wisconsin, Rhode Island, Michigan and Pennsylvania, where remains take longer to decompose because of cooler weather and lower water tables. Authorities exhumed those four bodies, plus a man recently buried in Florida. Two of the exhumed bodies contained traces of Mellaril, the same drug that killed Muriel Watts. Two suspicious deaths out of five exhumations indicated that Rosenfeld was poisoning people on a wide scale, said Wood.' (Nohlgren, 1992b, p.1)

The evidence of co-workers can be as self-incriminating as it is damning of the alleged murderer, as was shown in the Tenzer case. This reinforces the perception among colleagues that it is better to maintain one's silence in such cases and increases the difficulty of obtaining evidence.

'Pearson had told a county grand jury that she went on duty at 7 a.m. on Sept. 5, 2000, a few hours after Neff allegedly was assaulted. She told of being met

on arrival by a private aide who had been in the room next door, court records show. The aide told Pearson of hearing a ruckus in the room next door that "sounded like a husband and wife fighting," with a lot of banging and knocking. Pearson told the grand jury that she checked Neff's face and saw no injuries, though he complained of pain later in the day. She said that although Neff's pain increased daily, she did not see the severe bruising on his torso until three days later. Along with Tenzer, the grand jury last year indicted Pearson; the home's former administrator; and its registered nurse. Also charged was a hospice-care nurse assigned to Neff who worked for an outside agency' (King, 2003c).

In the overwhelming majority of cases concerning nurses who murder patients, the evidence is typically circumstantial, as was the situation in the Majors case:

'Drug vials found at a house where Orville Lynn Majors once lived were traced to shipments sent to Vermillion County Hospital, a detective testified today in the former nurse's murder trial. Indiana State Police Detective Maurice Allcron told jurors he used tracking numbers printed on the vials to find out what company made the drugs and where the company had shipped them. Allcron said containers of potassium chloride and epinephrine were part of a shipment sent to Vermillion County Hospital, where Majors was a nurse and where prosecutors allege he gave lethal injections of those drugs to seven elderly patients. But Allcron later admitted containers with the same tracking number went to other hospitals in western Indiana and he had no purchase records to prove the vials found at Majors' former home came from his hospital' (Slagle, 1999c).

In the case of Timea Faludi evidence was difficult to obtain. The motive was alleged to be mercy killing. There were many conflicting issues, but evidence was scant and bodies were cremated. The result was a largely circumstantial case:

'... she later retracted her confession and police could only find eight cases in which she was strongly suspected of having helped predominantly elderly patients die. ... Legal experts have said the prosecution's case will be made difficult as the alleged victims have been cremated' (Reuters News, 2002).

The police sought physical evidence in the Mori case to establish the crime, but here again it was hard to come by and the evidence on which the conviction of Mori was based was purely circumstantial, with the exception of the retracted confession. (*Kyodo News*, 2004a, 2004b)

The texts constituting the discourses surrounding the gathering of evidence in these cases suggest a sense of frustration on the part of investigators and prosecutors. Defendants have a stronger chance of escaping conviction because of the

impediments that obstruct the getting of evidence. Defence lawyers have an easier time of it because of these impediments. At least, they do unless their client confesses, as they will sometimes do. In the absence of confession, however, the investigator has to gather the evidence.

How the evidence is obtained

Evidence has to be obtained lawfully for it to be admissible. Rainey's admissions as to her part in the murder of Willie May Ryan resulted in her receiving 30 years in prison; those admissions were vitally important, however, in securing the conviction of her co-accused, Gayla Wilson. The defence in such a case would usually be the existence of a reasonable doubt and thus it would not be safe to convict. In this case that could have been achieved by both staying quiet and refusing to admit anything so that there would always be a reasonable doubt as to who had done what. The prosecution relied almost exclusively on Rainey's testimony as one of the co-accused in the brutal murder of Willie May Ryan (Davis, 2004, p.13) but the location of the lead 'knuckles' in Wilson's home gave weight to that testimony' (The Associated Press, 2003, p.5).

This was damning evidence in every sense of the word, and not surprisingly it brought about a conviction. The texts constitute an emphatic discourse around the evidence from co-workers very often being the key to these cases from the prosecution's perspective amid the context of difficulties and obstructions as earlier described. Mori's case is no exception to this and became a possibility because of the actions of co-workers.

'...Mori...made an attempt to dispose of the empty containers, workers of Hokuryo Clinic in Sendai became suspicious and prevented him from doing so....Police have already seized several empty glass vessels of the muscle relaxant, believing that Mori kept them hidden in the clinic, the sources said, adding it is the first concrete evidence connecting Mori and muscle relaxant' (Kyodo News, 2004a).

The eye-witness account – particularly that of colleagues – is an invaluable form of evidence and can be extremely important in securing convictions in murder cases.

'A nurse testified today she saw Orville Lynn Majors with a syringe in his hand and standing over the bed of a patient whose heart stopped beating minutes later. Nadine Shonk told jurors in Majors' murder trial that the patient, Mary Ann Alderson, was sitting up and chatting with visitors only 20 minutes before she died.

"He's standing at the head of Mrs. Alderson's bed. With his left hand he is using the control to let the head of the bed down. In his right hand he's holding a syringe and pulling the curtain closed," said Shonk, describing Majors' actions. Shonk, who worked at Vermillion County Hospital for 22 years as a nurse before retiring last year, said there was no medical reason for Majors to have a syringe at the time' (Kelly, 1999b).

The Mgwatyu case also illustrates the importance of the testimony of colleagues in the conviction of nurses who murder patients.

'Two state witnesses who had been on duty in ward H testified that they had seen their colleague kicking and trampling the accused, who was lying on his back on the floor, in the abdomen. Both described the kicking as "hard" ' (Greyling, 2003b).

In the absence of such testimony the prosecution's task would have been extremely difficult. There are occasions though where eyewitness accounts can be problematic. such as in the Akin case where conflicting evidence was given by his co-workers. Another deterrent for nurses to give testimony is the possibility of self-incrimination, as occurred in the Tenzer case. The evidence of Heidi Tenzer's colleagues revealed much about Tenzer herself:

'Yesterday, former Alterra aide Virginia Ballard said she had worked with Tenzer that night, changing a patient who shared the room with Neff. Ballard said Tenzer uttered an obscenity upon seeing that Neff had fouled his bed. Ballard said Tenzer handled him roughly as she disrobed Neff. "She was jerking, pulling him around," she testified. Ballard said she offered to take over, but Tenzer refused. "She said, 'No, I got him.'" Ballard left to tend other patients, but said she heard noises from Neff's room as she returned. "I'm thinking, 'Dang! She's still in there messing with him?' " Ballard testified. Tenzer, she said, was in the bathroom with Neff. "She said she had to give him a shower." When police began to investigate, Tenzer visited her apartment, Ballard said, and asked her to speak by phone with Tenzer's lawyer. Tenzer then coached her on what to say, passing a handwritten note, then burning the note on the gas stove, Ballard testified. ' (King, 2003b)

In the Tenzer case a number of her colleagues who provided eye-witness accounts were also co-defendants and that raises other issues in relation to the standing of the testimony. There are parallels here with the case of Rainey and Wilson but these examples should be taken in the context of my comments elsewhere as to the role of

nurses as whistleblowers (King, 2003b). Sometimes, too, it is the more innocuous evidence that will sway a jury to convict. There is in the discourse of euthanasia as a defence a particular emphasis on the right of the patient to choose whether that is what they want and when euthanasia or mercy killing is raised as the motive for killing patients, there is a demand for authenticity. Eyewitness accounts from colleagues can negate this, as was clearly the case in the Majors case:

'...The patient, Mary Ann Alderson, appeared tired but otherwise healthy, licensed practical nurse Judy Wagle said at Majors' murder trial. "She told me at that time she would probably be going home tomorrow, and she was very excited about that," Wagle noted Alderson's good spirits about 10:15 a.m. on Nov. 7, 1994; seven hours later, Alderson was dead...' (Slagle, 1999a).

It is clear from the discourses that obtaining evidence, whatever form it may take, is a complicated and painstaking process that can also be time-consuming. Often evidence can prove unreliable. Mostly, the offenders are somewhat sociopathic which means they may have but a casual acquaintance with the truth. Moreover, they are quite often charming, charismatic and clever people who think nothing of manipulating family, friends, acquaintances and anyone else necessary to achieve their own ends. At the other extreme are those who manipulate via brute force. Thus, there may be intimidation of co-workers to coerce their silence as was shown in Tenzer's case and Rainey's case, for example. These are dangerous people. After all, they are murderers. It is not at all surprising that people might be intimidated by them. The discourses show that some of these murderers are intimidating and some are not. Fear of rocking the boat is one major reason why nursing colleagues stay quiet in such circumstances. Predictable inaction on the part of the organisation is another. In both cases, there is a barrier to a sometimes rich source of evidence. However, even where evidence is available, getting to it can be an expensive process.

The cost of obtaining the evidence

In cases of nurses who murder patients, the discourses suggest that the challenge for prosecutors is usually obtaining sufficient evidence first to lay charges then subsequently to secure a conviction. That was not the situation in the Jackson case where the investigators had an avalanche of evidence:

'Authorities...say mounds of evidence overwhelmingly point to Jackson as the killer -- in fact, one of the state's most prolific killers. (Brown, 2006a)

Where there is a large volume of evidence, there will be a very significant cost attaching to an investigation. This will always be a concern for resource-strapped law enforcement agencies. However, to not go after the evidence would be unthinkable in the context of contemporary law enforcement and perceptions of the 'public interest'. In the field of murder by nurses there have been some very large investigations. For example, the cases of Charles Cullen, Richard Angelo and Benjamin Geen all involved extensive investigations. The cost also impacts on the health services involved in any such investigation, and this emerges in the texts as a concern for those services. Finally, even after the evidence is in hand, its use in the prosecution has to be in accordance with the rules and there is a discourse around this aspect as well.

The complexity of the rules of evidence

One area of legal discourse that only rarely finds its way into the public discourses is that of the rules of evidence which often produce results that are manifestly unacceptable to the general population because they are perceived to produce unfair outcomes. There was, for example, an element of hearsay in the evidence provided in the case of Wood and Graham. Moreover, the evidence of Graham's guilt came largely from others who may have had a vested interest in seeing her convicted. For example, some of the most damning evidence against Graham came from Wood's ex-husband but it was evidence of what Catherine Wood had told him.

Graham suffocated six patients with a washcloth, Wood [Catherine Wood's ex-husband] testified. His ex-wife said they chose weak, incontinent patients because "they couldn't fight back" and it would "be easier to get away with it," he said (Perlman, 1989b).

Procedurally, too, there is a willingness to accept changes that may disadvantage a nurse who has committed murder. In the Graham case, the medical examiner changed the cause of death from natural causes to asphyxia in the absence of any diagnostic evidence to support that finding.

Medical Examiner Stephen Cohle testified Wednesday that he formally changed the cause of death on their death certificates from natural causes to asphyxia due to suffocation. However, he said he had no scientific evidence to support that conclusion and based his findings on information from police. The patients, both of whom suffered from Alzheimer's disease and other ailments, could have died from natural causes, he said. (Perlman, 1989b).

This conduct should at the very least impair the weight given to the information. The texts that constitute this discourse also focus on the possible injustice that might potentially be a consequence of 'jailhouse confessions'. In the case of Rosenfeld, evidence provided by his cellmate was highly probative:

A jailhouse informant reported that Rosenfeld had admitted to 23 murders. "The snitch identified six victims by name, which even Rosenfeld's lawyer, Larry Hoffman, called "devastating." It turned out that every name matched a person who had died on Rosenfeld's shifts. (Nohlgren, 1992a, p.1).

As already indicated, the bodies of texts relating to murder of patients by nurses frequently contain texts that constitute a discourse of fairness i.e. natural justice and due process for the nurse. In the Majors case some of the evidence that was admitted may have provided insights into the thinking of the man but perhaps should not have been admitted in the interests of a fair trial.

'A longtime roommate told jurors Thursday that former nurse Orville Lynn Majors often said "old people should be gassed," ... Prosecutors want jurors to hear what Harris told state police detective Maurice Allcron during five interviews. In those interviews Harris said he heard co-workers talking about the increased number of code blues and deaths when Majors worked.... Defense attorneys said testimony about the rumors could sway jurors to believe Majors was involved in more deaths than those he is charged with. Yelton ultimately ruled Harris could not testify about that. Yelton already has ruled that prosecutors cannot use statistical studies showing the number of sudden and unexpected deaths that occurred on Majors' shifts at the hospital. 'prompting defense attorneys to ask for a mistrial. Special Judge Ernest Yelton declined the request, but asked jurors to leave the courtroom while lawyers ironed out what the witness would be allowed to say during his testimony. "I heard him make comments that old people should be gassed. He would say that fairly often," said Andrew Scott Harris, who was 18-years-old when he moved in with Majors in 1989' (Slagle, 1999b).

Expert Witnesses

Throughout the texts related to these cases of nurses who murder, there is a discourse about the evidence and in particular, the evidence given by expert witnesses. Such witnesses are a mixed blessing – especially in the USA where litigation is almost a sport. That was evident in the Akin case which demonstrates the standard practice of rebuttal of the expert witness testimony with that of another expert witness.

'Chief Deputy District Attorney Roger Brown presented a rebuttal witness, Dr. George Neal Kay, who testified that because Mr. Price's liver was in such bad shape, his body probably could not process the lidocaine quickly.

Dr. Kay also disputed Dr. Benowitz's testimony that Mr. Price's heart could not be restarted immediately after receiving an overdose of lidocaine.' (McIntosh 1992c, p.4)

Jurists can struggle with the technical complexity of the evidence given by expert witnesses. The discourses around expert witnesses nevertheless still value them highly. Being prepared to give your opinion on matters requiring specific expertise seems to be generally regarded as a hallmark of professional esteem, particularly by those outside the field of expertise. It might be expected that because there are expert witnesses who rebut each other's evidence this practice would lose its relevance but it seems to do the reverse. It seems to be strengthened by the ability to hire a person to say whatever is required. There will always be differences of professional opinion, particularly in those areas of greatest ignorance. There will always be variations, for example, in the sense that experts make of particular conduct. Forensic psychologists are at the leading edge of what they would call a developing science so there will naturally be differing opinions. These knowledges reflect a discourse of expertise and are highly prized in our community. They are prominent in magazines, journals and television talkshows, and they are no less valued in a court of law.

The Defence

The defences that are most commonly used are those of innocence because death was due to natural causes or accident, or if it was murder, the person charged did not do it (Agency France-Presse, 1993; Shankland, 2006), or because other staff are jealous and seeking revenge etc (Agence France-Presse, 1998a); insanity; and mercy killing (Souhard, 2003). In some cases, no defence is offered at all (Brown, 2006b). The discourses around defences are sparse and they subsume all of those mentioned here. In relation to mercy killing or euthanasia, there is some solace in thinking that nurses would only kill out of compassion. However, it is equally clear that in the cases included in this study, compassion is not really a credible explanation. The courts have certainly not been persuaded on this matter, as Malevre's case illustrates. Overwhelmingly, except in those cases where they confess, these nurses plead

innocence. For the most part, this does not persuade the courts even on some occasions when it clearly should.

The Court

The Court is among the most powerful institutions in society because it is charged with the responsibility of interpreting and applying the law. The decisions of courts shape the presentation of law in society and the law itself is a powerful instrument of social construction. In cases of nurses who murder there is a need for the courts to balance competing pressures. For instance, the courts take very seriously the principle of sanctity of life but in contemporary society must balance that against the groundswell of demand for a right to voluntary euthanasia. Moreover, the dictates of social utility militate against actions that might impair the capacity of nurses or other health professionals to discharge their role in society whilst justice demands that cases of nurses who murder patients are dealt with in a way that reassures society and punishes appropriately.

Cases involving nurses who murder patients present quite a challenge for the courts so far as achieving justice is concerned (K. Burge, 2003, p.1). Like other members of the public, judges regard the nursing profession as highly ethical so there is a strong discourse around the breach of faith involved when a nurse murders a patient or patients (AP, 2003a, p.12). This sentiment was explicit in the case of Charles Cullen, with the judge telling Cullen "*You betrayed the ancient foundations of the healing professions.*" (*The Canadian Press*, 2006); and again where a judge in the de Berk case noted the harm done to the nursing profession by such instances (Castle, 2003). In keeping with this, even the courts may be shocked by the callousness of the nurse who murders patients (Herbert, 2004a, p.5) and there is a discourse within the media texts around a recognition by the courts of the difficulties confronting prosecutors in obtaining convictions against these nurses (Agence France-Presse, 2002a; Mulvihill, 2006a).

The approach by prosecutors is to generally paint a picture of the defendant nurse as a murderous, inhuman monster and this image is so much at odds with the stereotypical nurse that it causes significant dissonance, but it also cements the

otherness of the individual (Gorlick, 2001). The defences vary but always it will seek to show the unreasonableness of that image compared with the person they see before them in the dock. Where the defence argues mercy killing, the situation becomes more complex. Generally, if a case has reached court it is unlikely to be construed as euthanasia but that does not deter some defendants pleading this as their defence (Masters, 2006, p.14). Almost always it is unsuccessful as was the situation in Andermatt's case (Agence France Presse, 2006). Errors can occur in courts and in the case of Wagner, the prosecution argued that she should be convicted of murder because euthanasia is unacceptable. However, it is not possible to construe Wagner's actions as euthanasia in any shape or form (Porubcansky, 1991). In most cases the court gives both parties considerable latitude because of the particular nature of the case but there is a discourse that implies that the prosecutor's task may be slightly easier where the victims are babies (AP, 1986a) and where there is clear evidence of premeditation (Agence France Presse, 2006; AP, 2003a, p.12; Moss, 1988a). This will have a significant influence on the sentencing outcome and that is particularly true where the death sentence is available. In many cases where a conviction is obtained, the judges feel constrained by the law in the sentences that they may impose (Moss, 1988a).

The complexity of proceedings in a case of murder by a nurse can be extraordinary so it is not surprising that among those who are convicted, there is a high rate of appeals. However, there is a very low rate of success of those appeals (AP, 1994; *Mainichi Daily News*, 2006; M. Smith, 2002a). The discourse of failed appeals serves to reinforce the appropriateness of the trial court's decisions and to reaffirm to society the fairness of the process. The importance of these discourses constituted by the texts of the media re-presenting the voices from the court have a powerful influence in shaping the understandings and meanings of nurses who murder in the minds of the public because they define the terrain in which those understandings and meanings can emerge.

Sentence

Sentences handed down to the nurses in this study range from a mere five years imprisonment through to several hundred years in prison. They are set out in Table

6.1 so I will not dwell on the actual sentences here. What is perhaps more important in this context is the discourses around the sentences and the process of sentencing and it is those discourses with which I want to deal here. How the court deals with a particular case is influenced by a number of factors. Chief among these is whether the nurse is perceived to be bad rather than mad. If perceived to be bad, the sentence is likely to be harsh. Texts around the appropriate form of punishment also constitute a discourse that has interesting dimensions.

Whether the nurse is judged mad or bad seems to be the key determinant of the sentence imposed. This tends to be a point of divergence between the discourses of the media and the courts. The discourses of the media imply almost that all nurses who murder are mad by definition. The courts are not moved by this in the same way because they are confronted with the plea of insanity as a defence and must apply the particular rules that relate to that defence. Thus when Ackley pleaded not guilty by reason of insanity, the court rejected that plea (*Rocky Mountain News*, 2004, p.31) Her motive was theft which gave to her conduct an element of rationality. This stands in sharp contrast to the case of Beverley Allitt who pleaded not guilty but was sentenced to life in a secure psychiatric hospital because the court was persuaded that she was mad. This dichotomy is a perennial discourse in the matter of culpability of nurses who murder.

It is evident from the Table that the most common sentence involves life imprisonment. This is so even in countries such as The Netherlands where life imprisonment is rarely imposed (Castle, 2003, p.17). In cases such as those of Cullen, Geen and Graham (Perlman, 1989a, p.27), the multiple life sentences both ensure they will not be released and provide a powerful source of comfort to families of victims and survivors. So far as Cullen is concerned, he is to serve his term in the highest security prison available (Mulvihill, 2006a). This seems calculated to reassure the public rather than to impose an additional punishment on Cullen.

There is a considerable reticence to invoke the death penalty even where it is available. The case of Kristen Gilbert makes that very clear. The case was unusual because it occurred in a state that does not have the death penalty but because the murders took place in Commonwealth property, it fell within the Federal jurisdiction

and thus Gilbert could have received the death penalty. Even with a special hearing to consider the matter, the death penalty was not invoked, much to the disappointment of some relatives of her victims. There remains considerable ambivalence about the death penalty (P. Gelzinis, 2001). In some cases where the prosecution would like to go for the death penalty, they may have to trade it away in a plea bargain in order to secure a conviction.(AP, 2004a). Notwithstanding these comments there is at least one case where a nurse who murdered patients was sentenced to death. That case was Robert Diaz and, having been sentenced in 1984, he remains on death row. Even now, there continues to be some speculation about his innocence, which he has always maintained. (M. Taylor, 1994, p.6).

These discourses around sentencing give some sense of how the courts regard murder by nurses. They clearly believe that it is a crime warranting the harshest penalties available short of the death sentence and that dressing it up either as euthanasia or as a manifestation of madness will generally be regarded as mere artifice.

Conclusion

It will be apparent from this Chapter that the bodies of texts constitute from their texts many discourses within the sphere of murder of patients by nurses. Some of those discourses involve the ability of the nurses to commit murder; some the detection, apprehension and detention of those nurses; and still others the judgement of those nurses by the community. In this Chapter I have canvassed subsets of those discourses with respect to enabling conditions, seriality and apprehension, the charge, the evidence, the defence, the court, and the sentences. Collectively these issues illuminate the broad terrain of the factors that make it possible for nurses to murder, but equally it has considered what leads to them being caught and judged. I have reached the point in this chapter where I must now reflexively reassess the process and progress of this analysis of nurses who murder against the six elements of discourse. That is to say, I need to take stock of the extent to which I have addressed the texts, discourses and contexts of the phenomenon of nurses who murder along with the operations of power, knowledge and subjectivity.

The bodies of texts have been examined and the discourses constituted by the texts have been made explicit. They are manifold and they are complex. Here I will barely do more than enumerate them. In Chapter Nine I will endeavour to derive more comprehensive understandings. The first cluster of discourses revealed in this chapter I have styled as enabling factors to the extent that they facilitate the murder of patients by nurses. They include trust in the context of patients being vulnerable individuals relying on a moral nursing profession; in the context of the public being able to trust health service organisations to protect them, government to regulate the nursing profession and the legal system to remedy wrongs against them; and in the context of nurses being able to trust their colleagues. This cluster also includes discourses around the employment mobility of nurses which patently contributes to the length of an individual nurse's killing trajectory and discourses around the silence of nurses when they know or suspect, or ought to know or suspect, that a colleague is murdering patients.

Discourses around the seriality and apprehension of nurses who murder are also plentiful in this chapter. Subsumed within this are discourses relating to seriality itself, to the number of victims of individual nurses, to the patterns that these killings represent and other dimensions of the killing trajectory; and the reliance on colleagues to blow the whistle. As well, there are further discourses around these nurses themselves that include the propensity for inflating the numbers of murders committed in the event that they confess; the motives that they declare or, more commonly, have attributed such as the discourse of thrill killing; the relationships they may have with other staff and sometimes with conspirators; and the response to publicity.

There is a further cluster of discourses around the investigation, the prosecution and conviction of these nurses. Within this cluster are discourses around the evidence with its attendant difficulties ranging from scarcity to inundation; the need to comply with the rules of evidence; its relationship to the process of charging the nurse, with all of the implications that hinge on the precise nature of the charges laid; and issues of fairness and justice. There are discourses around the dissonance between the lawyer's and the layman's understandings of these matters, and the relationship between law, justice and politics.

I have sought to contextualise the discourses throughout the process of surfacing them from the texts, and throughout this entire complex of discourses, I have endeavoured to expose the ever-present flows of power along with the incursions of particular knowledges. Most prominent among the subtexts is that of power, and it finds its expression in the vulnerability of patients that emerges time and again in this work. It is this that epitomises the subjectivity that is so embedded in this work. The commitment to the six elements of discourse identified in Chapter 4 is intact.

Table 6.1 - Sentences

Name	Age (at time of conviction)	Sex	Nationality	Nursing Status	No of murder convictions	Sentence	Victim Profile
ACKLEY, Christine	38	F	US	RN	1	Life	Disabled adult
AKIN, Joseph Dewey	35	M	US	RN	1	15 (pleaded guilty to manslaughter to avoid a 3rd hearing)	Adults
ALLITT, Beverley	23	F	English	EN	4	Life	Babies
ANDERMATT, Roger	32	M	Swiss	EN	27	Life	Elderly nursing home patients
ANGELO, Richard	25	M	US	RN	1	61 years to life	ICU/CCU patients
CALEFFI, Sonya	38	F	Italy	RN	12	20 years	No information
COONS, Michael	?	M	US	RN	0	0	Terminally ill patients
COUSE, Peggy	43	F	US	RN	1 attempted	TBA	Elderly nursing home patient
CULLEN, Charles	43	M	US	RN	29 killed 6 attempted	Life x 18	ICU/CCU patients
DE BERK, Lucy Quirina	41	F	Dutch	RN	7 killed 3 attempted	Life	Babies - through to elderly patients
DIAZ, Robert Rubane	46	M	US	RN	12	Death	Coronary Care Patients
DUDLEY, Bobby Sue TERRELL	35	F	US	LVN	3	65 years	Elderly
FALUDI, Timea	25	F	Hungarian	?	1 murder; 6 attempted murder	9 years, increased to 11 years	Elderly
FELTNER, Jeffery	26	M	US	EN	1	Life	Elderly

Name	Age (at time of conviction)	Sex	Nationality	Nursing Status	No of murder convictions	Sentence	Victim Profile
FIRTH, Alison	36	F	Scottish	RN	1	Life	Elderly
GEEN, Benjamin	25	M	English	RN	2 murder 15 attempted	Life x 17	Hospital patients
Name	Age (at time of conviction)	Sex	Nationality	Nursing Status	No of murder convictions	Sentence	Victim Profile
GIERSBERG, Michaela	27	F	German	AIN	4 murders 4 attempted murders 1 mercy killing	Life	Elderly nursing home patients
GILBERT, Kristen	33	F	US	RN	4	Life imprisonment without possibility of parole	VA Hospital patients
GRAHAM, Gwendolyn	25	F	US	EN	5	Life x 6	Elderly
GRUBER, Maria	23	F	Austrian	EN	Attempted Murder x 2	15 years	Elderly nursing home patients
GUIMARAES, Edson	42	M	Brazilian	EN	4	67 years	Unconscious or comatose ICU patients
HARVEY, Donald	45	M	US	EN	37	Life (avoided death penalty by plea bargain)	Mainly elderly or extremely ill; not always patients eg neighbour, partner
JACKSON, Vickie Dawn	40	F	US	EN (LVN)	10	Life	Elderly hospital patients
JENKIN, Pamela	42	F	Australian	RN	0	Discharged by court	Allegedly Terminally ill patients
JONES, Genee	33	F	US	EN (LVN)	1	99 years + 60 years concurrent	Babies

Name	Age (at time of conviction)	Sex	Nationality	Nursing Status	No of murder convictions	Sentence	Victim Profile
KANNER, Wanda	49	F	US	AIN	1	5 years	Disabled adult
LEIDOLF, Ilene	21	F	Austrian	AIN	5	Life	Elderly nursing home patients
LETTER, Stephan	27	M	Swiss	EN	12	Life	Mostly frail elderly; one victim as young as 40
MAJORS, Orville Lyn	38	M	US	EN	6	360 years	Hospital patients and others who offended him in some way
MALEVRE, Christine	33	F	French	RN	0 - 6 counts of assisting or causing the deaths of terminally ill patients.	12 years	Terminally ill patients
MARTIN, Justin W.	19	M	US	AIN	1	35 years	Elderly nursing home patient
MAY, Cheryl A.	33	F	US	RN	0		
MAYER, Stephanija	43	F	Austrian	AIN		15 years	Elderly nursing home patients
MULLINS, James	56	M	US	RN	0	2 years imprisonment	Hospital patient
MGWATYU, Luvuyo	27	M	South African	RN	1	12 years	Elderly
MOHAMMAD, Aida Nureddin	25	F	Egyptian	RN	1	Death, but on appeal, awarded new trial	Hospital patients in neurologyICU
MORI, Daisuke	29	M	Japanese	LVN(EN)	1 killed 4 attempted	Life	All ages
NORRIS, Colin	29	M	Scottish	RN	0	?	Elderly hospital patients

PAVIA, Daillyn*	32	F	US	RN	1	5 years suspended	Elderly, end stage terminal illness
RACHALS, Terri		F	US	RN	0	17 years	ICU/CCU patients
RACHMAN, Hal Speers	46	M	US	RN	1 attempted	9 years	AIDS sufferer
RAINEY, Shermika	18	F	US	AIN (nurse's aide)	1	30 years	Elderly
ROEDER, Michaela	30	F	German	RN	5 murders 1 attempted murder	11 years	ICU patients
ROSENFELD, Brian K.	34	M	US	Orderly, then LVN	3	Life	Elderly
SALISBURY, Barbara	47	F	British	RN	2 attempted murders	5 years	Elderly
TENZER, Heidi	34	F	US	AIN (nurse's aide)	1	30 years	Elderly
U, Martha	U	F	Dutch	AIN	4	9 years	Elderly
VAN OORT, Christie	26	F	Canadian	EN	1	50 years	Elderly
WAGNER, Waltraud	32	F	Austrian	EN	15 murders 17 attempted murder	Life	Elderly nursing home patients
WILSON, Gayla Ann	44	F	US	EN	1	Unknown	Elderly
WOOD, Catherine May	26	F	US	AIN	5x2nd degree	20 to 40 years imprisonment	Elderly

Chapter 7

Angels of Mercy or Angels of Death: Constructions of nurses who murder

Introduction

In this chapter, I attempt to make sense of the perceptions and perspectives of those who are impacted by this phenomenon and whose voices are evident in the discourses that surround it. At the same time, there are silences that need to be explained because those silences often represent voices that are conspicuous by their absence. They also represent significant exercises of power so I will point out these absent voices as I report the analysis of this material. I will begin by exploring the understandings of the word 'nurse' in the literature, and in particular in the mass media with specific emphasis on newspapers. Only when the meaning of the term 'nurse' is clear is it possible to reveal the discourses that pertain specifically to those who are embraced by the term and who murder patients.

What is a nurse?

In developed countries, nursing is conventionally a regulated sphere of activity. A nurse requires licensure in some form and at some level in order to practise nursing. The bodies of texts contribute to a range of discourses around this notion and the texts are constituted of multiple voices. There is a discourse of acknowledgement by society generally that the practise of nursing involves a relationship between nurses and patients which, because of the vulnerability of patients, involves an inherently skewed power relationship; thus, those granted the license to practise nursing must be fit and proper persons. In most cases this involves the establishment by government of a licensing body that determines criteria and standards for the granting of a license. The profession itself is vocal in this regard, dividing nursing into spheres and levels of practice according to skill levels, expertise and autonomy. Some see this as protecting the interests of the public; some see it as protecting the interests of the profession; and still others see it as protecting the interests

of the individual nurse. Another voice that is loud in this context is that of the employers of nurses and because in most developed countries the largest employer of nurses is the government, the voice of government as regulator is prominent. Each of these voices and their contexts is considered in this Chapter but the starting point for this discussion is the discourses around the nursing status of the nurses who murder.

Nursing Status of Defendants

The bodies of texts relating to the murder of patients by nurses do construct a strong discourse around the professional status of these nurses. The strength of the discourse lies as much in what is not said as much as in the visible texts. The imprecision of language around nurses who murder patients is evidenced by the inconsistent use in the texts of terms such as orderly, nurse's aide and enrolled nurse and registered nurse. When the *St Louis Post-Despatch* was reporting on the Austrian case of Waltraud Wagner, she and her co-defendants were categorised as 'nurses aides' (Prinz, 1989b; A. Smale, 1989). Even so, there is ambiguity because the headline of the article refers to Wagner as a nurse's aide but in the body of the text she and her colleagues are consistently referred to as 'assistant nurses'

'Nursing Aide Changes Confession; Colleague Believes She Killed 200 The assistant nurse, Waltraud Wagner, 30, is one of four who have been detained since April 7. ... another assistant nurse...Irene Leidolf, who also was detained. The others detained were Maria Gruber and Stefanie Mayer. All worked as assistant nurses at Vienna's Lainz hospital.'
(Prinz, 1989b)

There is no acknowledgement in the texts of the media that the meaning of 'nurses aide' varies among countries and jurisdictions and there is no attempt here to determine with any precision what the role of 'nurse's aide' entails. Thus, the power exercised in a statement of this nature lies in its capacity to harm the reputation of the whole of the nursing profession where it may have been more appropriate to single out the nurse's aides because of the lower levels of training and education. This is not an isolated example. The bodies of texts of the media that constitute the news commentaries about nurses who are accused of murdering patients more commonly than not, simply identify the individual as a nurse. Whilst the lack of precision is understandable because there is

no uniformity within the nursing profession itself or between the nurse regulatory authorities of different jurisdictions, the implications of this are significant in the context of this work.

There are many examples of commentaries where news reporters – who generally have no more knowledge of nursing, its organisation or its subtleties than the general public – report cases of nurses who have allegedly murdered a patient or patients, without explaining more about the status of the nurse than that mere epithet. One such example is that of Tobin reporting on the case of Brian Rosenfeld. From this it can be inferred that Rosenfeld is a nurse but at what level? There is no indication of his level of qualification or experience.

There is no clarity about the status of Brian Rosenfeld as a nurse. The fact is that he was initially an orderly and subsequently at least an LVN.

'A year ago, an anonymous tipster told the Kenneth City police that nurse Brian Kevin Rosenfeld had murdered a 93-year-old nursing home patient.'
(Nohlgren & Journey, 1990c, p.1)

In a follow up story, these writers provided fractionally more clarity:

'Before his arrest, Rosenfeld had worked at least eight years in Pinellas nursing homes as an orderly, and later as a nurse.' (Nohlgren & Journey, 1990a)

There are compelling reasons why the detail of a nurse's qualification and experience should be ascertained for inclusion in such reports. One such reason is the expectations of the care to be provided by a given nurse and this has to do with the scope of practice for each level of preparation. It may be too extreme to suggest that the public needs to be able to make judgements about whether the qualifications and experience of a nurse are a relevant determinant of the likelihood of a nurse murdering a patient or patients at some stage but the discourses that are constructed by the texts may signal that this is indeed the case. This would be significant because, if such a link is revealed, then members of the public may be far more circumspect (and much less trusting) of those categories of nurses who demonstrate greater proclivity for the murder of patients. Conversely, those

categories of nurses that demonstrate a reduced propensity to do so may enjoy an increased level of trust from the public who constitute their prospective patients. To labour the point of this argument for greater awareness of the qualification and experience of those persons labelled as nurses who have murdered patients, we can learn much from the many examples of texts that exemplify the lack of precision. We can also learn much by comparison of different reports on the same case, as will be shown below, but consider first the Swiss case of Roger Andermatt.

'A Swiss nurse described as the angel of death was sentenced to life imprisonment yesterday for the murder of 22 people between 1995 and 2001. Roger Andermatt, 36, killed his elderly victims...'
(McDermid, 2005)

I have already made the point that the general public rarely draws a distinction between different levels of qualification of nurses but neither did the reporter on this occasion. Just as McDermid, like so many others, demonstrates a lack of awareness of both the structure of nursing and the relevance of qualifications and experience (which may tell us much about perceptions that they have of nursing and nurses), the same is evident among reported comments of police on these matters. However, in the case of Roger Andermatt, the police did advise reporters that he was trained as a Nurse Assistant (AP, 2005d) but, once again, there is no indication of what that means.

'Police said he was a Swiss citizen who moved to Germany after his parents divorced, but returned to Switzerland in 1990 and trained as a nurse assistant' (AP, 2005d).

Andermatt's nursing status was reported in precisely the same way in the USA when *USA Today* (AP, 2005b) carried the story. Andermatt trained in Switzerland. Is a nurse assistant in Switzerland the same as a nurse assistant in Canada (where this report by AP appeared)? This is a perennial problem because not only is there apparently a poor understanding of the classes of nurses within countries but there is no uniformity between countries either so the likelihood of understanding the significance of the classification of a nurse by the news report is even further reduced in international reports. Notwithstanding this criticism, it must be acknowledged that some reports are more

attentive than others to this issue of clarifying what is meant by 'nurse'. For example, some reports are more explicit than others in identifying the level of qualifications, as in the following comment on the case of Orville Lynn Majors:

'Majors...was a licenced practical nurse at the Vermillion County Hospital in Clinton...' (Associated Press Newswires, 2000)

Similarly, the media was clear in its description of Jeffrey Feltner as a nurse's aide:

'...Feltner, 26, a certified nurse's aide, began confessing to killing elderly patients several weeks ago...' (AP, 1989a).

However, this injects a further term. Is a 'certified nurse's aide' in any way different to a nurse's aide. In the case of Daisuke Mori, some newspaper articles made it clear that he was a Licensed Practical Nurse but, in each of these cases, the report says nothing of what that means in terms of education and training:

'... Daisuke Mori, a 29-year-old former licensed practical nurse who allegedly tried to kill an 11-year-old girl by giving her an intravenous drip laced with muscle relaxant at a Sendai clinic, pleaded not guilty on Tuesday at a Sendai court.' (*The Daily Yomiuri/Yomiuri Shimbun*, 2001)

This implies that there is a general understanding of what these categorisations mean in the minds of the public but that is clearly not the case. The general label of 'nurse's aide' is confusing because it means different things in different places and to different people. In the case of Shermike Rainey, it was reported that '*...Nurse's aide Shermike Rainey, 18, has pleaded guilty to conspiracy to commit first-degree murder in Ryan's death...*' (AP, 2004e) and Gutis (1987) when reporting on the case of Richard Angelo writes '*...in the case of the 25-year-old registered nurse..*' making it quite clear that he is a registered nurse. The problem that this creates is the same as that with the nurse's aide situation. There is no precision between or sometimes even within jurisdictions as to what that term means, particularly where it has become a generic term with internal divisions such as in Victoria, Australia where the *Nurses Act 1993* (Vic) provides for Division 1 Registered Nurses (formerly registered nurses) and Division Two Registered Nurses (formerly Enrolled Nurses). This is not dissimilar to the situation in the USA where there are Registered Nurses and Licensed Practical Nurses (or depending on the particular State,

Licensed Vocational Nurses). This makes it very difficult for the lay public firstly to stay abreast of the nomenclature and secondly, to understand the distinctions.

Another case that demonstrates this lack of clarity, emphasis or understanding of the variable status of nurses is the case of Joseph Dewey Akin. He was a registered nurse but the reports on his case mostly do not focus on this at all. When the *Houston Chronicle* (Anon, 1991, p.8) reported on his case they wrote:

'A male nurse under investigation...Akin was working as a nurse at Cooper Green at the time...where Akin worked as an intensive-care nurse in 1990.'(Houston Chronicle, 1991, p.8).

Mostly reports of his case, like so many others, just indicate that he was

'...a nurse.'(Associated Press, 1997b)

but Yardley (1991, p.1) at least hinted at his status in reporting that Akin

'...worked as an (sic) critical-care nurse at North Fulton Regional Hospital from June 1990 until December...' (Yardley, 1991b, p.1).

The case of Christine Ackley is a further case in point. None of the following reports offer much insight, and in the case of the report from the *Rocky Mountain News* (2004a, p.24) the use of the term 'home-care nurse' possibly only serves to confuse because of the blurred nomenclature of care assistants and the total absence of any elaboration of its meaning: 'An Aurora home-care nurse...'(*Rocky Mountain News*, 2004a). Almost always, the reports simply refer to a nurse. There are numerous examples in the particular case but the following is typical: 'An Aurora nurse was convicted of murder in Douglas County District Court...'(*Denver Post*, 2002a, p.2). This is a recurrent pattern in relation to many of the nurses included in this study.

I have sufficiently established the lack of clarity in the texts as to the nursing status of nurses who murder patients. However, before moving on from this matter of nursing status, it is worth referring to the case of Wanda Kanner. She was charged with, *inter alia*, 'holding out'. This is the offence of representing oneself as something – in this case,

a licensed nurse – that one is not. Notwithstanding this, she was characterised by the reporter as an unlicensed nurse but, in the circumstances, this would seem to be something of a *non sequitur*.

'A nurse has been charged with murdering one of her patients with a bagel....Unlicensed nurse Kanner began working for the Amberiks in 1998 in Cleveland, Ohio.' (*The Express*, 2003, p.33)

The cases so far referred to in this section have shown clearly that this decontextualising of the nurses accused of murdering patients serves to cloud our understanding of the phenomenon for all of the reasons explained earlier. The texts are so prolific in this lack of clarity that I have elsewhere characterised it as a discourse of 'a nurse is a nurse is a nurse'. To reiterate, this discourse is dismissive of the knowledges of nursing; it devalues the expertise inherent in a registered nurse and it subjugates that knowledge to the need to be cared for. It implies that anyone can care for a sick person. This discourse enables registered nurses in particular to regard nurses who murder as different and therefore, as 'other'. They can dismiss reports as the media being mistaken – it could not possibly be a real nurse murdering patients - and consequently, the problem as represented is minimised. This is a problem in, of and for the profession of nursing.

In virtually all of the cases of murder in this study, the crime is committed in a context in which registered nurses have responsibility for leadership and standards of practice but this essentially goes unmentioned. Only when there is obvious neglect is it touched upon, as in the case of Heidi Tenzer where registered nurses and administration were charged with felony neglect and pleaded guilty to the less serious charge of misdemeanour neglect (Caruso, 2003; Rotstein & Lash, 2003). Nursing administration and management are the spheres that usually have the carriage of this responsibility and thus, when things go wrong it is they who bear the brunt of public and regulatory reaction. I will labour this important discourse no further here but I will return to it in Chapter 9. I want to move on now to explore another related element of the texts in the media around these cases of nurses who murder.

The 'Former Nurse'

The bodies of text constitute a discourse around the notion of the 'former nurse'. This signals that nurses who murder cease to be nurses. It assists in consigning them to the space of otherness. It implies a presumption that those who do bad things cannot be nurses. There is much in both the literature and the rhetoric of nurses that constitutes a discourse that could be encapsulated in the saying 'once a nurse, always a nurse' and this perspective – which is widespread among nurses – cannot admit of the possibility of a 'former nurse'. It is also inconsistent with the idea that 'a nurse is a nurse is a nurse' which seems so strong in the public discourse. While many nurses may think in terms of 'once a nurse, always a nurse', it is clear that not everyone shares the view. This discourse implies a tension between the dictates of a professional identification which holds nursing to be a vocation, and that of the regulatory framework that constructs a nurse as an individual upon whom has been bestowed the monopolistic right to practise nursing. This is an exercise of power at many levels and the right can be withdrawn as readily as it can be bestowed. Does this mean that nurses who murder patients are no longer considered to be nurses? Many of the commentaries on the cases of nurses who murder patients make reference to 'former nurses'. Take for instance, Mulvihill's report on the case of Charles Cullen:

'...Cullen, a former nurse who has said that he killed 30 to 40 patients at institutions where he worked over his 16-year nursing career, pleaded guilty...' (Mulvihill, 2004, p.3).

As with so many of the discourses constituted by the texts around the murder of patients by nurses, there is a consistency of meaning in relation to the 'former nurse'. Many of the texts reporting these cases in the media certainly imply that because a person has murdered a patient, they cease to be a nurse. In the case of Justin W. Martin he was reduced to a 'nursing home employee', and an 'ex-nursing home employee' at that.

'A 19-year-old ex-nursing home employee has been sentenced to 35 years in prison after pleading guilty to second-degree murder in the death of a 78-year-old patient' (AP, 1998d).

Martin's complete expunction from the entire field of nursing may have to do with the heinousness of the nurse's actions. Another way of understanding the 'former nurse'

epithet could be explained in terms of loss of licensure; however, some of those referred to as former nurses held no licensure in the first place. This matter is discussed elsewhere in terms of the role of the regulator and perceptions of the profession. The key point here is the inconsistencies between the two discourses of 'the nurse is a nurse is a nurse' and the retractable status of 'nurse'. This difference in the discourses is a difference in the way that power – and particularly knowledge as power – is exercised within society. It distorts the context of the nurses and in turn, the context of murder of patients by nurses. One aspect of those contexts is the meanings and understandings held by the public of nurses who murder. These are reflected in the characterisations of nurses who murder.

Characterisations of nurses who murder patients

The ways in which nurses who murder patients are characterised tells us much about the standing of nurses and the need to isolate deviant nurses in ways that distinguish them from the norm to the maximum extent possible. The most overt characterisation is that of the 'killer nurse' but by far the most common is the 'angel of death'. Even more commonly, the term 'angel of mercy' is invoked but that is most commonly and most appropriately applied to those nurses who engage in authentic euthanasia and that population has been excluded from this study. Thus, the key characterisations of nurses who murder patients with malice aforethought include the 'killer nurse', the 'angel of death', the 'thrill killer', the 'monster', the 'baby killer' and the 'serial killer'. These are the characterisations that emerge from the bodies of text that constitute the mass media – the newspapers, television newscasts, books, etc – and they will be discussed in this section. To aid in understanding how these particular characterisations have emerged, a range of different voices can be heard in the bodies of texts contributing to the shape of each of these discourses and those voices are acknowledged in a discussion of additional issues including the demeanour of these nurses, the comments of their colleagues, the perceptions of their relatives, the practice of ranking the killers, the place of power, the contribution of the media, the prosecutorial perspective and the health of these nurses.

The Killer Nurse

When a news item appears with the banner headline 'Killer Nurse', it will certainly capture the attention of the average person. Those who have need of nurses – and who are therefore by definition more vulnerable to a killer nurse – will be more susceptible to such a headline. It is enough to strike fear into their hearts. It raises a fundamental question that we would ask of ourselves at anytime that there is a killer in our midst: how can I protect myself against this killer, or if not this killer nurse, then any other, for the problem that this announcement of a killer nurse presents is that it admits the possibility of others. That is a question to which I will return in Chapter 9 in terms of the dichotomy between the need of the sick to place their faith and trust in their nurses counterpoised with the knowledge that some nurses kill patients out of malice. For now, however, it is enough to be aware that fear is a key determinant of the way in which we react to knowledge of a nurse killing patients.

In the period that this study encompasses – 1980 – 2006 – there have been literally hundreds of articles published with a headline along the following lines: 'Killer nurse charged over woman's death' (*Mainichi Daily News*, 2001). Just a few of the many among the nurses in the study to attract this descriptor have been Allitt (Shankland, 2006, p.33); Andermatt (*Daily Post*, 2005, p.14); Cullen (A. Stewart, 2006, p.23); Jackson (*The Advertiser*, 2006b, p.36); Mori (*Mainichi Daily News*, 2003); Norris (Thornton, 2005, p.17); and Wagner (Reuters, 1991),

This characterisation seems to convey a dual message. On the one hand, it sends a strong signal that some nurses can clearly be very dangerous. At the same time it mitigates the harshness of this message by singling out such nurses – killer nurses – as aberrant, as other. Normal nurses do not wilfully kill patients. The subtext seems to be that we should have confidence in our society's capacity to regulate nursing and to ensure that only those nurses who are not aberrant are permitted to practise and to continue to practise nursing. The fact that each of these articles is reporting on the arrest, and very often, the trial and conviction of these aberrant, other nurses may be taken as testament to the effectiveness of the regulatory authorities in our society to discharge this responsibility. So too may the rarity of such occurrences be taken as a measure of that effectiveness. That at least is one

possible interpretation of this characterisation and it would go some way towards explaining why people are so sanguine about nurses and their trustworthiness in the face of this evidence to the contrary. It is equally capable of sustaining an alternative interpretation, however, and that is that such nurses for the most part simply go undetected.

Angels of Death

Even more common than the characterisation as 'killer nurse' is that of 'Angel of Death'. Here again, a number of the nurses whose cases are encountered in this study have been characterised as angels of death. Note that it is generally the media that apply the epithet, just as it was in the case of 'killer nurse'. The following extract from a report on the case of Lucy Quirinda de Berk demonstrates this quality very well.

De Berk, dubbed the "angel of death" by the Dutch press, is accused of killing 13 patients at four different hospitals between 1997 and 2001 with a lethal cocktail of pain killers and tranquillisers and of attempting to kill five more. (Clements, 2002, p.38)

Lucy de Berk was widely described as an 'angel of death' and her case was often reported in this way, as shown in yet another extract:

A NURSE [Castle's emphasis] who became known as the "Angel of Death" was jailed for life yesterday for the murder of four patients, including three children, in one of the biggest murder trials staged in the Netherlands. (Castle., 2003, p.17)

Note the form of expression here – she 'became known' as the "Angel of Death". However, from the bodies of texts it is quite clear that it was the media that cast her in this role. The earlier article attributed her labelling as such to the Dutch press. Another example of the media being expressly identified as the source of the label of 'angel of death' is the case of Roger Andermatt. Dubbed the "angel of death" by Swiss media, he claimed that he 'acted out of sympathy and pity' (AP, 2004d). Other sectors of the media put a slightly different 'spin' on this characterisation of Andermatt, and at least one removed the angelic quality:

A Swiss appeals court on Wednesday upheld a life sentence for murder handed down to a retirement home employee known as the "nurse of death" (AFP, 2006).

It is not always the media who attach this label, though. As is frequently the case when nurses are accused of murdering patients, Kristen Gilbert was characterised as an 'Angel of Death' but in this case, it was reported that it was her colleagues who labelled her as such.

Gilbert, nicknamed the "angel of death" by her colleagues at the VA hospital in Northampton, was convicted in 2001 of killing four of her patients and attempting to kill two others (K. Burge, 2003, p.1).

Timena Faludi, too, was characterised as 'The Black Angel' by her colleagues. Nurses are renowned for their black humour but it seems that, in this case, the epithet was attributed by colleagues who did not harbour suspicions of murder being involved:

...known as the "Black Angel" to colleagues because of her penchant for dark clothes and apparent ability to predict deaths... (AP, 2003c).

This text shows the imagery of evil that the media so loves when sensationalising a story. So far, we have seen that the media and colleagues of such nurses may label the nurse as an angel of death but in the case of Stephan Letter, another nurse characterised as an angel of death, it was he himself who made this claim (Anon, 2006). Richard Angelo is a nurse who, having been accused of the murder of his patients, quickly became *'the "Angel of Death" nurse accused of injecting patients with the paralyzing drug "Pavulon,"'* (Gutis, 1987) and from Brazil came Edson Guimaraes described as follows: *'Guimaraes, 42, a quiet, black-eyed man quickly dubbed the "angel of death"...*' (Goering, 1999a, p.2).

It will be clear by now that around the world, many of the nurses that murder patients attract the label of 'angel of death'. Some consideration of this may shed a little light on a complex notion. Why should the act of killing patients be associated with angels, given that angels generally are conceived of as guardians, doers of miracles and generally harbingers of good? Perhaps it is more akin to their role as messengers of God. Properly defined, an angel is *'an attendant or messenger of God'* or in the alternative, *'a very*

virtuous person' or even a *'very obliging person*' (J. Pearsall & B. Trumble, 1995, p.50). On this definition, it is not too hard to conceive of a relatively close link between nurses and angels. It may have something to do with the historical association between nurses, nuns, religion and death. It may also have to do with notions of mercy and the easing of pain and discomfort. Both angels and nurses have a long and strong association of doing good for others. Nurses have long been compared with angels when soothing the fevered brow, as it were. Where nurses engage in authentic euthanasia, which we might otherwise label as mercy killing, it is a relatively small cognitive shift for the pro euthanasia lobby to include this act within the rubric of goodness and to maintain the positive association with angels. However, the dictionary has one other definition that assists the semantics here. Angel also means *'...an attendant spirit..'*(J. Pearsall & B. Trumble, 1995, p.50) which may be either a guardian angel or an evil angel. Thus, there are both good and evil angels.

This study shows that there are both good and evil nurses as well. In the case of authentic euthanasia, death may come as welcome and consensual relief, and an end to suffering that in the language of ethics at least, is the beneficial outcome of good and correct conduct representing a coalescence of beneficence and autonomy. The same cannot be said in the case of nurses who murder patients with malice aforethought, where it is immaterial that death may afford relief to the patient. In this latter situation, the angel of death must be construed as an evil angel, and the semantics are often made explicit by the appending of black to the epithet. That is to say, the angel of death is sometimes the 'black angel'. The association of black with darkness and evil is so well known as to warrant no elaboration here save to say that it is a common ingredient in these characterisations of nurses who murder patients.

This discourse of angels of death may assist in quarantining the fear that we might reasonably expect to be generated by nurses who are serial killers of vulnerable patients in hospitals and aged care facilities. However, these real cases seem not to capture the attention of the public. That role seems to fall to fictionalised versions sanitised or dramatised for public consumption within the steady diet of dramas and 'docudramas'

that constitute televised entertainment and paradoxically serves to desensitise the populace to the phenomenon. There is no obvious explanation for why this should be so but in Chapter 9 this matter will be revisited. For now, it may be more useful to consider what the discourses constituted by the data tell us about some of these angels of death to enhance our understanding of how we react to them.

The Demeanour of the Angels

It seems reasonable to assume that being accused, investigated, arrested and charged with the murder of one's patients would be, in the minds of most nurses, the most traumatic of experiences. Certainly that is the response of many of those nurses who have been acquitted of such charges or against whom the charges have been dropped. The manner in which these nurses who are accused of the murder of patients conduct themselves when they are detected and apprehended is among the most interesting elements revealed in the media texts. There is some variation in their reactions but there are also some common themes and the persona they project appears to have a significant bearing on how they fare in their trial and in the public opinion. A nurse who greets such charges with equanimity can be perceived in one of two ways: either they are guilty but a very smooth operator or they are confident of both their innocence and a positive outcome. How the media represents the nurse to the public is a key determinant of public opinion in each case. More will be said of the media's role later but no one should underestimate the role of the media in shaping public opinion.

The cases encountered in this study demonstrate the media roles well. For example, Akin is presented as relaxed and confident in the face of a murder charge.

'Tanned and smiling, Mr. Akin surrendered Thursday afternoon, a day after he was charged in the death of intensive-care patient Robert J. Price, 32.'

'Mr. Akin, 34, wearing a dark suit, lime-green shirt and paisley tie, arrived at the jail in a black Saab. He only smiled and blushed slightly as reporters shouted questions about the murder charge.' (Yardley, 1991b, p.1)

The emphasis in the news report is to imply that he does not seem too bothered by the adverse attention. More importantly, this report gives a strong sense of relaxed reasonableness on the part of the accused. At the same time, it reads like a fashion report

and in so doing, trivialises the seriousness of the offence with which Akin is charged. One of the limitations of the snapshot/soundbite approach to the reporting of such matters is that the reader is only provided with glimpses of the accused. This makes it difficult to get any real sense of the person. In other cases, a single feature of the accused is revealed or attributed. For instance, some nurses who kill patients have been described as ruthless. Salisbury was one such nurse.

A nurse was jailed for five years yesterday after a jury convicted her of trying to kill two elderly patients in a "ruthless" attempt to free hospital beds. (Herbert., 2004, p.2).

Notwithstanding the selective reporting, we should not underestimate the extent to which the presentation of the individual is an important determinant of how the media portrays the person.

Feltner, 27, stands 5 feet 3 inches tall and weighs barely 100 pounds (AP, 1990).

In Feltner's case, it is his diminutive stature that is highlighted. How could such a man be a threat to any one? It would be no surprise that such a man would become a nurse. Earlier in this Chapter the need to perceive these nurses as aberrant was discussed. This perception that nurses who murder patients should somehow be abnormal is widespread so it surprises people who know them when they recollect these individuals as nice people who seem perfectly normal. An example of this can be found in the case of Benjamin Geen:

'Last July, Geen and his fiancée Megan Crabbe, also a nurse at the Horton General Hospital in Banbury, moved into the newly decorated terraced house in London Road, which they rented while the owners went travelling for six months. The couple lived there with another friend until February when Geen's trial began at Oxford Crown Court. A neighbour said: "As far as we were concerned they were very nice neighbours. "They kept themselves to themselves and we did not really know them apart from to say 'hello' to.'
"The first I knew about this was what I saw on the television - it was a shock."
One businesswoman in the town, who had dealings with the couple, described Geen as very quiet. "They seemed like a normal couple," she said. "To be honest with you, I hardly noticed him. I do not think he said two words the whole time he was here.

"Looking back, it may have been because this was going on." (*Milton Keynes Citizen, 2006*)

The voices of the public are loud in this discourse of normality. It is an important discourse because it highlights the implicit assumption that a nurse who was so deviant as to murder patients would be expected to display other signs of aberration. Such a nurse could not be expected to display no other signs of abnormality. This is, after all, a monster with which we are dealing. I will return to this notion of the monster subsequently, but first it may be helpful to pursue the idea of normality and the way in which nurses who murder patients are perceived by their colleagues.

The Comments of Colleagues

There are two key discourses that characterise the perceptions of colleagues of nurses who murder patients. The first is that of suspicion and suspicion denied. In many cases the colleagues of nurses who murder are suspicious of that colleague. This is a matter discussed elsewhere in this dissertation, particularly with respect to the length of time it takes them to act on their suspicions. The second, and much more easily admitted, is that often nurses who murder patients are highly regarded by both patients and other staff. Stephan Letter provides an excellent example of this phenomenon.

To his patients, Stephan Letter was a kindly young man who did everything he could to relieve their suffering. Unfailingly friendly, Letter was popular at the Bavarian hospital where he worked as a nurse. (Harding, 2006, p.18)

In such circumstances it is difficult to suspect the nurse who is murdering patients because of the cognitive dissonance between an obvious warm and caring relationship with patients and the notion of murdering them. This is a key reason why evidence may accumulate without suspicion attaching to the nurse as was the case with Terri Rachals (Manners, 1995c). Where management considers the motive to be mercy killing and where elderly people are the victims, they are more likely to continue to support the nurse who murders patients after that nurse is exposed.

A former nursing home aide who has publicly admitted killing at least six patients to relieve their suffering was viewed by his boss as a conscientious worker, the employer said. "He gave good care," said Bill Powell, administrator of Clyatt

Memorial Center, where Jeffery Feltner worked for about a month. (AP, 1989a, p.1)

It is not just patients and colleagues who can feel very positively about a nurse who is murdering patients. Relatives, too, can fall into this trap.

Perceptions of Relatives of Angels

The commentaries of relatives and friends of the nurses who murder patients can shed significant light on the type of person they are, the family history, biographical data and more. Sometimes, those family members hold similar views to those of the patients or colleagues, be they positive or negative. At other times the views of relatives may be at odds with those of everyone else. An example of the former situation is that of Vicki Dawn Jackson:

Jennifer Carson, 18, [daughter of Jackson, said "I don't know if she did it or not, but she's perfectly capable of it..." (Brown, 2005b).

It will be obvious from this that, even before trial, the media seek opinions that may be patently prejudicial to the defendant e.g. from relatives. A childhood friend of Beverly Allitt described her strange behaviour and one of them even described becoming mysteriously ill which with hindsight is eerily similar to her later deeds (N. Davies, 1993a).

Perceptions of Relatives of Victims of Angels

For the relatives of the victims of nurses who murder patients, it is difficult to believe that a nurse could do such a thing. In many cases, they place a significant emphasis on evil. Charles Cullen's case provides an example of this. There is a strong emphasis on sensationalising the 'satanic' characterisation of Cullen.

"The sentence followed an emotional hearing during which the victims' relatives finally got their opportunity to confront Cullen, with one describing him as "Satan's son."

"The monster who played God can justify his actions; sometimes he possibly believes he was an angel of mercy," Dolores Stasienko, whose father was killed by

Cullen, told the sentencing hearing. "Let us correct him. He was a demon from the lowest depths of hell," Stasienko said.' (GH, 2006; *Hobart Mercury*, 2006, p.25)

Petti McLellan – the mother of the one little victim of Genevieve Jones of whose murder Jones was convicted – visits her grave in the Garden of Memories Cemetery in Kerrville on her birthday and the anniversary of her death in 1982. Every time there is a bouquet of flowers already placed on the grave. Petti throws the flowers as far away as possible. She believes that Genevieve Jones is sending the flowers and she is taunting her from her place in gaol (Elkind, 1990a, p.400).

Ranking the Angels

Within the media there is a discourse of seriality that enshrines within it a proclivity among journalists, crime writers and others for ranking these nurses who murder patients. There seems to be an internal ranking within nursing i.e. where does this particular nurse rank relative to all other nurses who have murdered patients, and an external ranking against all serial killers generally. The parameters for ranking seem to be the number of victims and the brutality/creativity of the method. Some examples of how the ranking is expressed may assist in understanding this discourse. It is now a matter of record that, for Indiana, a nurse became their worst ever serial killer with the conviction of Orville Lynn Majors. His conviction was reported by AP who said *...After Majors is sentenced, he will be the only Indiana inmate ever convicted of six murders, Department of Correction spokeswoman Pam Pattison said. Two other inmates are being housed for killing five people. "He is Indiana's serial killer," Pattison said...* (AP, 1999a). Donald Harvey, who was convicted of significantly more murders, was not awarded the same status as Majors in these stakes: *Donald Harvey, who agreed Tuesday to plead guilty to killing 24 people in Cincinnati, is one of the more prolific murderers in U.S. history...* (Associated Press, 1987, p.18).

However, Stephan Letter achieved a similar level of notoriety in Germany when he was arrested for the murder of what ultimately turned out to be 29 elderly patients:

A MALE [Boyes' emphasis] nurse accused of the worst serial killing spree in modern Germany claimed yesterday to have relieved the suffering of 29 elderly

patients by fatally injecting them with a mixture of sleeping drugs and muscle relaxants. (Boyes, 2006, p.39)

The question that this discourse of ranking raises is, why? How is it important if a nurse kills more patients than another nurse? Is it important that a nurse claims the national title as worst ever serial killer, which seems to be the case in Germany, Switzerland, France, the United States and some other countries? Does it make it a competition? There is some evidence to suggest that it has been internalised as such. We know, for example, that Lucinda de Berk used Beverley Allitt as her role model. We have seen the pride that serial killers of all sorts – and serial killing nurses no less than any others – in achieving record numbers of victims. There is a real concern that the media, through reporting on these murderers in this way, contribute to the competition. It is clear that in the case of at least some of these nurses who murder multiple patients, it is very much about the scoreboard of notoriety. It is about achieving celebrity for otherwise damaged or insecure individuals who happen to practise nursing. The media has a responsibility in this regard to limit the harm that it can potentially produce through the way it bestows celebrity upon individuals. I was aware of this as a potential hazard of this study also and it was a matter that caused me to reflect at considerable length before embarking upon the undertaking.

The Monsters

There is a practice within the media of representing serial killers as monsters. The general public shares that view but at the same time enjoys being confronted by its worst fears from behind the safety and security of a television screen. The current vogue in the televised crime genre is very much focused on serial killers, their forensic investigation and apprehension. This produces an anomaly. It seems at once to fill the public with dread whilst simultaneously desensitising them to the horror of serial killers who mutilate and murder. It may also be that it lends creativity to the unimaginative and thus enables those few people who dream of being record-breaking serial killers to achieve their ambitions. It may even be that some nurses are numbered among those few. Medical murder has begun to appear in the mainstream films of this genre. Nursing entered the

genre with a 'docudrama' of the Genene Jones case and much more recently with a dramatisation of the Beverley Allitt case (Etherington, 2006).

Members of the public tend to regard nurses who murder patients as monsters but this is much more the case where they are relatives of the victims. Mulvihill reports that Cullen *...kept his eyes closed as about 20 relatives of his victims called him a "monster" and "garbage"...* (Mulvihill, 2006b) and this was widely reported. The Canadian Press reported that *...the sentence came down in Somerville, New Jersey after relatives of his victims called him "the monster" and blamed him for wrecking their lives...* (Broadcast News, 2006). In the Geen case, it was reported that *...during his trial at Oxford Crown Court, Geen was described as "a maniac on the loose" by prosecutor Michael Austin-Smith...* (Wickham, 2006b, p.1).

There are other examples that could be included here but these cases make the point sufficiently well. There is one category of nurses who murder patients that is more maligned and more incomprehensible to the average person than any other, however. That is the category of nurses whose victims are babies and children.

The Baby Killers

This group of nurses that murder patients has been discussed elsewhere in this dissertation with respect to victims. However, so significant is their conduct in the context of this discussion that we need to revisit this group in connection with a number of discourses. The characterisation of a nurse who murders patients who are babies is generally more condemnatory than of those who despatch the elderly, and this attitude appears to carry through to the Courts.

The State Board of Pardons and Paroles unanimously denied parole Wednesday to convicted baby killer Genene Jones, whose case sparked more than 1,000 letters to the board. (Holmes, 1989, p.11)

This group – which includes Beverley Allitt, Genene Jones, Lucy de Berk and others – emphasises the vulnerability of their patients but it also highlights the inability of the

parents of their tiny victims to protect their own children. So repugnant are the actions of these nurses in the eyes of the community that they attract the harshest disapprobation from all quarters. This may be compounded by the fact that it takes time to detect these nurses because their actions are so far outside the range of what might be considered normal human behaviour. This may have something to do with our apparent need to characterise these nurses as 'sick'. This is a strong discourse. For instance, the allegation is made that 'baby killer Beverley Allitt is the most notorious sufferer of Munchausen's by Proxy (*The Mirror*, 2000, p.23), a claim which is at best debatable. These nurses all went out of their way, in 'super nurse' mode, to appear kind and caring. In some instances they made friends of the parents, thereby compounding the guilt and duplicity. Genene Jones is a case in point (Elkind, 1990a)'.

The Thrill Killers

Among the nurses who murder patients are a number who have been characterised as thrill killers. They are nurses who have killed patients for the adrenalin rush of the emergency. Among their numbers are Joseph Dewey Akin, Richard Angelo, and Benjamin Geen. The media have placed a significant emphasis on the thrill killing aspect of some of these cases but in others they have defined similar conduct as attention-seeking. To give an example of the thrill killing emphasis, the following extract relating to Akin's case is exemplary. This extract casts Akin as a thrill-killer who was in ecstatic frenzy during the emergency:

...a nurse accused of giving a quadriplegic a fatal dose of a heart medicine just for the thrill of watching the patient die. The assistant district attorney, Roger Brown told jurors that the nurse, Joseph Dewey Akin, "was in a frenzy" while a trauma team worked to revive the patient and at one point shouted: "This boy's dead." (AP, 1992, p.28)

The extracts from commentaries about the case of Benjamin Geen also make this theme explicit. For instance, one headline read '*...Nurse 'revelled in A&E dramas'...*' (Payne, 2006a, p.13). Other writers reported the case in the following ways:

'He poisoned 17 victims: A twisted male nurse killed two patients and poisoned 15 more in a hospital's A&E department because he loved the thrill of trying to revive them.

Benjamin Geen, 25 - described in court as "a maniac on the loose" - was found guilty of murder yesterday and now faces life behind bars...' (Wickham, 2006b, p.1).

'A NURSE [Willey's emphasis] poisoned 18 patients with potentially fatal drugs to "enjoy the excitement of trying to revive them", a court heard yesterday'(Willey, 2006, p.11).

'A thrill-seeking hospital nurse who gave patients deadly injections so he could enjoy the excitement of reviving them was yesterday found guilty of murder...' (Simpson, 2006d).

It may well be that people generally can understand the notion of thrill killings. Most people enjoy a little 'adrenalin rush' and certainly most people would be familiar with the notion of 'adrenalin junkies'. Whether people generally can accommodate the notion of inducing cardiac and respiratory arrests in patients – who may or may not be very ill – purely for the purpose of creating excitement is another question and the overwhelming majority of people would doubtless answer this in the negative. This form of Russian roulette is still a vastly different proposition to the cold and calculating logic of the pragmatic nurse who murders patients.

The Pragmatists

There are cases where nurses have murdered patients for pragmatic reasons. For example, nurses have murdered patients to steal their money or property; they have murdered patients to lighten the workload; they have murdered patients for convenience; and they have murdered patients because they were annoyed by them. Few nurses who murder patients have been so overtly pragmatic as to do it to free up beds, as was the case with Barbara Salisbury:

'...colleagues said she made no secret of her annoyance with elderly patients, many of them critically ill and dying, who blocked the beds on her ward...' (Herbert., 2004, p.2).

The media characterised the conduct of Barbara Salisbury in the following way:

'A "callous and unprofessional" nurse was jailed for five years yesterday for trying to kill two elderly patients in a bid to free up beds...' (Butler, 2004, p.1).

Such pragmatism should strike fear into the hearts of all those people who show disrespect to older people and join in the popular discourse that labels older people as 'bed blockers'. These attitudes appear to create a space where a minority of nurses are enabled to abuse and murder the frail and vulnerable elderly.

The impact of the murder by nurses of elderly patients contrasts sharply with the impact of the baby killers so one is forced to consider whether there is some sympathy with the likes of Salisbury. Is it a case of nurses generally subscribing to a view that old people block beds when they have no business doing so, and killing old people is not such a big deal because they may well die shortly anyway. I touch on this discourse of age in Chapter 5 in the context of the nurses but the texts that construct the discourse of age constitute a number of different discourses and the different reactions to the murder of old versus young victims is one of them. This discourse and its implications will be explored more extensively in Chapter Nine but it signals again the perennial issue of power.

The Place of Power

Within the discourses around nurses who murder patients, power is a recurrent theme. Murder of patients is about ultimate power – the power of life over death – and it has been articulated by many texts that constitute the discourses of power in the mass media and in nursing. This sometimes takes the form of overt references to the power of life and death, as in the case of Waltraud Wagner.

'Wagner became "mistress over life and death" as she and her co-workers killed patients whom they found tiresome, Kloyber charged...' (AP, 1991d, p.12).

In this case it did seem to be very much a case of the capricious exercise of the power of life and death over vulnerable patients who had no means of defending themselves. The evidence certainly pointed in that direction and the prosecutor was persuaded that this

was the case. That is important because the texts of the prosecutors often seek to represent the nurse who murders patients in terms of power. Referring to Benjamin Geen, Paterson (2006, p.17) wrote:

"The accused wanted to be the arbiter of life and death," said Peter Koch, state prosecutor. "He selected his victims according to his own whims" (Paterson, 2006, p.17).

There are many other equally overt examples of the power over life and death peppered throughout this dissertation. The key to understanding this discourse is the element of vulnerability. The texts that contribute to the discourses around the murder of patients cannot escape the vulnerability of the victims.

Spaces and places – nursing specialities and the murder of patients

The murders considered in this study primarily occur in nursing homes where the victims are elderly people; in intensive care units where the victims are people who are dependant on technology for their survival; in paediatric wards where the victims are young children; or in mental health institutions where the victims are people with mental health problems. The power relationship between nurses and patients is inevitably skewed but it is no accident that murderers appear to choose areas where the power differential is greatest. It is the site of greatest vulnerability where the locus of power is situated almost exclusively in the nurse.

Aged care is a space wherein some of the most brutally cruel murders of patients by nurses have been located. They have been perpetrated predominantly by nurse aides or assistants in nursing. In the minds of the public nursing homes are something to dread in your old age because they are an indication of lost capacities and looming mortality. They are also an indication that there may be no one close to take care of the individual. There is a perception of nursing homes as the scrapheap of life. Notwithstanding these aspects, in the age of the nuclear family aged care is a growth industry in most countries. Australia has seen fiscally driven changes in the aged care industry. The government changed the name of nursing homes to aged care facilities which had the effect, intended

or unintended, of severing the association of these services with nursing and nursing care at a bureaucratic level. The public discourse is nevertheless still couched in terms of 'nursing homes' with an implication that they provide nursing care. The 'hands on' care in reality is predominantly delivered by assistants in nursing (AINs). Salaries are lower than in hospitals and Aged Care is unpopular as a field of nursing practice. As a nursing specialty, it is generally regarded with scepticism and disdain even among nurses.

Many scholars have drawn attention to the relationship between knowledge and power and this is a particularly prominent aspect of Foucault's thinking. For Foucault knowledge and power are inseparable (Foucault, 1977). That linkage is prominent here in the form of the knowledges of the different levels of nursing qualification. The relationship between educational preparation of the deliverer of care and criminal activity is not lost on those who advocate for the frail elderly. In a rare example of informative reporting, this text explains how little education can be required for certification in aged care:

'Nancy Allison, president of Arkansas Advocates for Nursing Home Residents, said Friday that she was appalled by the assault. "I don't know how anyone can do anything as horrible as this," she said. People with dementia "aren't [intentionally] doing things to make it difficult on the [Certified Nursing Assistants] CNAs. They can't help it." Allison said she does not believe nurse's aides are adequately educated and prepared to do the menial but important work at nursing homes. "We believe CNAs don't get enough training," she said of the 75 hours needed for state certification. "They don't understand what they're getting into. They certainly don't understand dementia." In addition, Allison said, most nurse's aides earn minimum wage and many nursing homes "treat these CNAs like trash. ... We need to put some importance in the job they do." Bradford agreed that education and preparation might play a key in preventing abuse of nursing home patients. "Certainly the more education a person has, the better equipped he is to do a better job," he said." (Bowers, 2004, p.15) (Bowers, 2003, p.15).

Whilst the existence of registered nurses who murder patients demonstrates that education alone cannot guarantee that a nurse will not murder patients, in aged care at least there is a preponderance of enrolled nurses and AINs who are convicted of this crime.

While these examples demonstrate overtly the importance of power in the dynamics of these cases of nurses who murder patients, power is exercised here just as extensively in covert ways. For example, the investigative system, the professional network and structure of nursing, and the court system are all examples of players in these cases who exercise power. No player is more significant than the mass media, though, in terms of the images constructed and the sense that we make of nurses who murder.

The Contribution of the Mass Media

The power wielded by the mass media is a product of its capacity to control the discourses and thus to construct the images that we have of these nurses. There is an extensive literature on the functioning of the media that elucidates the processes in which it engages in constructing information. It involves the content that is reported or not reported, as the case may be. Put another way, it involves the voices that are heard and those that are not. It involves the voices at the margins - but in health care services, in health professions and among the consumers of health services, whose voices are heard and whose are not? Some examples of the media at work may assist in exposing these operations.

In an earlier section of this Chapter, the point was made that the media plays a significant role in determining the characterisation of nurses who murder patients. When AP (2005d) reports that '*...Andermatt—nicknamed the "angel of death" by Swiss media—is the country's worst serial killer...*' the characterisation is self-evident. So too with Beverley Allitt when Kellaway & Millbank (R. Kellaway & J. Millbank, 2004, p.8) write '*...WARPED [Kellaway & Millbank's emphasis] nurse Allitt turned from carer to killer, murdering four babies and injuring nine more on the ward where she worked at Grantham and Kesteven Hospital, Lincolnshire, during 1991...*' Kellaway & Millbank (2004, p.8) may have captured the essence of public reaction in characterising Allitt as the public's worst nightmare - '*...Allitt was society's worst nightmare—a professional nurse who killed because she craved sympathy or attention...*' - or perhaps it would be more accurate to say that they constructed her as such.

The following extract, again in relation to Beverley Allitt, demonstrates the consolidation of her image as aberrant and indeed, bizarre. It maximises the distance between Allitt and normality. It exaggerates her otherness through a process of guilt by association. This is indeed an exercise of the power of the media.

'Beverley Allitt, one of Britain's most evil women, has announced she wants to marry her sadistic blood-drinking boyfriend Mark Heggie. Both these individuals are spending the rest of their lives behind bars...' (*The Sun*, 2001a, p.5) .

This brief excerpt demonstrates the role of the media (and the prosecution) in developing images of nurses who murder patients:

'Jury of six men and six women in murder trial of former nurse Richard J Angelo will be asked to decide whether evidence he wantonly (sic) injected patients with drugs Pavulon and Anectine, killing four of them so he could play heroic role in efforts to revive them...' (Rather, 1989, p.1).

The report has inbuilt mechanisms that denigrate the accused, trivialising his actions and casting him as inadequate and foolish. This image may or may not be accurate but it will carry weight with the public because it is the public's primary source of information on the case. It is for this reason that the way in which the nurse who murders a patient, or patients, is regarded by the public is very much a construction of the media. The following extract is an example of the power of the media being harnessed by the prosecutor as he persuades members of the community of the danger that Akin poses to them.

In Birmingham Thursday, the prosecutor on the Price murder case acknowledged that it had proceeded slowly, and she remarked that the Georgia investigation was even more complex because it involved so many more patients. "They are, at this point, not in any prosecutable stage," Ms. Pulliam said of the GBI. "I know from experience it's rough going. It simply requires a lot of time, a lot of study, and a lot of experts to help guide a prosecutor and/or a law officer through the medical field." (Yardley, 1991b, p.1).

Almost always, the texts weave a discourse of aberration coupled with weakness of character. There is no sense of the dissonance between this image of weakness and craving attention on the one hand, and being a 'syringe-wielding maniac' on the other.

Were a film of his murderous exploits ever to be made, this syringe-wielding maniac would, but for the obvious inconvenience of a life sentence, be first in the queue to play the lead role. For being the man of the moment, the centre of attention, is what he craves... (*Birmingham Post*, 2006, p.6; Evans, 2006a).

Newspapers dramatise and sensationalise nurses who kill patients, as is the case with this headline from *The Times*: '*...Night-shift killer gave fatal dose to at least 16 patients...*' (Boyes, 2004, p.7). The higher the number of victims, the more papers the headline is likely to sell but equally, the media is a key player in ranking the killers.

Part of the fear generated by a nurse who murders in the way that Geen did is the clandestine nature of the exercise. This is epitomised in the epithet '*The quiet killer*' (*Milton Keynes Citizen*, 2006) applied to Geen in the *Milton Keynes Citizen*. Reading of Geen's exploits and methods would have shocked and frightened the patrons of Banbury Hospital and perhaps eroded the confidence of residents in their local hospital. They were no doubt much reassured to read that the hospital was investigated and cleared of any failures on its part. It had not breached its duty. There was nothing else it could reasonably have done to prevent the Geen episode. It was a dark day but it was not the fault of the hospital. The local community must feel greatly reassured (Vinter, 2006).

If health services can discharge their duty of care even though a case like Geen's can occur whilst they do so, how are health care consumers to protect themselves against the likes of Gwendolyn Graham? The Graham case is unusual in many respects but primarily it differs from most because it was a team effort between Gwendolyn Graham and Catherine May Wood. This was the difference that enabled the prosecution to obtain evidence. For the purposes of this study I have included novels and books as part of the relevant mass media. That is significant here because Graham and Wood gave conflicting evidence against each other. However, Lowell Cauffiel (Cauffiel, 1997) wrote a book portraying Wood as the main player.

The prosecution, according to Cauffiel, made a deal with the devil - or close to it. Her name is Catherine May Wood. Wood's lover, Gwendolyn Gail Graham, acted as executioner. She suffocated at least five elderly residents of the facility where

both worked as nurses' aides ... All that Grand Rapids heard about the case, according to Cauffiel, were Wood's elaborate deceptions. In court, she was the injured party, a pathetic pawn made party to the killings by her dominant lover, Graham.

Much of Cauffiel's book is devoted to piling up story upon story detailing Wood's loathsome and manipulative character. He describes an insane world with Catherine Wood at its centre (Guthrie, 1992, p.7).

This is another example of a case where the emphasis is on the aberrant nature of the players. It does not matter whether it was Wood or Graham who was the lead player. Each was involved in a pathological relationship that lay beyond the ken of the 'normal' person. Such individuals could be expected to behave in aberrant ways and on this view, no one should be surprised that such pathological deviants would stoop to the murder of vulnerable old people for their own gratification. That is the discourse underpinning the media. Foucault would have been impressed with the predictability of the media in this case (Foucault, 1965).

Had the public known it, its big dilemma would have been in deciding whose version they should believe. However, very little of Cauffiel's material was in the public domain prior to the conclusion of the case. Again, it was a question of whose voices were heard. The media is a potent filter and whether it is filtering by intent or by negligent investigation, the outcome is the same. The public will make its judgement on the information before it and again, as this is a case of two deviants, the public will be happy for both to be punished. There should be no need to apportion blame – they were both in it. This is in keeping with the media's proclivity for implication by default that there is some stereotypical image of a sadistic serial killer.

'Meek, pudgy and pale in jailhouse attire, nurse Brian K. Rosenfeld looked nothing like a sadistic serial killer Thursday...' (Nohlgren, 1992a, p.1).

This capacity of the media for editorialising is not new and it is not limited to speculating in a general way. The press, or elements of the press, has its own capacity for

characterisation of nurses who murder patients: ...*Judge Crane saw right through this evil weirdo...* (*Daily Star*, 2006, p.6).

Even though there is a media preoccupation with sensationalising cases of nurses who murder patients, and emphasising particular characterisations, this seems not to produce any enduring effect. The media runs stories about nurses who murder patients. It paints them as a blight on the profession and a threat to humanity, but the public appears not to be persuaded by these remonstrations.

'Twisted nurse poisoned his patients so he could help save them. A nurse who poisoned his patients for kicks was yesterday found guilty of murder...' (Simpson, 2006a, p.12).

There are some exceptions to the media practices in this regard. For example, such comments are inexplicably rare in the Akin case, the treatment of which is comparatively objective.

Both sides presented opening statements Wednesday in the murder trial of a nurse accused of giving a quadriplegic a fatal dose of a heart medicine just for the thrill of watching the patient die.

Assistant District Attorney Roger Brown told jurors that nurse Joseph Dewey Akin "was in a frenzy" while a trauma team worked to revive the patient and at one point shouted: "This boy's dead"... (Harwell, 1992b).

Such examples constitute a minority – most cases do not get even this measure of objective, reasoned treatment. The role of the media in determining public perceptions of nurses who murder patients cannot be overlooked. A key beneficiary of the media's capacity to filter the voices is that of the prosecutor in these cases. They are perceived as a rich source of accurate data (even though there are examples of the prosecutors flagrantly manipulating the media to their own ends such as in the case of Genene Jones (Elkind, 1990a)); accordingly, the voice of the prosecutor speaks loudly and authoritatively in the media.

The Prosecutorial Perspective

Needless to say, the voice of the prosecutor is intent on presenting nurses who murder patients in a particularly bad light because people are generally shocked by the breach of

trust and this allows them to exploit that shock. The case of Kristen Gilbert offers an example of this:

...prosecutors portrayed Gilbert – the first person in Massachusetts in more than 30 years to face a death penalty trial – as a cunning predator who viciously dispatched her four victims as they lay sick, trusting and vulnerable in their hospital beds... (Mashberg, 2001, p.1).

The fact that she had murdered war veterans immediately put Gilbert in a difficult position because of the respect for veterans in the community. The prosecution was well able to exploit that advantage. Prosecutors are keen to demonstrate the coldness and calculating nature of nurses that murder.

What Nancy Cutting discovered Monday - when federal officials told her was that they believe Gilbert killed Cutting's husband after asking a supervisor if she could go home early if Cutting died. "That's been a little hard to get over," Cutting told the Herald last night, emotion breaking her voice. "What was she thinking? Why? What was so important that she had to leave that she had to kill him? She couldn't get anybody to watch him?" "She called me - Kristen Gilbert. She called me herself and said he died, and I guess it was right after that that she took off. There's a lot of things in this whole thing that are just scary, you know? "At that moment - all I heard was 'Mrs. Cutting, I'm sorry. Your husband's dead. He died at 7:02... (Talbot & Ranalli, 1998, p.18).

This text relating to Gilbert reinforces that it is that the information that the media reports that determines the perception of the nurse by the public. It was true in the case of Gilbert and it is true generally.

Cases involving multiple defendants are unusual. When a case has the two elements of shock and horror on the one hand, and rarity on the other, it is bound to get more than its fair share of media attention. However, when such a case arose in 1989, it got a very muted response. It may have been because it was an Austrian case and no doubt there would have been huge coverage within Europe. However, there was little coverage in the English speaking world and consequently, little reaction. Even so, it did get a mention, as the following extract shows and whilst it is unusual to have a gang of nurses who murder patients, in such gangs, there will be a leader.

Police announced at a news conference that the ring's 30-year-old "mastermind" came up with the idea in 1983 of systematically killing patients, and had confessed to killing one patient a month at the outset in 1983 and an average of three a month recently... (Holland, 1989, p.2).

It should be noted that prosecutors also often seek to represent the nurse who murders patients in terms of power (Paterson, 2006, p.17). The discourse of power juxtaposes the power of the murderous nurse with the overt vulnerability of the patient, their victim. This is a prosecutor's dream come true. Jurors are eminently persuasible on the emotional underpinning of the possibility of finding themselves in the shoes of the victim, as could so easily happen in the case of nurses who murder patients. Add to this scenario a suitably offensive and scary motive and a conviction becomes more and more likely:

A nurse described by a prosecutor as a man who "simply likes to kill people'... (*The Dallas Morning News*, 1992, p.5).

The comment constitutes discourses both of motive and of characterisation of this nurse, and prosecutors are certainly keen to characterise the defendants in ways favourable to a conviction. To this end, the prosecution in cases of nurses who murder patients will often try to characterise the defendant as 'evil' (Jules Crittenden, 2001a, p.17; 2001b, p.18; 2001c, p.1; 2001d, p.6) . It does not stop at 'evil' though. The prosecution provides grist for the media mill when it comes to embellished characterisations of nurses who murder patients, as exemplified in the Geen case:.

"The 25-year-old "maniac" administered drugs to 18 patients - two of whom died - to make them stop breathing so he could savour the thrill of trying to revive them, a trial heard... (Evans, 2006a).

The voice of the prosecutor is patently a prolific force in the media. The prosecution will often seek to represent the nurse who murders patients as somehow less than human.

Asst. U.S. Attorney William Welch had called Gilbert a "shell of a human being" who deserved to die for the cold and calculating way she murdered her victims: injecting them with overdoses of the heart stimulant epinephrine, also called adrenaline, causing their hearts to race out of control.' (*Providence Journal*, 2001, p.6).

The texts will often reveal a degree of contention in cases of nurses who murder patients as to whether they are pathological or genuinely nice people. Prosecutors tend to take the former view.

Assistant County Prosecutor Dan Kasaris called Kanner "a born liar" after the two-hour sentencing hearing and said she deserves every year in prison... (Nichols, 2004b, p.1).

Little more need be said here with respect to the prosecutor's voice in the media. However, I have written elsewhere in this dissertation on the matter of the difficulty of obtaining evidence and achieving convictions. If justice is to be served, it may well be that it is necessary for the prosecutor's voice to be so strident.

The Health of Nurses who murder patients

There is an extensive discourse within the media that revolves around the health of nurses who murder patients. Sometimes this revolves around the mental health of these nurses, at other times it involves their physical health. With respect to physical health, the media noted that Jeffrey Feltner has HIV but made no further comment on this matter.

'Feltner suffers from a life-threatening condition. The Daytona Beach News-Journal quoted police Thursday as saying he has acquired immune deficiency syndrome... (AP, 1989b, p.1).

Those lapses never amount to anything however, even where they hold considerable potential such as when the nurse has AIDS, as in the case of Jeffrey Feltner. Thus, while consolidating Feltner's aberrance by mentioning in passing that Feltner has AIDS, the media finds no mileage in pursuing a physical condition. For the public, they assume that by definition, if a nurse chooses to murder patients, they must be sick (in the psychiatric sense).

More commonly, the reference to health involves the need to regard nurses who murder patients as metaphorically sick; this regularly manifests itself in some areas of the media, as it does in the Geen case where Mackay reported that ...*Sick Geen, 25, was told he would serve at least 30 years for murdering two men...* (Mackay, 2006, p.23). A

discourse of illness seems more calculated to establish an excuse for aberrance and carries with it a tacit exoneration by way of the diminution of responsibility attendant on a lack of capacity associated with a mental disorder.

Much has been said in this section about the characterisations of nurses who murder patients. It will be clear by now that there are dissonances and discontinuities within and between the characterisations that have been explored as well as within and between the voices that give effect to these characterisations. Two voices that have been highly conspicuous by their absence are those of the nurse who murders and of the nursing profession.

An equally conspicuous absence throughout this surfacing of the discourses of the characterisations of nurses who murder has been the voice of the nurse who murders. Often, as we saw early in this Chapter, that voice is masked by the lawyers of the defence. Their role in reconstructing and re-presenting the voice of the nurse makes that voice a separate entity. The subjective voice of the nurse may only be heard in the event that they confess to the crimes of which they are accused. Even then there may be distortions of that voice attributable to the pressures of the legal system. There may be other distortions that are consequent upon the individual's desire to claim more glory than they are rightfully entitled or upon their desire and enjoyment of celebrity. It may be that only after conviction can we anticipate hearing the voice of the nurse who murders patients.

Madness or badness

The final discussion within this chapter has a significant bearing on these characterisations because it involves a consideration of whether or not those nurses are mad or bad. I noted in the previous section the discourse of sickness. In most cases this is a discourse of sickness in the sense of aberration, although as was demonstrated, there are occasional departures where reference is made to physical ill-health.

The first question that usually springs to mind when a new case of a nurse murdering patients comes to light is why: why would a nurse – whose entire professional activity is geared to the provision of compassionate care – choose to murder a patient/s, and possibly more than one patient? Why would they become a serial murderer of patients. As Howard Price (1998, p.1) points out:

"There's some disagreement as to what turns those responsible for providing compassionate care into murderers. "The classic case are those who believe they are ending the suffering of very, very ill patients," said Rick Wade, spokesman for the American Hospital Association. But others see something far more sinister. Joseph Deters, prosecuting attorney in Hamilton County, Ohio, who tried Donald Harvey, a nurse's aide who pleaded guilty to killing 37 patients, calls the mercy-killing theory "bull." "Most have some excuse they think will be socially acceptable. But the reality is they have a compulsion to kill," Mr. Deters said in a telephone interview. Ms. Yorker sees most killer nurses as "sociopaths" who victimize others to make themselves look more important. Such individuals are "particularly drawn to the health care field," she said, because it offers a vulnerable population.'(Howard Price, 1998, p.1).

This short piece raises a number of key points that need to be addressed and these include the discourses around the notion of a compulsion to kill, sufficient insight to recognise the need for an acceptable rationale for their actions and the role of power and vulnerability. Power and vulnerability I discuss elsewhere in this dissertation; the implications of a compulsion to kill coupled with insight are the matters that I want to explore here. The compulsion to kill suggests the presence of a personality disorder and Beverley Yorker (in Howard Price, 1998, p.1) considers most nurses who murder patients to be sociopaths. Assuming that by 'sociopath' she means a person suffering from sociopathic personality disorder, it is instructive to look to the DSM-IV TR to see what that means. The DSM does include personality disorders as psychiatric disorders but this is contentious.

According to DSM-IV TR, '*A Personality Disorder is an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment.*' (Accessed on line 8th April 2007 at <http://www.psychiatryonline.com.elibrary.jcu.edu.au/>).

There are specific personality disorders and these include Antisocial Personality Disorder which subsumes previous diagnostic categories of psychopathic personality disorder and sociopathic personality disorder. Antisocial Personality disorder is defined as follows:

Diagnostic criteria for **301.7** Antisocial Personality Disorder

- A. There is a pervasive pattern of disregard for and violation of the rights of others occurring since age 15 years, as indicated by three (or more) of the following:
 - 1. failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest
 - 2. deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure
 - 3. impulsivity or failure to plan ahead
 - 4. irritability and aggressiveness, as indicated by repeated physical fights or assaults
 - 5. reckless disregard for safety of self or others
 - 6. consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations
 - 7. lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another.
- B. The individual is at least age 18 years.
- C. There is evidence of Conduct Disorder (see [Diagnostic criteria for Conduct Disorder](#)) with onset before age 15 years.
- D. The occurrence of antisocial behavior is not exclusively during the course of Schizophrenia or a Manic Episode.

(Accessed on line 8th April 2007 at <http://www.psychiatryonline.com.elibrary.jcu.edu.au/>).

Presumably murdering patients would satisfy Criterion A1, and for at least some of the nurses who murder patients it would be possible to satisfy another couple of the criteria to satisfy Criterion A. Criterion B would rarely be in issue (although Shermika Rainey would not have satisfied this requirement) and there would be cases where Criterion D would not be satisfied. However, it is Criterion C that may prove the most difficult to satisfy in cases of nurses who murder patients. Assuming that the requirements for a

diagnosis of personality disorder are met, what are the implications of that status in terms of culpability and prosecution?

Personality Disorders and Capacity to Stand Trial

A logical starting point for a consideration of this issue is the commentary on a case where the defendant was diagnosed with a personality disorder. The case of Vicki Dawn Jackson is just such a case.

Vickie Dawn Jackson has a mixed personality disorder with anti-social, narcissistic and histrionic personality traits, Dr. Lisa Clayton wrote in a report in which she said Jackson was competent to stand trial. ...

James Shupe, an Irving psychiatrist who evaluated Jackson two weeks later, found she was sane at the time of the alleged offenses and competent for trial (Brown, 2005b).

Shupe was not suggesting that Jackson did not have a personality disorder. He was simply saying that having a personality disorder did not amount to insanity. This is a critically important distinction if Yorker's view of nurses that murder patients is accepted because it would mean that, even if in most cases it is arguable that a nurse who murders patients has some form of personality disorder, this should be no barrier to them standing trial. I share Shupe's view of this because this is still a rational human being who knows the quality of right and wrong. The legal competence of a defendant to stand trial turns on their ability to both know what they are doing and to know that what they are doing is wrong. This principle was decided long ago in the English courts in the famous M'Naghten's case (*M'Naghten's case* (1843) 10 Cl & Fin 200 at 210; All ER718) and came to be known as the McNaghten Rules.

It may be significant that Jackson was accused of the murder of a significant number of patients. This fact can extinguish public sympathy and also politicise the case. It casts doubt on the capacity of the authorities to protect patients in the health care system and it generates a much higher level of fear. These factors may colour the treatment of the defendant by the legal system. It would be much more comforting if people could believe that only a person who was crazy could murder patients. The thought that someone could coldly premeditate, calculate and execute the murder of patients is more shocking and

more disturbing for families, investigators, prosecutors and the public at large. Thus, we want to believe that only a crazy person could do such a thing.

The case of Harvey is equally provoking for slightly different reasons. He demonstrates his rationality through his views on murder which imply what might be regarded as an ethics of murder. The attitude of nurses who murder patients varies but Harvey's dispassionate analysis is unusual.

Harvey said he does not like the style of former Ohioan Jeffrey Dahmer, who has told Milwaukee authorities he dismembered and cannibalized his victims and stored body parts in his refrigerator. "OK, like I said, murder is murder," Harvey said. "But to kill somebody and then cut 'em up and eat 'em, I find that very sickenin'." That does not mean Harvey excuses the murders he committed - even though he has labeled some of them mercy killings. "Whether they were mercy killings or just shooting someone with a gun, that's still murder," Harvey said. "It's nice to have the title of being a mercy killer, but murder is murder, no matter how you look at it... (*The Plain Dealer*, 1991).

There was no suggestion that Harvey was psychiatrically ill.

Harvey was never found to be insane or mentally incompetent. Dr. Emmanuel Tanay of Detroit, a psychiatrist who examined Harvey before he entered his guilty plea in London, said last week that Harvey was "a deformed person, but he's not a sick person." Harvey knows the difference between right and wrong but lacks the inhibitions most people have about killing other people, Tanay said. "He is what I call a compulsive killer," Tanay said. "He derives pleasure out of killing just as you might derive pleasure out of sexual relations..." (*The Plain Dealer*, 1991).

So psychiatry lays bare the notion that people might simply enjoy killing. Some people just derive pleasure from killing other people. It does not mean the person is sick. Does it mean they have a personality disorder? If so, does that personality disorder amount to mental illness? If so, is it a sufficiently severe form of mental illness to protect them from culpability for their otherwise criminal actions? If so, should they be freed or subjected to compulsory treatment? If not, should they be punished or treated? For personality disorders there is no real treatment. Does that mean they should be punished because of the failure of psychiatry? These are the vexed questions that flow from Tanay's view of Harvey, but they are equally applicable in the case of every other nurse who murders patients.

Confirmation of this view of pleasure from killing is found among a number of cases. Gwendolyn Graham showed very clearly that the lust for killing can be very powerful in nurses who murder patients.

While the inquiry [at Grand Rapids] was under way, she [Graham] moved to another hospital and told a female lover that she 'liked walking past the nursery and she wanted to take one of the babies and smash it against the window'. She did not have access to the nursery and was fired when the hospital heard of the inquiry... (Gerard, 1993, p.10).

Thus, there are many examples of cases where the Court has considered the string of questions identified earlier and they have done so with the assistance of evidence (or opinions) of expert psychiatrists. In the case of Lucy de Berk, for instance, it was reported that there was a psychiatric element to de Berk's personality but it was not the key determinant in her homicidal activity.

Psychological and psychiatric analyses showed that despite having personality disorders, de Berk is not a psychopath... (de Hemptinne, 2004).

It seems likely that de Berk did not help her own cause, as the following extract demonstrates:

The psychiatric assessment concluded that she has borderline personality disorder, is clever, manipulative, suppresses anger and easily becomes hysterical, but that she is not a psychopath, as the prosecution argued throughout the five-day trial in September.

"I've always known I have a complex personality and now an expert says the same thing," Ms. de Berk said hotly in court. "Look, I'm not a psychopath and I'm not the serial killer they say I am."

T. A. Wourers, the supervising psychiatrist from the evaluation, was called in as an expert witness to clarify questions for the court. "She has a lot of anger inside, suppressed anger as well as a serious amount of self-hatred. But we cannot see, from our assessment, that she directs any of her anger toward others, or even to whomever might cause her to be angry," he testified. "Rather, she directs all of her anger toward herself..." (Cowan, 2003, p.16)

Benjamin Geen was another nurse with respect to whom a Court was convinced that he was not mentally ill at all.

The judge, sitting at Oxford Crown Court, said Geen suffered no mental health problems but had "an abnormal attitude to human life"... (Payne, 2006b, p.15).

In each of these cases the finding of no mental illness, or at least no mental illness that would impede rational thought and thus, no mental illness that would provide a barrier to prosecution and accountability, aids the legal process immeasurably. At the same time it robs the public of any sense of security derived from knowing that only a crazy nurse would murder patients. Thus, the dominant voices are those of the disciplines; they are the voices of the law and of psychiatry and they are voices that hold great authority. Beverley Allitt is a case in point because she was deemed insane and confined to a secure psychiatric hospital (AP, 1993). Whilst it is possible to exclude mental illness as a protection from culpability, accountability and prosecution, it cannot be excluded in the same way where there is a long-standing history of mental illness.

Pre-existing Mental Illness

In cases where a nurse has a history of mental illness prior to murdering a patient, the situation may be more obvious. There are examples of nurses who have killed a patient in rage, spontaneously, in an unpremeditated attack, and where that nurse has a longstanding history of mental illness. There are also examples of cases where nurses with some history of mental illness have quietly murdered a patient for no apparent reason. In such cases, the questions that were raised earlier in relation to Harvey are more easily answered. In some cases a nurse who murders patients will have a psychiatric history extending over years before they commence murdering patients, or at least, before their murders are detected. This is more frequent where a nurse murders just a single patient in the kind of circumstances outlined here. An example of this was the case of James Mullins (Hartnett, 2001, p.1) who had a history of post traumatic stress disorder following service in the Vietnam war and for no apparent reason gave a patient a lethal injection of propofol that was not even prescribed for the patient. In such cases there is more likely to be a lack of rationality.

Other cases involving a defendant with a history of mental illness have involved more deaths. The case of Bobby Sue Dudley Terrell is an example.

Dudley, a 35-year-old Illinois native with a history of mental problems, has been in the Pinellas County Jail since March 1986. "She seemed to be calm and rather resolved" at her sentencing, [Judge James R.] Case said... (Moss, 1988b, p.1).

Dudley was charged with the murder of four patients but in the two weeks that she worked at the particular 50 bed nursing home, 12 patients died. Whether her mental illness rendered her unfit for trial is a difficult question and one that I will return to when examining mental illness as a defence.

Mental Illness and Nursing Licensure

In most jurisdictions in developed countries, there are regulatory provisions for the nursing profession that provide for the revocation of a nurse's license to practice where the nurse becomes incompetent due to mental illness. For example, here in Queensland, Australia, the *Nursing Act 1992* at S.104A, which sets out the grounds for disciplinary action against a nurse, specifically makes impairment such a ground and defines impairment to include mental illness. Thus, under that legislation a nurse who is, or becomes, mentally ill may have their license suspended or revoked. In some cases, (and one would hope, in most cases) the psychiatric illness of a nurse who murders patients will have intruded on their licensure before their murders are detected. This was so in the case of Bobbie Sue Dudley.

Dudley had a history of mental problems, court records show. Illinois state regulators had suspended her license for "mental instability" and self-abuse. She was admitted to two mental hospitals in Pinellas County before her arrest in 1986. Police found that she had kept notes on patients' deaths at her home... (Moss, 1988).

This is a clear example of the State granting the privilege of practice to nurses as a mechanism of control. How effective that mechanism is in preventing the murder of patients is a matter that will be canvassed in Chapter Nine.

Mental Illness as a Defence

Among nurses who are accused of the murder of patients, a proportion seek to plead insanity as a defence, or at least base their defence on psychiatric conditions. This

extends to making much of matters such as abuse in childhood. In the case of Stephan Letter,

Der Spiegel news magazine wrote that he suffered from a severe lack of affection from a cold mother who had feared that her son would be born handicapped. Though this was not the case, she routinely subjected him to doctor's visits and painful treatment and placed him in a school for the handicapped... (SBS World News, 2006).

This is unlikely to sustain a defence of insanity, but although ineffective, it is a common approach. Feltner, too, claimed a psychiatric history.

Feltner, 26, who had been under voluntary commitment at a Daytona Beach area mental health facility, was arrested on a first-degree murder charge... (AP, 1989a, p.1).

Christine Ackley sought to escape liability by pleading insanity.

She pleaded not guilty by reason of insanity in January... (*Rocky Mountain News*, 2004a, p.24)

She was unsuccessful in her attempt but it may have helped her to escape the death penalty and this is often a key determinant in the decision to use this defence. There are cases though where it can sometimes be genuinely difficult to distinguish between actions attributable to mental disorder and actions for which a person should be accountable. Once again, Dudley's case serves as an example of such a situation.

Dudley was the overnight nurse at North Horizon Health Care Center in November 1984 when patients under her care began dying at an alarming rate. She was fired a few weeks later when nursing home officials discovered that she had stabbed herself and staged a violent break-in. After a long and difficult investigation, two St. Petersburg police detectives arrested Dudley in March 1986... (Moss, 1988).

Beverley Allitt takes us into some truly fascinating terrain. Like many nurses who murder patients, Allitt was deemed to suffer from a psychiatric disorder. In her case this was Munchausen's Syndrome by Proxy as the next two extracts show:

She has been diagnosed as having Munchausen's Syndrome by Proxy, a personality disorder in which people injure others to attract attention... (Associated Press, 1993, p.17).

and

Medics had been baffled by the deaths until one heard about a psychiatric condition called Munchausen Syndrome by proxy. The sufferer, desperately seeking attention, hurts others around them but appears to be caring and basks in the glory of being a 'hero'... (R. Kellaway & J. Millbank, 2004, p.8).

This description of Factitious Disorder by Proxy (formerly Munchausen Syndrome by Proxy) is decidedly distorted. Factitious Disorder by Proxy (FDBP) according to DSM-IV-TR has as its diagnostic criteria the following:

- Intentional production of or feigning of physical or psychological signs or symptoms in another person who is under the individual's care.
- The motivation for the perpetrator's behaviour is to assume the sick role by proxy.
- External incentives for the behaviour such as economic gain are absent.
- The behaviour is not better accounted for by another mental disorder.

(American Psychiatric Association, 1994, p.725)

I consider that even if MSBP is a legitimate diagnosis – and I am not conceding that it is – it is not appropriately applied in the context of cases such as Beverley Allitt whose conduct can be explained by more obvious but less acceptable explanations. The use of MBPS in this way seems more calculated to assist the public to accept the bizarre conduct of the defendant as an aberration grounded in mental illness and that is consistent with the discourses that have been described thus far in this dissertation.

The defence of insanity will often be raised in cases of nurses who murder patients. Insanity is a term that does not form part of the language of psychiatry. It is in fact a legal term and in this legal context, Jackson's defence decided to plead insanity when her mental state appeared to have deteriorated.

A former nurse accused of killing 10 patients with lethal drug doses recently reported hearing voices in jail, putting her case on hold until authorities determine if she is competent to stand trial. Vickie Dawn Jackson told her lawyers she heard them and her daughter talking to her when they were not there, her attorney Bruce Martin said during a hearing Saturday. A psychiatric evaluation then was ordered for Jackson, a former Nocona General Hospital nurse. Martin plans Monday to seek a competency hearing and file notice of an insanity defense, although he may decide before trial not to use an insanity defense, he said Sunday. Martin said he found out about his client's new behavior Thursday and noticed changes in her Saturday. "I sense a paranoia that I have not witnessed before," Martin said. "I've been looking at Vickie for three years, and I've never seen that look she had today, that deer-in-headlights look..." (AP, 2005a).

The alleged deterioration in Jackson's mental state raises some further interesting aspects of the way in which the law deals with mental disorder. For example, the consequences of mental disorder will to a great degree depend upon when that disorder manifests itself. If it is present at the time of the commission of the crime then the M'Naghten rules will apply. If it occurs subsequent to the commission of the crime but prior to trial, then the relevant consideration will be whether the person is fit to stand to trial (or, in other words, is competent to stand trial). If the mental illness manifests itself after conviction, it will simply warrant access to appropriate mental health care. Thus, timing is everything when it comes to a plea of insanity as a defence to a charge or charges of murder.

Two examples among the cases that have been encountered during this study where a nurse who was charged with the murder of patients required psychiatric intervention between being charged and being tried were Jeffrey Feltner and Charles Cullen. Feltner required psychiatric assessment and treatment.

PALATKA - A former nursing home aide slashed his wrists Wednesday morning in jail before he was to appear in court on a charge of first-degree murder in the death of a woman in a retirement home. Jeffery Feltner, 26, did not cut himself deeply enough to cause serious harm, according to Capt. Dick Schauland, spokesman for the Putnam County Sheriff's Department. Doctors diagnosed Feltner as having superficial lacerations to both wrists resulting from a "suicidal gesture," Schauland said. Feltner apparently did not intend to kill himself, but he will remain under special suicide watch conditions at the Putnam County jail, to which he was returned after being treated and released from Putnam Community Hospital, Schauland said. Feltner has confessed to killing seven elderly nursing

home and retirement home residents. He is scheduled to stand trial for the Putnam murder charge in early January... (Millburg, 1989, p.4).

Cullen, too, required psychiatric intervention between arrest and trial.

Oct. 30, 1997 -- Cullen taken to Greystone Park Psychiatric Hospital after being treated for depression in the emergency room of Warren Hospital in Phillipsburg.

Jan. 3, 2000 -- Cullen lights a hibachi full of charcoal in his Phillipsburg apartment. Investigators call it a suicide attempt. He is saved when a neighbor calls police... (The Associated Press, 2004a)

There are many other cases where the defence has sought to rely on psychiatric disturbance. The defence sought to establish that Stephan Letter had emotional problems, indicating that the *...defence case will centre on a psychological analysis of Letter to establish a motive for his killings...* (Boyes, 2006, p.39). It usually does not succeed except perhaps to mitigate the severity of a sentence and the attempt can be very half-hearted where the prosecution has a strong case, as was the situation in the case of Brian Rosenfeld.

Georgia Palmer, a psychiatrist at the jail, testified that Rosenfeld "appears to have a mental illness that involves hearing voices." But with the help of medication, he was capable of standing trial, Palmer said... (Nohlgren, 1992).

One more example of an unsuccessful plea of insanity is the case of Richard Angelo. His plea had a slight twist in that he pleaded temporary insanity at the time of each of the ten deaths with which he was charged.

Angelo pleaded at his 1989 trial that he suffered from a mental disorder that precluded him from understanding the nature of his offences. Two psychologists testified that he suffered from a personality disorder called associative identity disorder, formerly known as multiple personality disorder... (Ramsland, 2006).

There appears to be a strong reticence on the part of the Courts to reduce the culpability of nurses who murder patients by conceding defences of insanity. This would seem to run counter to the discourse of mental illness that permeates the mass media. One could be forgiven for thinking that within the multiple voices of the law, the prosecutorial voice carries more power here than that of the defence. Moreover, the unified voice of law

carries more authority than the tainted and speculative whisper of psychiatry when it comes to seeking to excuse the conduct of murderers who have not merely murdered patients but in so doing have breached the trust of society. Even so, prosecutors are not beyond making use of the voice of psychiatry in the pursuit of their own ends – namely, a successful prosecution.

Psychiatric Assessment – Prosecution's Request

Most people in developed countries have watched enough television dramas to know that the prosecution of a criminal charge against a perpetrator is something of a game with complex rules and protagonists who know that the outcome will be a product of their decisions with respect to the approach taken to any defence proffered on behalf of the perpetrator. Among the strategies at their disposal, prosecutors will often seek to have a psychiatric assessment of a defendant to ensure that the defendant is not mentally ill – or at least, and more importantly, is competent to stand trial. As often happens in cases involving nurses who murder patients, Faludi was subjected to psychiatric assessment.

According to a court psychiatrist, Faludi had a "well-developed ability to empathise, while internally she felt she was God". "She alternately put herself in the place of the doctor or in that of the patient and took decisions instead of them," the court said in its verdict... (Agence France-Presse, 2002b)

Roger Andermatt provides a further example of this use of psychiatric evaluation. Killing of this nature is regarded as mad rather than bad.

The man [Andermatt] is to undergo psychiatric testing before investigation continues... (AP, 2001c).

So too with Anthony Geen. Prosecutors in cases of nurses who murder patients work hard to ensure there is no hint of psychiatric disability that may allow the defendant to escape liability.

One psychiatrist, speaking off the record after reading of Geen's exploits, said: 'He probably is not mad but he has probably got some sort of personality disorder, like a fire starter who likes to set fires and wait for the ambulances and the fire engines to come.' In court there were no admissions on the basis of insanity, but rather

lucid, cool-headed denials, coupled with the audacious belief that he could persuade a jury of his innocence... (Evans, 2006).

Prosecutors were certain that de Berk was bad rather than mad and the purpose of having a psychiatric evaluation was to ensure that she could not rely on insanity as a defence.

Prosecutors have depicted Ms. de Berk as a dangerous, cunning woman—either increasing dosages of medicines already being administered, or giving her victims large doses of substances that are difficult to detect... (Simons, 2002, p.8).

These are important steps in the ritual of prosecution. Whether it results in justice is a moot point. When combined with the practice of plea bargains, which practice in the context of nurses who murder patients has been discussed elsewhere in this dissertation, justice becomes an even larger question.

Media Characterisations of Mental Illness

The attitude of the courts and the psychiatrists to nurses who murder patients have been discussed earlier in this Chapter and it was noted that it seemed at odds with the position(s) espoused by the media. The legal system seems largely to reject mental illness as a defence even though the media seems to focus on characterising these nurses as mad rather than bad, or at best, mad and bad. Nurses who murder patients are often cast as mad, bad and scary. Such was the case in the Tenzer case.

By the summer of 2001, Downey said, Tenzer told her about the ongoing investigation, calling it "a big frame-up" and saying police were "harassing" her. He said he urged her and her son to move to Florida for a fresh start, and let them share his home in the Florida Keys. In October 2001, detectives served her with a subpoena to appear before a grand jury. "She started shaking," Downey recalled. "She said, 'They're going to try to pin it on me, and I can't handle the stress.'" Tenzer checked into a mental-health clinic for several days. Upon her return, she quarreled with Downey, cursing him and then packing her car to leave. "She was scary, very scary," Downey recalled. "Had you ever seen her like that before?" prosecutor Zellis asked. "Never," Downey replied... (King, 2003b).

Earlier I have suggested that there is a tendency to want to believe that nurses who murder patients are mad rather than bad, and a number of nurses have sought to encourage this belief, as shown earlier in this Chapter. As I have shown in many other sections of this dissertation, the media frequently frames its reports on cases of nurses

who murder in this way. Charles Cullen provides the object of one more example of such a report. One might expect some untoward behaviour from a nurse who murders patients and Cullen did not disappoint, but even by the standards of US courts, this is an unusual situation.

'Cullen, a former nurse who killed at least 29 patients in Pennsylvania and New Jersey, was gagged with a cloth and duct tape at his sentencing hearing after he began loudly repeating "Your honor, you need to step down" hundreds of times in court. Cullen received six more life sentences yesterday, raising the total to 18... (*The Boston Globe*, 2006, p.2).

Conclusion

Through the detailed examination of the semantics of nurse, the characterisations of nurses who murder and the relationship of madness and badness in the treatment of these cases, I have sought to demonstrate the complexity of the discourses and the voices within them. I have also sought to show the interplay of power in shaping not merely outcomes for these nurses when they come to trial, but also the public perception of both the nurse and their deeds. There is an indelible stamp of manipulated and constructed perceptions of these nurses and the phenomenon of their murders. This process is regulated by those who hold official power within society and thus far, despite many cases, and many high profile cases, it has not attracted attention as a prominent threat to those who become patients in hospitals.

Chapter 8

Reaction to the Murder of Patients by Nurses

Introduction

Throughout the past few Chapters, as I have explored various discourses around the murder of patients by nurses, there have been many glimpses of the reactions of various players in these catastrophic episodes but in this Chapter I want to bring those reactions into sharp relief and focus specifically on the discourses involved. Those involved are the organisations that employ nurses (the organisational response); the government regulatory authorities with specific responsibility for nursing (the regulatory response); the nurses and other health professionals who work with these nurses who murder and who share their profession (the professional response); the consumers of health care (the public response), and the relatives and friends of the victims of these nurses (the relative's response). The discourses in which each of these stakeholder groups engage will of course, differ markedly. For the most part, they are drawn from the print media, and most notably, from newspaper reports.

The Organisational response

The murder of patients by nurses is generally considered to be a terrible thing, as has been shown in the analysis of the phenomenon in this dissertation. While it appears to impact on the public only in an ephemeral and transitory manner, it has a much more fundamental effect on those who are directly affected – and none more so than the organisation that employs the nurse and however unwittingly, plays host to their homicidal activity.

Timely Interventions

There are times when an organisation will proactively intercede in response to a suspicion that a nurse may be involved in the deaths of patients. This may be in

response to statistics showing a sudden spike in the death rate in a specific unit or in a hospital generally, for example. This was true in the case of Orville Lynn Majors:

Hospital administrators suspended Majors in early 1995 after they discovered the death rate had tripled on the intensive care ward where he worked... (AP, 1997).

Likewise, when there is a sudden series of deaths in an aged care residential facility it must be cause for concern and investigation. This was the situation in the case of Bobby Sue Dudley.

Third-shift nurse Bobby Sue Dudley acted perplexed when 12 elderly patients died mysteriously at a St. Petersburg nursing home three years ago. "There is wonderment," she told a reporter. "Was it all coincidental? Or did something else go on?" Something else, detectives said. In April 1986, after investigating the nursing home deaths for a year, they charged Dudley with four counts of first-degree murder... (Moss, 1988b, p.1).

These two cases had very short timelines and demonstrate relatively early intervention. Among the cases explored in this work early intervention is a rare occurrence. Much more commonly, the murdering goes on for a protracted period of time and when it surfaces, it is apparently a surprise to all concerned - with the exception of the murderer, of course. For this reason, it is the discourses around delays that are loudest.

Delay, Obstruction and the Voice of Criticism

Health service organisations do not always respond with positive action when suspicions arise. More commonly, in the face of a perceived problem of a nurse suspected of being involved in the deaths of patients, the discourses are constituted of texts relating to tardiness, delay and hinderance (if not actual obstruction) rather than attempts to acknowledge, confront and address the issue. As the case of Genee Jones (Elkind, 1990a; Wolfe, 1989, p.4) illustrates so graphically, there have been some notable, (even extraordinary) failures of organisations that have made it possible for nurses who murder patients to continue doing so.

In Texas in the early 1980s, a large medical center politely asked a pediatric nurse [Genee Jones] suspected of causing life-threatening seizures and hemorrhages in more than a dozen babies to find another job, and sent her on her way with a good recommendation. She proceeded to get a job in the office

of a small-town pediatrician, where she murdered a child, and attempted to murder several others... (Wolfe, 1989, p.4).

A more detailed account of Jones' cases shows how severe the consequences of organisational apathy can be. There are times when the organisational response to suspicions of murder by nurses can be extremely muted.

The more sobering, equally horrifying aspect of this case was that almost from the first she was suspected, investigated and confronted. Her superiors were afraid to act. One lost his job. She received warnings from the head nurse, but her record was kept clean. Ms. Jones left Medical Center to work at a small pediatric clinic in Kerrville with a glowing reference, hired by a doctor well aware of the dark rumors that surrounded her. The pattern was reestablished in Kerrville, and she killed again. For this last crime she was finally charged, sentenced and convicted. The last death rounded out the total to 16... (Peter L. Robertson, 1989)

So significant, in my opinion, is this discourse around delay and obstruction that, at the risk of labouring the point, I intend to provide numerous and fairly extensive examples from the texts. They point to these delays and obstructions as contributing directly to a higher number of victims in many cases. In Japan there was a clear failure of the organisation to respond to concerns about Daisuke Mori, and this led to additional patients being harmed.

According to Japanese law, "unexpected death in relation to medical acts or suspicion of such acts; unexpected death in the act of injection, anaesthetising, operation, test, childbirth and any other acts related to medical treatment; and death relatively soon after medical action", are supposed to be reported to the police. The deaths at the Hokuryo Clinic certainly fit that category, especially since senior doctors were themselves so suspicious of the deaths that they decided to keep blood samples and leftover intravenous fluids from patients whose condition had changed suddenly. The deputy director of the clinic, Ikuko Handa, later admitted she was suspicious of Mori but was "so terrified that I dared not ask him to explain". Instead of investigating or calling in the police, the doctors helped cover up the crimes by citing other causes of death – heart attacks, strokes and pneumonia. An editorial in the Asahi Shimbun blamed what it called the three taboos of the medical system: do not involve the police, avoid being reported in the media, and do not get caught up in court cases... (Hadfield, 2001).

There is a clear discourse of criticism of the health care organisations by the media, the lawyers and the regulators here that is express in its condemnation of the perceived failure of the organisations to actively pursue suspicions of each of the suspect nurses. This report on the Mori case is interesting in that it carries the voice

of the clinic's management but it also gives the media additional authority by quoting the editorial from another newspaper as it seeks to impugn the medical profession by attributing to it the three taboos – all of which involve avoidance - noted in the article. These cases provide excellent examples of what can happen when an organisation avoids its responsibilities in the hope of a quiet resolution of a matter involving a suspect nurse.

There is a tendency to criticise on a wide range of levels any hospital that has been the employer of a nurse who murdered patients. The mere fact that an employed nurse is enabled to kill patients is a sufficient indictment. However, during an investigation and trial the hospital will be subjected to intense and close scrutiny and this means that any and all failings will receive a public airing. In these cases many parties have a stake and generally they will all be represented in the proceedings. Among the stakeholders will be the relatives of the murdered patient(s), the defendant nurse(s), the employing organisation, the nurse registering authority and the government health department. The interests of each stakeholder are not coincident so the information that each stakeholder will want to see aired in court (and in the media) will naturally vary.

During the trial, the reputation of the Northampton hospital was battered for more than the actions of Gilbert, whom prosecutors described as a cold-blooded killer. Witnesses described illicit on-the-job drug use and testified that it was not uncommon for nurses and other workers to take drugs from medicine cabinets. Gilbert's lawyers, who said the victims went into cardiac arrest from natural causes, also suggested that some of the doctors were inexperienced or unqualified... (AP, 2001f).

The texts of this report of the case of Kristen Gilbert illustrates the sorts of revelations and allegations that may emerge in the course of a trial of a nurse for the murder of patients. The interests of the stakeholders can generally be inferred. For example, the relatives will want justice in the form of a conviction of the nurse for the murder of their relative but in countries such as the United States of America, those relatives are highly likely to be looking for ammunition with which to ground a civil action (usually in negligence) against the health care organisation. Quite a number of the cases encountered in this study have given rise to civil actions by families against the health care facility involved. It is thus eminently understandable that such health care facilities would take measures to protect themselves against

such civil actions. In the case of one of the victims of Richard Angelo, it was alleged that a death certificate was issued knowingly misstating the cause of death. This allegation by the family's attorney, if substantiated, would indicate a response more focused on protecting the institution than either establishing the truth, assuring patient safety or assisting the families.

The lawsuit also charges that the hospital issued a fraudulent and false death certificate, stating that Poultney had died of a heart failure when in fact, he died of Pavulon poisoning at the hands of Angelo. "On Jan. 14, 1988, the medical examiner, after autopsy, disclosed on a death certificate in lieu of the original death certificate, that my father was a victim of a homicide and had been a victim of poisoning by Pavulon," said the daughter... (PR Newswire, 1988).

When a large Vienna hospital became the focus of public attention on account of the activities of Waltraud Wagner and her three colleagues who killed many, many patients, it sought refuge in a plea of ignorance. The reaction of the organisation, the Lainz Hospital – the fourth largest hospital in Vienna – was to plead shock, horror and distress, but above all, it was to plead ignorance.

Franz Pesendorfer, who heads the department where the murders occurred, said he and his doctors could not have known about the mass slayings because the crimes were committed in a secret and sophisticated way. Edelbacher said police met "a wall of silence" when they tried to get the name of the doctor said to have been told about suspicious events in the ward... (Prinz, 1989b).

This hardly gives an impression of openness or any desire to resolve the matter in the interests of justice and fairness.

The health care organisation has a further interest to protect insofar it will not want to see a diminution in its patient numbers with its concomitant reduction of state funding. Thus, it would clearly be preferable for there to be no hint of scandal but a nurse who murders a patient or patients will certainly constitute a scandal if it comes to public notice. Even so, the institutional response is interesting in its defensiveness and rationalisation:

The hospital management has denied all responsibility. Gabor Takacs, the managing director, tried to pin the blame on a staff shortage which meant that nurses often worked unsupervised. "The people who died were people who would have died anyway," he said... (Vajda, 2001).

This avoidance response is unlikely to inspire confidence in the health care organisation on the part of either consumers or regulatory authorities. As noted earlier, government, and those authorities charged with responsibility for the regulation of health care facilities on its behalf, also have a vested interest in avoiding scandals of this or any other sort. The texts are strident in constituting a discourse of self-protection. The authorities will also want to investigate, inquire, and punish an offending facility. The nurse regulatory authorities will want to ensure that the profession of nursing is not impugned by one errant practitioner and will take steps to publicly withdraw the miscreant's license to practise nursing, thereby sending a message of reassurance to the public that aberrant nurses will not be tolerated. A key objective of regulators and administrators in situations that come to light where a nurse has been murdering patients is to protect themselves from adverse consequences including litigation.

Vermillion County officials are not liable for civil damages sought by relatives of patients who died while Orville Lynn Majors was a nurse at the former county hospital, the Indiana Court of Appeals ruled Tuesday... (Associated Press, 2003, p.2).

The subtext of this criticism is that patients could not possibly be murdered in a normal, well-functioning hospital. This serves at least two purposes. On the one hand, it reassures the public that their hospitals and health workers are safe, competent and trustworthy. On the other hand, it creates a sense of otherness, an alienation of the particular hospital as a repository of aberrance and dysfunctionality. It is a mechanism by which society is reassured that its health system is healthy and that the general public should feel confident that, should they have need of the hospital's inpatient services, they need not fear for their lives on account of murderous nurses.

Even the murder of patients by nursing staff may not be enough to galvanise a health service into improving its organisational practices. An inquiry was instituted but not everyone was confident about the potential for the inquiry to shed light on and rectify the problems at the Leighton Trust following the Salisbury conviction.

Healthcare Commission chief executive Anna Walker said: "We aim to focus on patients in everything we do. "That is why an important part of this investigation is to ask patients and relatives about their experiences." We

appreciate that people may have concerns following the conviction of a nurse. Our aim is to find out what went wrong, what systems the trust has in place to ensure this does not happen again, and how we can help them to make further improvements to protect the safety of patients." The views of patients and local people are crucial to this." Barbara Pennington, director of nursing at Mid Cheshire Hospitals NHS Trust said: "It is hugely important that whatever lessons need to be learned are learned. It has always been our intention to take stock of the circumstances surrounding these crimes and we welcome the Healthcare Commission's involvement. "We look forward to working with them over the coming weeks and months and will co-operate fully with their inquiry." The views of the public and patients are vital to us in everything that we do and we hope that they will take this opportunity to share their experiences of the services we provide for older people... (E. Stewart, 2005).

Here in the texts relating to the murder of patients by nurses the voice of regulatory authorities is loud and the political imperative is driving the discourse constituted by those texts. The body of texts constitutes discourses of failed duties, inadequate oversight and inaction. The need to reassure and placate the public is evident but, as the next extract reveals, the inquiry referred to by Stewart (2005) failed in its key objectives, at least in the evaluation of some observers. It is a long extract but the commentary is important in demonstrating the extent of this discourse. Investigators engaged to evaluate the Crewe Leighton Hospital four years after the apprehension of Barbara Salisbury were highly critical:

Patients are still suffering serious lapses in care at Crewe's Leighton Hospital nearly four years after ward sister Barbara Salisbury attempted to murder two pensioners in her care. Investigators called into Mid Cheshire Hospitals Trust (MCHT) found there have been serious lapses in the care of elderly patients since 2002.

They found no difference in hospital practices between 2005 and 2002 when Salisbury, aged 48, attempted to kill Crewe pensioner May Taylor, aged 88, and 92-year-old Frank Owen, of Nantwich. Suspended chief executive, Simon Yates, had resigned ahead of the publication of today's report. Reviewing the Salisbury case, the dossier by the Healthcare Commission found: Chief executive Simon Yates was not involved in the decision to call in the police. It took executives three weeks to look into the Salisbury allegations. Discrepancies in the version of events surrounding the allegations and no proper records kept. No internal investigation until Salisbury was convicted in 2004. In addition, commission officials found a shortage of nurses, over reliance on agency staff, patients being admitted to the wrong ward or repeatedly moved and a lack of training and equipment. Today's report states: "Staff could not differentiate the systems in place in 2005 from those in place at the time of the incidents involving Salisbury at Leighton Hospital, with the exception of the management of controlled drugs." It adds: "Several nurses reported that the most significant change since the Salisbury case was that patients now suffer more pain." The trust has also been asked to look at its

higher than average mortality rates. Investigators found the trust was dominated by financial matters and targets. They criticised suspended chief executive Mr Yates for having too much of an "informal" and "hands-on role"... (Nicola Irwin, 2006, p.2).

This is an extraordinary indictment of the health regulatory authorities, of the hospital itself and of the public apathy. The aftermath of the Salisbury case in England was indeed grim. However, across the Atlantic in the United States of America, in an almost identical story, the reporting injects the beginnings of a defence on the part of the organisation involved by inferring that they sacked the suspect nurse when he appeared dishonest.

Akin had been dismissed from the hospitals in Georgia and Alabama, although administrators at North Fulton Regional Hospital said he was let go because he had falsified the record of his nursing education by exaggerating his credentials... (New York Times Service, 1991) (*Austin American-Statesman*, 1991, p.6)

The conclusion appears to be that the murder of patients is one thing, but to forge one's qualifications is quite another. It is clear from the following transcript of a news interview that employers of nurses in the USA have some difficulty in getting access to the information that would allow them to know that a particular nurse constitutes a hazard and should not be employed. There is once again a subtext of avoidance of responsibility and systemic failures:

'Mr. MILLER [President and CEO, Somerset Medical Center]: Yes, Katie [Katie Couric, co-host – *NBC News- Today*]. It's outrageous the fact that this individual was being investigated for homicide by two different hospitals in two different states and that information was not available to us during an employment check. We do a criminal background check, we check licensures, and nobody was able to give us information that this person was investigated for two hospitals for overmedication and homicide. That's outrageous.'

'Mr. MILLER: Absolutely not. You know, what the problem is, that other employers that we called, and we did a complete criminal background check on this individual, and a complete reference check on this individual, and everybody said the following, he left in good standing and his license was intact. And that's the outrageous part of this. What I've been doing, I've been contacting all of my state legislators and federal legislators, I want to go to Washington and I want to see legislation proposed that says we need to have full disclosure of anybody who has been investigated for criminal activity who is a licensed care professional. That is the way we'll stop this from happening again, Katie.'

'COURIC: Background checks for doctors are far more stringent, I understand, than background checks for nurses.'

Mr. MILLER: That's correct, with the exception of the fact that even with doctors, you would not know information if they were being investigated for a crime but not convicted. What we're going to need to have is at least three things: One, hospital employers or all employers are going to have to be free from liability to give honest evaluations of why people were terminated.' (Couric, 2003).

Often an organisation will not exercise sufficient or appropriate control over staffing, with disastrous consequences:

The director of the facility conceded that patients on Tenzer's night shift had suffered a disproportionate number of unexplained injuries. Yet the director did not study all the reports until after the suspicious death. Seven days before the alleged assault, McCray had warned a supervising nurse about Tenzer's behavior, having seen her take a patient's anxiety pills. McCray was fired the next day. Tenzer was not disciplined... (King, 2003a).

Organisations rarely acknowledge their failings in matters involving the prosecution of members of their staff for murder of patients.

Police are questioning clinic officials, who reportedly admitted their lax management of the relaxant... (*Kyodo News*, 2001a).

Organisations that employ nurses have failed both the public and the profession through their inability or unwillingness to collaborate with regulatory authorities with respect to suspicious conduct by nurses, and the Akin case provides an excellent example:

Joseph Dewey Akin continued to work for hospitals and temporary agencies this year, despite being fired four times and targeted in an investigation of mysterious deaths, because local hospitals and a state regulatory agency routinely will not discuss a nurse's employment record... (Perl, 1991, p.1).

All of these texts contribute to a discourse of avoidance of responsibility. There are excuses but little if anything that really legitimately excuses the management of the organisation in each case. Perhaps not surprisingly, organisations will look for ways to distance themselves from allegations of murder by nursing staff:

Feltner was fired from the nursing home about a week later because he failed to show up for work, Powell said... (AP, 1989a, p.1)

Organisations, like society, feel betrayed by the nursing profession when a nurse murders patients:

Veterans Affairs Medical Center President Bruce Gordon told employees the five-year ordeal was the work of "a single person" who murderously defied the hospital's mandate. "Those actions contradict the ideals of a profession in which we place our most sacred trust," Gordon said... (AP, 2001f).

There is no acknowledgement here of the conditions that made it possible for Kristen Gilbert to defy 'the hospital's mandate', and those conditions lie primarily within the province of management. This is not to say that this aspect of health service management is without its challenges, and the hospital's responsibilities may be difficult to discharge. So far as nurses who murder patients are concerned, some are very smooth operators while others cause concern among colleagues for reasons unrelated to the murders. An example of such a case is that of Tenzer.

Employees who worked the 11 p.m.-to-7 a.m. shift at Alterra Clare Bridge, a personal-care facility near Yardley, ...said they were aghast that Alterra managers, some of whom knew of Tenzer's problems, let her look after helpless - and often difficult - patients. Bucks County prosecutors say that concern was affirmed on Sept. 5, 2000, when a frail old man in Tenzer's care was fatally stomped in his room... (King, 2003a).

Those employees may have been aghast after the fact, but did they do anything to remove the risk? Yet another case that raised concerns after the fact was that of Hal Speers Rachman who managed to circumvent the hospital's protocols and precautions to the extent that he was able to pose as the victim's doctor and orchestrate an unprescribed dose of insulin. That a person could bypass the hospital's safeguards for protecting patient safety and security with such apparent ease was a matter of major concern for the institution in the Rachman case.

Hospital officials are alarmed because the telephone caller was able to bypass identification standards by using highly technical medical terminology to convince a nurse. "The caller was obviously some sort of medical professional, or at least had the knowledge of one," said David Langness, vice president of the Hospital Council of Southern California. "We don't think of it as an isolated incident. We think it is a matter of great concern," Mr. Langness said. "We're looking at a security system that will prevent this from happening ever again." Physicians routinely give prescription orders over the telephone for their hospital patients. While that is not likely to change, the new procedures will center on a more secure method of physician identification, according to officials who declined to give details. A tighter system is already in place at St. John's, said Armen Markarian, the hospital's director of communications... (*New York Times*, 1986).

The advent of a case of a nurse murdering patients is highly destructive to a health care institution, and in particular, to a private sector facility. It is difficult to imagine how a health service could function if patients were too afraid to accept injections from nurses. However, in some facilities it was reported that such was the case.

Hospital sources said the affair had caused unrest in the clinic, with many patients demanding transfers to other hospitals and refusing to accept injections from nurses... (Associated Press, 1989, p.15).

As one might expect, the source at the hospital was not identified and thus the credibility of the report cannot be verified. This fact does not disqualify the voice from contributing to the discourse but it does make it difficult to ascertain the motivation. Equally destructive is any perceived inaction. For example, in Akin's case, the alleged perpetrator was neither suspended nor dismissed until the organisation had no alternative because of adverse publicity. Until that occurred, patients remained at risk.

Mr. Akin was suspended Tuesday from his job as a research nurse at the Atlanta AIDS Research Consortium, a research organization that monitors the effects of experimental drugs on AIDS patients. His whereabouts early today was not known; the executive director of the AIDS consortium said Mr. Akin called in Tuesday to say he was taking a leave of absence. Mr. Akin was hired June 5 and suspended indefinitely with pay amid the sudden swirl of news reports Tuesday, said Executive Director Amy Morris. "His resume checked out when he was hired, but now we are realizing there were some holes in it," Ms. Morris said. "It came as a shock to us..." (McIntosh 1991b, p.1).

The litigious nature of US society contributes to a reticence to act decisively. It seems to put organisations between a rock and a hard place. If they move against the suspected employee, they risk being sued by the employee. If they do not move against the employee, they risk being sued by affected patients who survive the ministrations of such nurses or the families of those who are not so lucky.

North Fulton's administrator said Tuesday night there has been no conclusive proof linking Mr. Akin's employment to deaths in the intensive-care ward. "The individual we are looking at was not terminated for that reason because we have no proof of that," said the administrator, Frederick Bailey... (McIntosh 1991b, p.1).

Some of these cases of nurses who murder produce positive changes in health service organisations, where operational systems may be altered or other steps taken to

minimise the risk to patients of exposure to aberrant health professionals, and in particular, to nurses who murder. For example, the health service made changes to its system in order to avoid any repeat of the circumstances surrounding Rachman's attempt on Lebowitz's life.

A man claiming to be Lebowitz's doctor phoned St. John's late Sept. 20 and persuaded a nurse to give the patient insulin, authorities have said. The medication caused Lebowitz to begin slipping into a coma, but doctors were able to revive him. Detective Shane Talbot, who leads the investigation, said last week that the caller must have been familiar with the patient and with the experimental treatment he was given. The hospital has since changed its procedures for accepting telephone orders from doctors, Markarian said... (AP, 1986b) .

Turning again to Akin's case, the hospital employing Akin clearly sought to deny responsibility but weakened their own position by their actions.

The hospital has admitted billing the dead man's family for the lethal drug while maintaining none was administered... (McIntosh 1992a, p.2).

Even in the face of evidence suggesting culpability, the voice of the hospital is heard only in the context of denying liability. The hospital's approach to the case was to deny liability at every opportunity. However, they had charged the patient for lidocaine but denied that they had given the patient lidocaine.

Assistant District Attorney Roger Brown admitted in opening arguments that the Price family was "accidentally" charged for one gram of lidocaine after their son's death. Hospital officials repeatedly have denied that Mr. Price was given lidocaine on the day he died and have insisted that the overdose must have been administered without authorization. Medical personnel were suspicious about the death and contacted the county coroner and police... (McIntosh, 1992b, p.3).

Much of the animus generated by this case might have been minimised had the hospital endeavoured to understand the family's position but the hospital failed to work with the family of the victim in the case of Akin.

The family also said it was never consulted by doctors when they decided to stop attempts to save the life of Robert J. Price, who died at Birmingham's Cooper Green Hospital on March 27, 1991... (McIntosh, 1992b, p.3).

This is not uncommon. The families are as much political tools as stakeholders in the institutional response, as was illustrated in the Salisbury case. The regulatory authorities exploited their distress.

At the time of the original investigation, we feel the relatives of the deceased patients were still grieving and vulnerable. "For this reason the family is not satisfied that the questions put to the relatives were such as to fully ascertain their views on the care given by Barbara Salisbury. "Now that they have had time to reflect, will the Healthcare Commission team be questioning them on this again?"... (Jackson, 2005, p.1).

The texts reveal the clear lines of the exercise of power between the stakeholders in incidents where nurses murder patients. It is these regulatory authorities that are the next object of attention in this study.

The Regulatory Response to Nurses Who Murder Patients

In most countries the government has set in place a regulatory framework for nursing. The level of sophistication of that framework varies with the stage and level of development the country has achieved, the standing of nursing in the country and the economic prosperity of the country. The intent of the framework however, remains the same irrespective of other variables. The intent is to establish minimum standards of practice and to assure adherence to those standards in order to protect the public from sub-standard nursing care that might result in injury or death for patients. One of the mechanisms within such frameworks is the assurance that those authorised to practise are persons who are fit and proper for that practice. Thus, these regulatory bodies – variously known as nurse registering authorities or nursing councils or nurses boards or by some other similar epithet – have an obligation to ensure safe practice by competent practitioners who are fit to practise nursing. It also amounts to the creation and regulation of a monopoly practice. This is an onerous undertaking so it is not surprising that there are occasions when the system breaks down.

Most of the cases encountered in this study at least admit the possibility of an alternative explanation to an act of cold blooded murder committed with malice aforethought and in such circumstances it is perhaps understandable that there could be some delay in acting against the suspect nurse. Most commonly, any question of

acting against an individual's licensure does involve a protracted period of time – often amounting to years. The Akin case is unusual in that, as soon as charges were laid, the issue of his licensure was raised:

A nurse at the center of an investigation into as many as 11 suspicious deaths of patients says he is innocent but may offer to surrender his nursing license today, his attorney said...Mr. Akin already was facing disciplinary action from a state licensing board for allegedly falsifying his credentials... (McIntosh 1991b, p.1).

The strongest discourse constituted by the texts relating to the authorities that regulate nursing is that of their protective jurisdiction. They see their primary duty as the protection of the public. In practical terms, this means they license practitioners and if some serious doubt arises about the competency, conduct or suitability of an individual practitioner, action may be taken to revoke that person's license. In the case of Charles Cullen, that was of course very much *ex post facto*.

"The Department of State's first and foremost priority is to protect the public's health and safety," said Cortes. "This order now gives us the avenue by which we can proceed to permanently revoke Charles Cullen's nursing license"...On Dec. 19, 2003, the State Board of Nursing, through its Probable Cause Screening Committee, issued an immediate 180-day suspension for Cullen of Phillipsburg, N.J.

Under state law, the Board is permitted to suspend a nurse's license temporarily without a hearing when the licensee poses an immediate danger to the public's health and safety... (*PR Newswire*, 2004).

The issue of the protective jurisdiction appears to be the strongest motivation for action and the assumption in the case of Joseph Dewey Akin is that surrendering his license is an adequate response to this imperative.

The attorney said he would surrender his client's Alabama nursing license to the Alabama Board of Nursing "very shortly . . . to calm the situation." Mr. Matteson turned over Mr. Akin's Georgia nursing license Wednesday, ending an investigation of a complaint by Georgia Baptist Medical Center that he had falsified his credentials... (McIntosh & Montgomery, 1991, p.1).

However, the voices of the regulatory authorities also resonate with self-protection. The State authorities in the Cullen case acted with some alacrity when he finally

came before them but the employers who had had previous suspicions breached their responsibilities in not bringing Cullen to the attention of the authorities sooner.

"First and foremost, every board and commission under the Bureau of Professional and Occupational Affairs' purview has the duty to protect the public's health and safety," Secretary Cortes said. "By imposing this action, the State Board of Nursing is taking the appropriate measures to ensure that all Pennsylvania residents are steered clear of any danger and harm..." (*PR Newswire*, 2004).

The implication here was that, had Cullen's former employers discharged their responsibilities as employers of nurses, Cullen's killing trajectory could have been significantly truncated. Many of his victims may have still been alive. Those voices contain no hint of introspection, no self-examination to determine whether the processes of the regulatory authorities are in any way deficient or less effective than perhaps they could be; whether those processes could even have contributed to the ability of Cullen to kill patients over such a long period of time. However, there is some commentary by others that opens this door just a crack. For example, in the cases of co-conspirators Wilson and Rainey, there was never any question about the pair having murdered a patient. There was no plausible alternative explanation. Even so, the response to the actions of Wilson and Rainey was fairly muted, especially taking into account the brutality involved.

Carol Shockley, director of the Office of Long Term Care, which oversees the state's 241 licensed nursing homes, said there were 31 substantiated cases of employees attacking patients in 2002, but no deaths. "This is the first one I've been associated with," she said Friday. "These people [Wilson and Rainey] are now on our [abuse] registry, or will be added soon," she said, noting that her office is awaiting the go-ahead from the state attorney general to renew its investigation of what happened to Ryan. Shockley, who spent much of Friday explaining to the Legislative Council how her agency conducts background checks of nursing home employees, said her agency showed that Wilson was a certified nurse's aide "in good standing" with no criminal record prior to Ryan's assault. Rainey, though uncertified, also had no criminal record, according to a background check done in July. The agency, however, cited the privately owned nursing home earlier this year for failure to address patient aggression against other patients, Shockley added. Linda Scales, the nursing home administrator, has declined to discuss Ryan's attack, citing advice from the prosecutor... (Bowers, 2003, p.15).

Here the texts reveal the voice of the authorities as clearly concerned with self-exoneration. The assertion is that the regulatory agency had no grounds on which to

suspect that either Wilson or Rainey might be a threat to patients. Neither had a criminal record and Wilson was a certified nurse's aide in good standing. This seems to be a somewhat inadequate response in the face of such brutality but there is no commentary in the media that would suggest that this is so. Sometimes it is difficult to discern whether the regulator is most concerned with protecting the public or protecting themselves but perhaps the best way of achieving both is by utilising any and all available means. An example of this can be seen in the case of Orville Lyn Majors where the accusations were of murder but in the absence of proof or confession, the only avenue for action was a technicality and the suspension of his registration was grounded on an allegation of practising beyond his scope.

The State Board of Health initially accused Majors of being involved in the deaths of as many as 26 patients, but later withdrew the allegations. On Dec. 22, 1995, the State Nursing Board revoked Majors' license for five years for practicing beyond the scope of a licensed practical nurse... (AP, 1997).

There has been added pressure on these organisations in recent times and this is evidenced by the criticisms directed at the Oregon Board with respect to the case of Michael Coons. The details of this case are provided in Chapter Three but essentially the issue was that the Board was slow to act on allegations in relation to Coons and by the time they were ready to act, he had let his registration lapse so the Board no longer had any jurisdiction to pursue the matter. (AP, 2000a, 2000b; Oregonian, 2000, p.1; Tims, 2000b, p.9)

It seems that the regulatory authorities can only act retrospectively in the case of nurses who murder patients. The long killing trajectories of some of these nurses may point to serious inadequacies in the structure and processes of these regulatory authorities, given the number of individuals admitted to the practice of nursing who go on to murder patients. The silence in the media commentary as to the role of the regulatory authorities also suggests that there may be other issues at play that will be explored further in Chapter Nine.

Professional response

If the regulators of nursing have been quiet on the issue of nurses who murder patients, the silence of the profession of nursing has been deafening. There has been

some publicity associated with nurses who murder. This has primarily consisted of media articles that have addressed particular cases and where the authors have sometimes, to add weight (or volume) to otherwise scant facts on the specific case, felt obliged to add a catalogue of well known serial killings. Sometimes this is a generic catalogue of the worst serial killers; at others, it is confined to nurses or maybe medical killers. In general, these are not authored by nurses, but more commonly by journalists, lawyers and by medical practitioners and with one notable exception, (B.C. Yorker et al., 2006), these articles appear in the mass media rather than the professional literature. Even this, however, has not galvanised the profession. There is no leap to defend the profession, to point out that only a miniscule proportion of the profession would ever do such a thing. Even more oddly, there appears no need to do so, and again, this is a matter to which I will return in Chapter Nine. The question that must be canvassed here and now, though, is how does the profession respond? What voices from within the profession find expression in the texts of the public domain to comment on the phenomenon of the murder of patients by fellow nurses, and what are those voices saying? In truth, it must be said that they are few and they are saying very little.

The impact on a health service organisation of a patient or patients being murdered by one of its nurses can be devastating not just in terms of the organisation's public image and, in the private sector, the impact on the bottom line, but for the people who preside over units where those murders occur. There is a discourse of personal pain and grief, professional failure and shame on behalf of the health professions. The sense of betrayal by one's own professional colleagues is profound in some cases. This was evident in the Wagner case:

"The head of the internal medicine clinic, Professor Franz Xaver Pesendorfer, said: "I am deeply and utterly shaken. We need all the help we can get to overcome this crisis of confidence, we just don't know how to carry on..." (*The Seattle Times*, 1989).

Note, however, that it is not the voice of nurses that we are hearing in this excerpt. Rather, the task of public comment has fallen to someone with 'authority'; it is the medical practitioner in charge. For another example of this particular phenomenon, the case of Daillyn Pavia is illustrative. Although the circumstances were a little

different because Pavia was a clear-cut case of authentic euthanasia, the extract reveals the proclivity of hospital administrators and the medical profession for commenting with authority on these matters. Medical practitioners are particularly good at lecturing nurses on the ethics of their practice, as shown by the Pavia case.

Susan Hakes, a hospital spokeswoman, said, "This was a criminal act of an individual and not a failure of a hospital process, policy, practice or procedure." Hakes said the hospital does criminal background checks on all new employees and follows strict guidelines to control medications. The generally accepted code of ethics for nurses comes down clearly against any act intended to cause death. Dr. Stephen S. Lefrak, a professor and director of humanities in medicine at the Washington University School of Medicine, said a patient's age, health and socioeconomic standing should not be factors in the care administered. "All life should be valued equally," Lefrak said. Otherwise, he said, a nurse might take lethal action just because a patient "looks terrible." "You have to assure the public that's not going to go on," he said. Periodically, there are cases of nurses taking it upon themselves to administer fatal doses to dying patients... (Bryant, 2003, p.1).

Among the discourses, especially where medical practitioners are among the most audible voices, are the justifications and excuses. For example, excuses were made for why Stephan Letter was not picked up earlier.

Doctors said that the number of deaths was not remarkable for a clinic specialising in treating the elderly and that Letter had chosen to work mostly at night. As a result the killings had gone unnoticed... (Paterson, 2006, p.17).

When it is a nurse who is suspected of murdering the patient, the texts reveal the voice of the medical profession very clearly in discourses of censure and control and justifications for why they – the doctors – may not have noticed what was happening. Where is the voice of nursing? It is almost completely absent but when it does emerge, it is subdued, almost platitudinous:

I applaud the few nurses who blew the whistle on Cullen... (Mason, 2004, p.11).

This implies a positive attitude within the profession towards the identification and exposure of the reporting of nurses who murder patients. Even if such an attitude exists – and the evidence for it is miniscule – it is of itself inadequate as a response. Much more is needed to constitute a professional reaction that would reassure the public that nurses are on guard against such deviant conduct. Perhaps, however, I am being too harsh here, so I will now review the literature of nursing for its

commentary on murder of patients by nurses. The earliest work that I have found in this area is that of Loy Wiley (Wiley, 1981) who detailed the cases of nine nurses who had been charged with murder in the United States between 1975 and 1981. The cases reviewed there were those of Leonora Perez and Filipina Narciso (1975); Mary Rose Robaczynski (1978); Linda Kurle (1980); Jani Adams (1980); Judith Foley, Nancy Robbins and Anne Capute (1980); and Robert Diaz (1981). Although most of these cases occurred prior to the period covered by this study or did not involve a conviction for murder, the outcome of each tells us much about the perceptions by nurses of the indictment of nurses for murder at the commencement of the period included here.

In the case of Leonora Perez and Filipina Narciso, after an FBI investigation, the two nurses were tried and convicted for a number of murders. This was in spite of the absence of any real evidence and in spite of the hospital ensuring that only nursing staff were harassed in relation to the matter. The conviction was so improbable that it was overturned in 1977 when the Federal Court ordered a new trial. It was so obvious that there was no evidence that the State prosecutors did not bother to try the nurses a second time. The two nurses protested their innocence throughout and in all likelihood, they were indeed innocent (Wiley, 1981, p.36)). In Robaczynski's case, she was accused of turning off the patient's ventilator, then turning it back on after the patient was dead. She admitted that she had turned it off, but only after the patient had no blood pressure and no pulse. To secure a conviction, the prosecutor needed to persuade the jury that Robaczynski had disconnected the ventilator before the patient ceased to have spontaneous brain function. The matter ended in a hung jury (Wiley, 1981, p.37).

Linda Kurle's inclusion in this paper is a little misleading because, although she experienced a legal ordeal on account of a suspicious death, her ordeal revolved around her suspension and dismissal. She was on duty when a sick, elderly but non-diabetic patient died. The patient was subsequently found to have a massive level of exogenous insulin in her bloodstream so it is likely that the woman was murdered. Staff were subjected to lie detector tests but Linda Kurle asserted her right and declined to participate. The hospital promptly suspended then dismissed her. Whilst it took her a year to find another job as a consequence of the adverse publicity that

she had received, no charges were ever laid against her. At least in the Jani Adams case, she was indicted by a grand jury for the murder of a patient. Much of the media attention around this case stemmed from the fact that it was in Las Vegas and a rumour had been circulated that the nurses in the unit where the death occurred had a practice of betting on what time a patient would die. The rumour was flatly denied but it did not stop the media from running with it nationally (Wiley, 1981, p.40). However, there was no evidence of that or of any other wrong doing and in fact, the grand jury did not even have the benefit of evidence of cause of death which was in fact septicaemia. The District Court dismissed the indictment out of hand and in all likelihood, there simply was no murder involved in this death.

The case of Judith Foley, Nancy Robbins and Anne Capute in 1980 almost made it into this study (Wiley, 1981, pp.41-42) but there seems to be a complete absence of any commentary after the trial of Capute so it was difficult to identify the outcome of the case. The three nurses were to have separate trials and the last mention of it that occurs in the media seems to be at the point that the jury retired to consider its verdict in Capute's trial following an impassioned address by her to the jury, during which she asserted her innocence. There is but one further mention which occurs in 1985 when there is mention in a media report of the restoration of Capute's nursing license after she was found innocent, and the dropping of charges against Foley and Robbins who also had their licenses restored (Anon, 1996, p.4). Finally, there was the case of Robert Diaz. In response to having his name linked in the media to some 25 deaths at the hospital where he worked, Diaz – who had not at the time been charged with any crime – filed a defamation suit against the government for releasing information that implicated him in the deaths in the absence of charges. By this time Diaz had been terminated, as had some other staff who were only remotely related to him, and it was reported that six of the deaths had occurred before Diaz began working at the facility (Wiley, 1981, p.43). The point that Wiley was making is that the nurses were being sacrificed ahead of other possible offenders such as doctors and that, if nurses are to be singled out in this way, then they needed to lose their naïveté and ensure that they sought legal assistance as soon as there was any hint of an investigation. The sting in the tail of this tale is that Diaz did make it into my study and is one of the very few nurses convicted of the murder of patients – twelve in all – who received the death sentence. He was convicted in March, 1984 and has

been on death row ever since. In considering the case of Diaz, a number of factors need to be noted. Diaz still protests his innocence, the state provided only the cheapest of defence attorneys, and there remains a doubt in the minds of some as to whether in fact any of the patients were murdered.

This paper by Wiley was valuable as a starting point with which to commence my review of the literature because it is one of just a handful of papers that are anything more than a news report of a particular case transcribed into the nursing literature. Those articles that are just a transcribed news report I have passed over because much of the data for this study is drawn from the news media. I might say that even of these there are very few. In relation to a case such as that of Charles Cullen, there are perhaps twenty articles in the nursing literature compared with some two thousand in the mass media.

It is not until 1988 that the next significant paper on murder of patients by nurses appears. This was the work of Beatrice Crofts Yorker. Like Wiley (1981), she reviewed nine cases, some of which were the same ones that Wiley had examined. Yorker (1988, 1327) pointed to the role of statistics in the identification of nurses who may have murdered patients. She too was critical of the way in which prosecutions had been conducted as witch-hunts with flawed legal processes and inadequate evidence. She made the significant observation that *'the correlation between a nurse's presence and a high number of suspicious deaths was deemed sufficient to establish probable cause and to bring indictments by grand juries'* (Yorker, 1988, p.1329). As this study has shown, whilst this is insufficient of itself to establish guilt, it does afford a fairly accurate pointer as to appropriate suspects. Carl (1989) takes issue with Yorker's emphasis on the statistics, pointing out that many courts do not allow statistical correlations as evidence because such correlations do not demonstrate an intentional act.

Ten years after Yorker's work, a paper by Jones (1998) presented similar information to that of Yorker but adding the UK cases of the early to mid 1990s and focused primarily on the context of the intensive care unit. The thrust of this paper was again the dubious quality of the prosecutions against nurses. Like Wiley (1981) and Yorker (1988), Jones proffers advice to ICU nurses in particular to guard against being

exposed to such risks and to seek legal advice sooner rather than later. These accounts all have an exculpatory flavour to them that smacks of defensiveness. None contribute a great deal to understandings of the phenomenon of murder of patients by nurses.

Fiesta (1999) published an article in two parts in which she considered the 'angels of death' cases which she defined as cases involving 'a single health care provider who commits multiple murders in a health care facility' (p.10). Her emphasis is on the case of Michael Beckelic who, as a medical technician, lies outside the purview of this study. Fiesta makes some valid points with respect primarily to the liability of the organisation in terms of its non-delegable duty of care. She is writing from a management perspective so whilst she does not address the issues of concern to clinical nurses, the issues that she does discuss resonate with the issues that I have raised here. Those issues include, for example, the employment of staff whilst ignoring feedback of the person's unsuitability. Thus, it is another useful contribution to this slim literature. Pyrek (2003) wrote in *Forensic Nurse* about the potential 'red flags' that might identify a serial killer. Whilst this was timely, forensic nursing is a specialised field in which not too many nurses dabble so this limits its likely dissemination. The twenty 'flags' that she lists are all factors that individually would not provide a clue but a large cluster of them could collectively point to a potential suspect. Pyrek cites Bruce Sackman, one of the investigators on the Kristin Gilbert case, in asserting that the 'red flags' include the following:

- Statistically, a patient's risk of harm is significantly greater when treated by the subject The subject is uncommonly accurate in predicting patients' demise
- Patient deaths were unexpected by staff or family, and the family was not at the patient's bedside
- Death certificate cites the patient's last illness as the cause of death, or a catch-all is noted, such as cardiac arrest
- Initial review usually finds insufficient evidence to pursue the case, with buy-in from management
- The subject often continues patient care during investigation, and is removed only after allegations become public knowledge
- Fellow employees often report allegations to investigators, not management
- There are no eyewitness to the crime _ Witnesses say they saw the subject with the patient shortly before the patient died

- The weapon of choice is usually a sudden death chemical readily available on the ward and often considered non-detectable or not checked at autopsy
- Syringes, IV lines and feeding tubes are the most likely portals of entry if poison is used
- If a code is called, EKG strips should be in the chart; their absence should raise suspicions
- Subjects are often charming and friendly, yet have difficulty with personal relationships
- The subject receives good written reviews from supervisors _ Prior employment records show questionable incidents
- The subject is given nicknames by the staff while still employed
- Drugs, poisons and related books are found in the subject's home
- Killing is non-confrontational
- The subject insists patients died of natural causes
- The subjects never show remorse for their victims
- Other patients complain about the subject but their comments often are ignored
- The subjects crave notoriety
- Evidence exists that the subject killed or attempted to kill off duty as well as on duty

It will be obvious that any one of this list of flags would not raise concern in isolation. A constellation of these indicators, on the other hand, may very well do so.

Like Fiesta (1999), an unattributed article in *Healthcare Risk Management* (Anon, 2004) deals with the hazards to the organisation in taking on new staff. The article addresses the concerns of management in determining the backgrounds of patient care staff and considers proposals to introduce legislative provisions to enable this and to ensure that organisations are honest with each other with respect to staff references.

In the 'News' section of the *American Journal of Nursing* (Sofer, 2004), just a couple of months after Charles Cullen confessed to the murders of as many as 40 patients, there is a lengthy item on the case. Apart from the descriptive account of the case itself, there is an account of proposed legislative changes to avoid the likes of Cullen being able to move from job to job so freely. There is no substantive discussion of what such a case means to and for nursing. Similarly, in an editorial in the *Journal of Clinical Systems Management*, Leah Curtin (2004, p.5) writes *...I suggest that State Boards of Nursing compile a "Red X" list [at risk list] for nursing...* In fact, Cullen's case did elicit a few editorials. Bliss-Holtz (2004, p.i-ii)

who was at the time living in the county where it all happened, wrote that '*...I have been sitting at the epicenter of quite a bit of local news that has not been picked up by the "wires"...*' and this of course has interesting implications for an analysis of the discourses mediated by the media as I am attempting to do in this study. She went on to say that *...what is alarming is that these events seem to be increasing.*

but here again, nothing new is added to the meaning of these events for nursing. Mason (2004, p.11) also wrote an editorial for the *American Journal of Nursing* following the Cullen case. She, too, points to the need for organisations to have in place mechanisms to prevent the employment mobility of miscreant nurses but she also represents the current failures to report suspicions as evidence of a code of silence within the nursing profession that needs to be abandoned.

Lipley (2006, p.5) reported on the case of Benjamin Geen in the UK. Geen was convicted of two counts of murder among other charges and sentenced to life in prison. He was widely characterised as a 'thrill-killer'. This is a more substantial report than that of the general media because Lipley addresses the fact that the South Central Strategic Health Authority held a seven month inquiry into the actions of Geen and published the resultant report. Apart from anything else it contained, it made 37 recommendations to be taken up by the Oxford Radcliffe Hospitals NHS Trust along with healthcare providers more generally. The recommendations are defensive in the sense that they are designed to guard against a repeat performance. They include recommendations on security for controlled drugs including increased checking and swipe-card access; locking emergency drug refrigerators; attention to pre-employment checks; verification of claimed educational qualifications; implementation of staff appraisal processes; and review of skills mix. There is a clear emphasis on clinical governance. The report appears to have overlooked the rather sage observation of Sir Cecil Clothier (1994) that you cannot stop the most determined miscreant. Again, Lipley makes no comment about the significance of the actions of Geen for nursing as a profession. It is purely descriptive of events.

In late 2006, Yorker et al (2006) published the most comprehensive review to date on nurses as serial murderers but it was as part of a review of health professionals generally. Moreover, it was in the *Journal of Forensic Sciences* which, excellent

journal that it is, just might not be the journal of choice for the overwhelming majority of nurses. It would be fair to say that the primary emphasis was on nurses however. The data identified in that study strongly concurs with the material examined herein. It also provided an excellent cross-check of the cases used here. Yorker et al had some additional cases but either they had no name attached or they did not fit the criteria for inclusion in my study. The most common reason for their exclusion was that they were not a nurse. Yorker et al essentially did a literature search based on the LexisNexis data base using its legal and newspaper domains, along with some other sources, and they covered the period 1970-2006. Nor did they confine themselves to cases where convictions had been secured. Essentially the paper provides a catalogue of cases and a summary of their characteristics. Yorker et al acknowledge the limitations of their study but summarise their conclusions as follows:

These numbers are disturbing and demand that systemic changes in tracking adverse patient incidents associated with the presence of a specified healthcare provider be implemented. Hiring practices must shift away from preventing wrongful discharge or denial of employment lawsuits to protecting patients from employees who kill... (B. C. Yorker et al., 2006, p.1362).

Leaving aside the reproduced news reports, this represents the sum total of the English language nursing literature of the past quarter of a century that seeks to cast any light on the issue of nurses who murder. In short, the professional literature of nursing is of little assistance in understanding the place of murder of patients within the profession. It hardly constitutes a sophisticated inquiry into why nurses are prominent in the group of health professionals who are serial murderers. Nor is there any real attempt to understand the phenomenon from a professional, philosophical or sociological perspective. Nurses, as a profession, seem uninterested in acknowledging the phenomenon of nurses who murder patients, and when confronted with it by the advent of cases, they seem capable of dismissing it. Is the nursing profession untroubled by these aberrations? Are nurses incapable of accepting these transgressions against the standards of the law and the profession as a basis for refinement and consolidation of those standards? We can only speculate

because, even in the face of increasing numbers of cases, the nurses are, on the whole, silent - and it is an intriguing silence.

What is significant here, however, is that, to all intents and purposes, discussion of any sort of murder of patients by nurses is, for the most part, conspicuous only by its absence in the professional nursing literature. I have shown that there has been just a relatively small number of articles relating to this phenomenon in the nursing literature during quarter of a century covered by this study. It is encouraging to see that the frequency and sophistication of the work is improving. This may indicate that there is a slowly increasing openness to the idea. It could mean that nursing is more confident about having ethical discussions now. Most likely, however, it is an acknowledgement of a perception of a steadily increasing frequency with which such cases are occurring and the impossibility of staying silent indefinitely. One thing is certain however. The almost total absence of commentary in the professional nursing literature on this phenomenon has meant that, in this study at least, it has been virtually impossible to hear the discourses of the profession of nursing relating to the murder of patients by nurses except to the extent that they appear in the texts of the media. In that context of course, the discourses are moderated by the medium.

Whilst the profession as a whole seems unresponsive to the phenomenon of nurses who murder patients, individual nurses within the profession will often react to the revelation that a colleague has murdered a patient or patients. Sometimes they react with shock, sometimes with disgust and in other cases, with a degree of nonchalance. The bodies of texts contain an array of texts that constitute the discourses of shock, disgust, and even indifference.

Hospital staff found the attacks "mind-numbing"... (BBC, 2006).

Jaki Smart, dean of the Faculty of Health Studies at BCUC, said: "We are shocked and saddened by what has happened..." (Bucks Free Press, 2006).

Colleagues at the private home were said to have been shocked by 36-yearold Firth's attitude to the patient...And the day after Mrs Grant died one of them called in police who arrested the married nurse on suspicion of murder... (Blacklock, 2001).

The professional response of nurses – especially those who are proximate to the case – can be confounded by other factors such as consequential litigation against other staff related to failures to act to protect those who become victims of the offending nurse. For example, it is a complex matter for the public to make sense of conflicting evidence from organisational staff members who are themselves facing charges, as was the case in the Tenzer case:

Patricia Policino, the former health care coordinator at Alterra Clare Bridge, challenged that theory with her testimony yesterday. Policino, a registered nurse, said a massive, blue-black bruise on Neff's left flank already was turning yellow at its edges when attendants first reported it on Sept. 7, 2000. The yellowing showed that the bruise could have been acquired at least two days earlier, she said. Policino, who also awaits trial on charges of neglecting Neff, recalled being furious when the injury was reported. "I was angry" that no one had seen it earlier, Policino testified. "It had to be a couple of days old..." (King, 2003d).

There are compelling arguments why health services should put in place risk-management strategies that include the encouragement and support of nurses to report actual malpractice or even suspicion of a risk of harm to patients. Mason (2004, p.11) wrote of the need to abandon an alleged professional code of silence:

...we need to talk among ourselves about the code of silence, how to end it, what the ramifications would be, and how to support nurses who report incompetent or potentially dangerous colleagues...institutions need to create systems for reporting and tracking such reports. Once in place, discussions of the code of silence could be included in new employee orientations, as well as the focus of nursing and medical grand rounds and unit meetings... (Mason, 2004, p.11).

There is some considerable evidence to support this position and it is also the case that there are some fields of practice that produce stronger responses than others, at least in the media. For example, if there is an allegation of a nurse murdering patients in a pediatric unit that will be big news, as was obvious in Toronto in the case of Susan Nelles (who it seems was wrongfully accused) and in the case of Genevieve Jones. There are times when cases of murder by nurses occurring in aged care settings have produced similar reaction. For instance, when a nurse is convicted of murdering patients in aged care facilities, it is likely that the regulatory framework of aged care will be singled out by the media, politicians and interest groups for particular attention as being inadequate. The criticism of aged care regulators, as

with aged care facilities, seems much harsher and more strident than that directed at the regulators of nursing.

For the estimated 1 million residents of the nation's assisted living facilities, the result is a patchwork of state regulations that's generally less stringent than the federal regulations for nursing homes. The situation "cries out" for tougher enforcement, an ad hoc group of advocates and state regulators warned in a 2003 report to the Senate Special Committee on Aging. States currently have sole authority to regulate assisted living facilities. Yet in the year since that warning, some budget-pressed states have curtailed oversight efforts. * In July, California dropped annual inspections of its estimated 6,550 residential care facilities for the elderly. Now, the state plans to conduct annual on-site checks of 20% of the centers, a cost- saving switch designed to ensure that no facility goes uninspected for more than five years... (McCoy, 2004).

The politics of this selective attention are fierce and the voices that are raised in the texts that constitute this discourse of discontent reveal an assemblage of disparate concerns and agendas. Still, all of this raises a central concern: can even the most adequate, the best of systems prevent a nurse who is inclined to murder patients from so doing? In a sense this question lies at the root of this study and will be considered in Chapter Nine.

Since this is a consideration of the professional response to nurses who murder patients, it needs to be acknowledged that some other generic considerations of murder of patients by health professionals have emphasised the presence of nursing. An example would be a paper by Thunder (2003) in the *Journal of Law and Medicine* where he effectively catalogued medical murderers as others have also done. He includes such notable cases as Graham and Wood and attributes the motive of sexual gratification:

Nurses Gwendolyn Graham and Catherine Wood were convicted in 1988 of murdering five elderly women in three months by suffocation at a nursing home in Walker, Michigan. They were lesbian lovers who obtained sexual gratification through their acts... (Thunder, 2003, p.211).

Other professional commentary from health professionals outside nursing can be seen in medical journals but more often than not it is an attempt to make the medical profession look (and perhaps feel) better after Dr Harold Shipman. An example is a letter to the editor of the *British Medical Journal* (Stark, Patterson, & Kidd, 2001) where the authors make the point that whilst medicine may have quite a few serial

murderers, it does not have more than other health professions, and they single out nursing as likely to have more than medicine. I should point out that the authors are a doctor, a psychiatrist and a nurse.

This issue is, however, extremely complex. I have addressed many of the discourses in this treatment of the professional response. One that I have said little about to date, except with respect to the mobility of nurses who murder, is the industrial relations discourse. In 1998, a US journalist, Howard Price, reported that:

Michelle Slattery of the American Nurses Association says hospitals could "get into problems with the Americans With Disabilities Act" if they refused to hire a qualified nurse with a history of mental problems... (Howard Price, 1998, p.1).

This text surfaces a discourse that is prevalent in the bodies of texts related to murder by nurses. There is a presumption that a nurse who murders patients must, almost by definition, be suffering from a mental illness. The conduct is too far from the norm to be capable of sustaining any other interpretation in the minds of the public, at least in the meanings shaped if not constructed by the media discourses. This interpretation reveals the difficulties for employers in those countries that prohibit discrimination in employment on the basis of mental illness. Fear of a complaint of unlawful discrimination or other litigation can, as I have discussed elsewhere, lead to appointments which, with the benefit of hindsight, may prove to have been unwise. Price went on to quote a nurse researching in this area, Ms Beverley Yorker, as saying:

'...the known number of such serial murders "is very minute - one to two reported cases per million health care workers per year," according to British research. But "the recent increase in reportings may indicate that the problem has been underdocumented," she wrote in a report published in the *Journal of Nursing Law*. '

and Price went on to further quote Michelle Slattery:

Miss Slattery called such incidents tragic but "extremely rare." "There are 2.6 million registered nurses in the United States," she said, adding: "Unfortunately, when something like this happens, it erodes public trust in the nursing profession..." (Howard Price, 1998, p.1).

I have provided substantial extracts of the texts from this article because it is a rare example of nurses themselves acknowledging that nurses may murder patients. Even so, both Yorker and Slattery are at pains to minimise the problem – just extremely rare aberrations, statistically speaking. Of course, while Yorker acknowledges that the phenomenon may be underreported, that small possibility does not deter her from speculating about its scale. I have implied throughout this work that the incidence of murder of patients may be substantially under-reported if there are nurses who murder just one or two patients over a long period of time because it will not form a pattern and thus is unlikely to be detected. For this reason I do not think it is helpful to speculate as to the true incidence of murder by nurses. This concludes my comments here on the professional response to nurses who murder patients and I now move on to a consideration of the public response.

Public response

Just what constitutes the public for the purposes of this thesis needs to be elucidated here and it is defined broadly. It is taken to include everyone. Even those who play a role in the processes of acting out the saga of the nurse who murders patients remain constitutive of the public to the extent that they too share an equal vulnerability to falling prey to such a killer, whether as victim, relative or friend of a victim, relative or friend or colleague of such a nurse, or in some other way. They each have a view about this phenomenon.

The enduring hallmark of the public response to the murder of patients by nurses is its transience and its localisation. It impacts only on those whose health care needs are served by the facility involved unless there is an extraordinarily high number of victims or the victims are babies. There is typically an initial response of disbelief and the dawning horror that a nurse could even be suspected of killing patients. As investigations progress and the body count rises (as it almost invariably does), the horror and the sense of vulnerability grows. The public reacts with anger, demanding answers and explanations from those responsible for permitting these aberrations to occur. The investigation concludes, the trials begin, time passes, the public moves on and there are then just sporadic resurgences of interest at landmark points in the case

such as hearings, conviction and sentencing. Within and around this process are buried many discourses that constitute the public response. These discourses warrant careful consideration here in the hope that they may shed some light on some of the apparent contradictions, discrepancies and anomalies within and among these discourses, and that is the focus of this section. This discussion begins with the general reaction of the public, but then explores specific discourses of reaction including those around reaction to the baby killers, around the issue of trust and loss of confidence in health services and health professionals, around shock and horror, and evil and otherness, around bizarreness and rationalisation. Through these discourses it is possible to discern the meaning for, and impact upon, the public of nurses who murder patients.

Trust and the Loss of Public Confidence in Health Services

A core tenet enabling the provision of health services in the way that health professionals deliver those services in this day and age is that of trust. At least in the Western world, many commentators argue that we have moved on from the era of faith healers (although in a large number of countries they remain an accepted mechanism for the delivery of health care and in many countries they continue on the fringe of modern medicine). The point here is that in one sense at least health professionals today are still faith healers for without an understanding of the technology of science and modern medicine – which is the case for almost all lay people – every encounter with the health care system entails an act of faith predicated on trust. It is the trust issue that is paramount in the harm done to the profession of nursing – and to some extent to all health professions - by nurses who murder patients.

"To think I could have died in hospital because someone who should have helped me, a man who everyone trusted injected me with drugs, is appalling. He is clearly very unwell." Jonathan, of Banbury, added: "The fact I thanked him for saving my life makes me feel very angry now. If he had injected a stronger dose I might not be here now. It has left me with a huge fear of hospitals..." (Box, 2006, p.33)

Anything that erodes the health service consumer's trust in the health service providers may impair the capacity of the health services to deliver health care. Some

of the commentary around the case of Stephan Letter affords an example of the texts that constitute this discourse:

The trial of Herr Letter –likely to start in the new year -will prompt the question: how safe are old people in hospital?...In the town pubs, pensioners are still telling stories of how they too could have died. One 72-year-old farmer was released six weeks after Herr Letter began work in the clinic. "I had pneumonia," he said over a beer. "If I'd got it six months later someone might have finished me off at night..." (Boyes, 2004, p.7).

The body of texts that constitute this discourse of insecurity is significant. The phenomenon of any health professional murdering patients will first make people insecure but it will then erode the trust of all health care consumers and some of the texts are calculated to do so, as I have just illustrated. Another example of text constituting this discourse further illuminates the potential problem:

Trust in the medical system has been seriously eroded. Herr Letter, described as shy but not reclusive, remains a mystery to the community... (Boyes, 2004, p.7).

There is an inherent and obvious dissonance between the stereotypical nurse and the reality of a nurse who murders patients. The public struggles to reconcile the competing perceptions of nurses as caring, committed and compassionate on the one hand, with that of the notion that nurses can be murderers on the other. This dissonance impairs the capacity of people to make judgements about the true nature of an individual nurse who is accused of the murder of a patient or patients:

Public opinion is divided on whether the tall, blonde de Berk is a killer or just an unlucky innocent whose patients unfortunately died during her hospital shift... (Clements, 2002, p.38).

These texts reflect the dismay of a community where a health professional cannot be trusted. Everyone is vulnerable. Everybody becomes ill at some stage. This means putting one's life in the hands of others with the expectation that those others will do all in their power to preserve and improve one's state of health. When Roger Andermatt was exposed as a murderer in Switzerland, the nurse provoked a profound reaction.

The government in Obwalden, the small state where Andermatt lived and where many of the murders took place, said it was in shock. "The motives of

the criminal are simply incomprehensible," it said. "The government regards it as tragic that such a crime could happen in such well-known and trusted surroundings," it said. Obwalden authorities have set up special counseling for families of those involved. Procedures at all state-run care institutions had been reviewed to prevent anything similar happening in future, the government said... (Associated Press, 2001b).

The bodies of texts related to the murder of patients by nurses carry within them many texts constituting discourses of shock, incomprehensibility, dismay and tragedy in response to these events that are variously characterised as crimes, tragedies, atrocities, etcetera. It is interesting that part of the official response in the case of Stephan Letter was to make available 'special counselling' for the families of the victims. When a nurse murders patients, it is perceived to be a huge breach of trust.

It is impossible to imagine a more sinister crime . . . or a more ominous murderer. Nurse becomes executioner. Kristen Gilbert may well be our worst nightmare, precisely because the atrocity she was convicted of orchestrating at the Northampton VA hospital defies all our notions of mercy and trust... (Peter Gelzinis, 2001, p.6).

Leaving aside the entirely apt but emotive characterisation of Gilbert's actions as an atrocity in this particular text, when health professionals, especially doctors and nurses, murder patients it does impair society's ability to place their trust in those professions.

The bodies of texts around murder by nurses reveal other responses to the phenomenon of murder of patients by nurses as well. For example, the notion of health care professionals such as nurses being prepared to murder patients has given rise concerns about legalised euthanasia in The Netherlands where there has long been a much more relaxed tolerance for voluntary euthanasia which is legal in that country. However, the place of euthanasia is always fragile given the implications of this acknowledgement of mortality. The Netherlands has a low incidence of serious crime generally and of serial murder in particular so when the de Berk case came to light there was considerable concern. For the most part, that concern took the form of a discourse around whether it would be safe to trust medical staff. If these staff were prepared to murder patients, then legal euthanasia could be a license to murder.

The [de Berk] case has touched a raw nerve in the Netherlands - the first country in the world to legalise euthanasia - sparking fears that medical staff could get away with murder... (Reuters, 2003, p.13).

This was reinforced by Castle who, in commenting on the effect of the de Berk case, wrote:

The trial sent shock waves through the Netherlands, a country unfamiliar with serial killings...Perhaps most shocking to a nation where euthanasia has been legalised was that De Berk often targeted children... (Castle., 2003, p.17).

The public occasionally recognises that it may not be enough to put their faith in government authorities, but it will usually only happen when a family or others are personally touched by a failure of the system. This is evidenced by those who seek to prevent others being harmed in the way they have been. They will sometimes form action groups or interest groups to take up the cause, just as in the following example:

On Monday night friends and family of Ryan gathered for a vigil in Little Rock's Riverfront Park. "Residents of nursing homes are depending on us to stand up for them," said Nancy Allison, president of Arkansas Advocates for Nursing Home Residents. "As much as we'd like to believe that the industry will look out for the safety and welfare of residents in their care, recent studies and inspection reports show us..." (AP, 2004b).

The bodies of texts around the murder of nurses have within them many examples of texts that constitute a discourse of lack of confidence in government to adequately look after the interests of citizens. The bodies of texts relating to the public response to murder by nurses constitutes a range of discourses that have as their focus the nurse in particular. In texts relating to the Salisbury case, the discourse is the deleterious effect of Salisbury's actions on the nursing profession. It is reflected in letters to the editors of newspapers.

Nurse Barbara Salisbury who tried to kill two elderly patients so she could free up beds on her ward brings disgust to her profession. Being jailed for five years seems hardly adequate given the gravity of her crimes. It is just as well the two patients did not die, but small comfort to the families who have to live with what she did... (B. Turner, 2004, p.35).

Where the media picks up a case and runs with it, it is difficult to determine whether the reaction is that of the media or of the public. Certainly the media is instrumental in shaping the public perceptions.

The case was publicized last month on the syndicated television show *Geraldo*, and since then the parole board had been besieged with letters. "As of this morning, over 1,200 letters had been received," Ms. Armstrong said... (Holmes, 1989, p.11).

Whilst the parole board no doubt would make its decisions based on the particular criteria of its operations, it is inconceivable that the board would not be influenced by a thousand or more letters objecting to the release on parole of a particular prisoner, in this case a nurse that kills babies. In the result, Jones' application for parole was refused. Was it because of a thousand letters?

The State Board of Pardons and Paroles unanimously denied parole Wednesday to convicted baby killer Genene Jones, whose case sparked more than 1,000 letters to the board... (Holmes, 1989, p.11).

Whether or not it was the letters that caused the outcome, it brings us to reactions to that special category among nurses who murder – that of the nurses who have been styled in the media as 'baby killers'.

Baby killers

Where a case involves the murder of babies by a nurse, it becomes headline news and it will spark strong public reaction – at least initially. Cases in this study where at least some of the victims were babies include those of Genene Jones, Beverley Allitt and Lucy de Berk. The media has clearly shaped the construction of the nurse who murders baby patients as among the most evil of human beings. The bodies of texts related to this category of murder by nurses resounds with the discourses of outrage and horror, and the meaning attached to such murderers by the public cannot help but be shaped by the texts of the media. The public appears far more shocked by nurses that kill babies than by nurses who kill older people even though there are many more of the latter than the former. Texts around the case of Genene Jones are typical, as the following extract shows:

The killings made the front pages of newspapers across the country. When the news show '20/20' profiled the case, television journalist Hugh Downs professed his own shock before the cameras. The number of deaths would be the principal horror, the one that got the tabloids pumping, the one that had San Antonio's newspapers trying to outscop one another... (Peter L. Robertson, 1989, p.8).

Notwithstanding the reality that baby killings attract considerable media attention, that fact, of itself, does not assure accuracy in the representation of the texts. The discourses of discreditation are also prevalent in the bodies of texts relating to these particularly emotive cases and the following extracted text illustrates well the fact that the stakeholders in these cases will each have potentially very different perspectives of the issues.

NBC's Monday movie *Deadly Medicine* was "a farce, a whitewash, a total lie," says the father of the baby girl killed by pediatric nurse Genene Jones. Reid and Petti McClellan, the child's parents, live in Houston now. They watched NBC's depiction of their daughter Chelsea's death and the investigation that followed it, and they were outraged. "We were sitting here in total shock," said Reid McClellan. "I feel we were victimized again. We are furious, and we're going to shout it from the rooftops -- on the TV talk shows, if necessary, or whatever it takes to keep something like this from happening again." McClellan said he and his wife were "violently ill" the first few minutes. "We could not believe how anybody could be so ignorant about the facts," he said. According to McClellan, the only truths in the movie were three names -- those of the doctor, the nurse and Ron Sutton, the district attorney. In the movie, the McClellans' names were changed... (Hodges, 1991, p.6).

Irrespective of its interpretation of the 'facts of the case', this film undoubtedly shaped the way the public perceived this case of Genene Jones. For this reason if no other, the case of Genene Jones represents an excellent example of the part the media plays in shaping public awareness and response to cases of murder by nurses at least where babies are involved. The solicitation on syndicated TV show of letters opposing parole noted above also seems to have borne fruit. These two examples reveal quite clearly the power of the media to take up a cause and shape, or at least influence, the outcome:

'Parole board spokeswoman Karin Armstrong, said the letters are "pretty much a direct result" of a segment on Jones on the nationally syndicated television show *Geraldo*. "When you have somebody get on national television and tell people to direct their protests to Mr. Keene, I think I can safely surmise it was a result of that," Armstrong said. "In recent recollection, this is the most letters we've had" on a parole hearing. ' (Obregon, 1989, p.7)

Where a case arouses strong feelings among the public, it is inevitable that the bodies of texts relating to the particular case will give rise to a discourse around the issues of appropriate punishments. In the texts relating to the Beverley Allitt case, Bushell

appears to be advocating that Allitt should have been executed, ignoring the absence of the death penalty in the UK. Bushell is also, by implication, dismissive of the notion that any relevance be placed on Allitt's mental state.

Is Beverley Allitt mad or bad, asked Real Crime. As the Lincolnshire nurse killed four babies and attacked 13 others, the more pertinent question is: Why is she still alive?... (Bushell, 2002, p.19).

The media reflects the inability of the public to accept that people capable of serial killing might hold the same aspirations as other people who do not commit serial murder. The body of texts around the phenomenon of the murder of patients by nurses contain texts that give rise to an express discourse of aberrance and otherness that I discuss elsewhere in this work and it seems to me that the inability to acknowledge that these nurses may also have aspirations for a normal life stems from the fact that to do so would be to acknowledge that they may actually be ordinary people aside from the fact that they kill people, and in some cases, they kill babies. For example, following Beverley Allitt's conviction for the murders of babies in the UK, she was sentenced to thirteen life sentences in a secure psychiatric institution. After some years at Rampton, she formed a relationship with another inmate, Mark Heggie who was himself committed to Rampton for an indefinite term for the attempted murder of a 63 year old woman. It was reported that they had decided to marry after their relationship had been continuing for about three years. The media was scathing. The following excerpts from the body of texts on this issue are texts that constitute what I have earlier called a discourse of aberrance and otherness, but it takes the form of highlighting the worst features of the individuals and it provides a graphic demonstration of the power of the media to shape the meanings that the public develop. The public is offended by any semblance of normality on the part of these murderers because it humanises them and brings them closer. It makes it harder to identify the potential murderer and that makes it more difficult to trust anyone.

A convicted criminal who wishes to marry baby killer Beverley Allitt is the son of a much-loved Scottish soap star, it emerged last night. Mark Heggie, who was jailed for drinking the blood of a woman he tried to murder, plans to wed the infamous nurse in a private service later this year...A spokesman for Rampton yesterday said: "Relationships do develop between patients. If it was to proceed to marriage that is something we would have to facilitate..."
(*The Express*, 2001)

Bride Allitt's vow for big day EVIL Beverley Allitt plans to marry her blood-sucking boyfriend wearing a white wedding dress, The Sun can reveal. The 31-year-old nurse -who murdered four children in her care and tried to kill nine others -told "vampire" Mark Heggie she wants a traditional gown as she has never been a bride. And the podgy Angel of Death is believed to have slimmed down so she will look her best on her big day. The couple...want the ceremony to be held in the secure hospital's St Francis Chapel -a church in the grounds with stained glass windows and an altar. ... Heggie, 34, told pals: "We want a traditional wedding with a cake. And Bev wants a white wedding dress and a reception." He added defiantly: "Why shouldn't we marry?" ... Rampton has no power to block marriages between inmates unless they are deemed unable to understand what they are doing. ... But a source at the hospital dubbed the match "a love affair made in hell" and called the marriage plan "sick". The pair are said to be besotted with each other. And although they are in different wards, they regularly get together for kisses and cuddles at Rampton social events. Another source said: "It is stomach churning that after what these two people did, they can carry on making wedding plans like this. "Their snogging has been bad enough. But the thought of them becoming man and wife is horrific... "It's sickening. On couples' nights they snog each other without an apparent care in the world. They also write to each other from their wards every day -and are always talking about each other." ... "Allitt wants it to be as near normal a marriage as possible. "But one thing is certain -the relationship will never be consummated."...The Sun revealed three years ago that the warped pair had formed a close friendship. At the time relatives of Allitt's victims slammed Rampton's "liberal regime"...Rampton would not comment on Allitt and Heggie's romance. But a spokesman said: "Relationships do develop between patients and also between patients and former friends from the outside. And if that was to proceed to a marriage, that is something we would have to facilitate. "We don't actually have the power in law to prevent marriage as long as both parties are considered of sound enough mind to make that decision and know what marriage entails. We have had weddings in the past..." (A. Taylor, 2001b).

If a reader looks past the sensationalism in this text, it is essentially a description of the behaviour that we might expect from a normal couple in love with each other. It is only the context of a secure psychiatric hospital that makes it different. The fact that the participants are murderers is in many respects immaterial. However, for this couple to engage in normal activity is patently unacceptable for the reasons outlined earlier. The public cannot afford to let the abnormal become normal. That would be too threatening. Even so, within this text there is the element of the limits on the authority of the hospital. The punishment ordered by the Court in each case was confinement to a secure psychiatric hospital and if these people are considered to be mentally ill as the sentence implies, to what extent can they be held accountable for their crimes? Moreover, logic suggests that if the object of the exercise is the security

of society, that is achieved by their confinement. In our society, that does not mean the person has no rights. Indeed, if they come within the official rubric of the mentally ill, they are entitled to be maintained in the least restrictive environment compatible with their safety and that of society, and to lead as normal a life as possible. In such circumstances, it is understandable that the hospital has no authority to prevent this marriage. The discourses in the texts of the newspapers suggest that their editors do not share this liberal view.

Harry Taylor, 59 -whose seven-week-old grandson Liam was first to die -said: "It's sick. She should have hanged, but wasn't even sent to prison. She gets concerts, dances, barbecues -all things Liam would have loved if he'd been allowed to grow up...Allitt gave up her rights when she killed four kids..." (A. Taylor, 2001a)

Moreover, the following examples of letters to the editor in *The Sun* (UK) suggest that at least some members of the public do not support the liberal view either:

'... ALLITT and Heggie's wedding plan is sick. These two monsters should not even be drawing breath, let alone enjoying a full and varied social life. They should be separated immediately and properly punished for their horrendous crimes... Mrs C MOULT, Northfleet, Kent ...

...RAMPTON staff say the wedding will be allowed because Allitt and Heggie are both of sound mind and able to know what marriage entails. It is time someone decided they were of sound enough mind to be moved to a proper prison. Let's see how their married life fares without the liberties they get at Rampton. CATHIE HUNTER, Preston, Lancs ...

...THANK you for keeping the public informed of the antics of some of the inmates at Rampton. It beggars belief that Allitt and Heggie will be allowed to marry. Rampton's easy-going attitude must be stopped. People like Allitt should be thankful that they're alive because we don't have the death penalty. JAMES MCGILL ...

...ALLITT and Heggie have ruined decent people's lives, so why the hell should they be allowed to have any fun at all? That is NOT justice. GAVIN FLINT, Halifax, W Yorks...

...I CAN'T believe Heggie feels Allitt is well enough to be released. As he is in a hospital for the criminally insane I don't feel his opinion should count. He probably does not think there was anything wrong with her in the first place. Mrs D HARTLEY, Bradford...

...ALLITT and Heggie have been locked up for their violent crimes and should be being punished. Instead they seem to be living fairly normal lives

and enjoying themselves. They should not even be allowed to have a relationship like normal people, let alone marry. It's disgusting. Mrs G ABBEYFIELD, Salisbury, Wilts ...

...IT is preposterous that the authorities are considering allowing Allitt and Heggie to marry. Surely it is a simple concept to keep patients at a secure hospital separated from the opposite sex. What happened to punishment? The sooner these do-gooders get it right, the sooner they will get the respect of the public. Allitt and Heggie should never be allowed to see each other again.
(*The Sun*, 2001b)

Heggie was transferred to a unit at Brighton and the wedding plans came to nothing. However, Allitt reacted in precisely the way one might expect when broken hearted – torrents of tears and loss of appetite. This, too, was considered disgusting by those around her (A. Taylor, 2004). These letters reveal much about the views of the public but only as mediated by the media. Presumably the editor exercises considerable license in the selection of letters that shape and confirm the views of the public from *The Sun's* perspective. Even if that is the case, however, the views expressed in these texts constitute discourses of outrage and failure of the system to maintain reasonable balance between justice, punishment and consideration of mental illness. Much of this is a failure to accept mental illness as exoneration from responsibility for their crimes. The discourses here demand harsher treatment, more severe punishment and in some cases, a return of the death penalty. The voices represented in these texts are not about to forgive Allitt and neither do they think that incarceration in Rampton is a sufficient punishment. It is not surprising then that they look askance at Allitt having access to children:

Mr Allitt and his wife Lilian regularly visit the top-security hospital where Allitt is awaiting sentence. He said another daughter, Donna, let Allitt hold her eight-month-old daughter, Katie, during the visits. Mr Allitt said: 'We have always had complete trust in her and still do...' (*The Evening Standard*, 1993, p.2).

The singular feature here is that these women have killed babies. That raises many issues but chief among them is the inability of people comprehend, much less find any justification, for the conduct. Women who are themselves mothers find it impossible to justify or excuse such conduct when it so contrived and deliberate but this is as much about the vulnerability of their own children if they have to place

them in the care of a hospital. Can the nurses be trusted not to harm the child? These 'baby killers' frighten the public.

Shock and Horror

The previous section illustrated the 'horror and shock' that results from the activities of those nurses who are baby killers but it is not confined to that group of nurses who murder patients. Within the bodies of texts around the murder of patients by nurses generally shock and horror is a frequent but weaker discourse. Often texts articulate this discourse directly and it is, of course, the most understandable reaction of patients, nurses, organisations, regulators and nations. For this reason I will not labour it here except to provide a few examples such as that of Stephan Letter, a Swiss case about which it was said that

...This case has shocked Switzerland, despite the country's relatively lenient attitude to euthanasia... (BBC News Online, 2004).

The media reports of cases of nurses who murder patients tend to imply that the standing of the victim has some bearing on the degree to which the public will perceive the crime as heinous, and thus on the degree to which the public will be shocked and horrified. In Tenzer's case, the fact that Neff was a veteran seemed to make the crime more shocking:

...and while their cases center on what happened after Neff's injury, grand jurors were just as distressed by what preceded it... (King, 2003a).

The Wagner case was considered to be the largest murder case in Austria since World War II. What made the discourse of horror so loud in this case was the notion that four nurses could together conspire to murder patients on a grand scale. Their conduct in developing their own special, undetectable technique was indicative of the degree of premeditation and planning involved. It demonstrated how deliberate their actions were and that there could be no doubt about the intention, and the shock and horror was compounded by the fact that the murders occurred in the biggest hospital in Vienna and targeted extremely vulnerable elderly patients.

Four nurses' aides accused of killing at least 42 helpless, elderly patients with overdoses of medicine or water torture went on trial Thursday in Austria's largest murder case since World War... (Alison Smale, 1991, p.5).

I have written elsewhere of the discourse of evil associated with the murder of patients by nurses and in this case it is not difficult to see why that association has developed. There can be no suggestion that such rational planning is consistent with madness. These nurses knew exactly what they were doing. There are other examples of cases where the discourse of premeditated evil is loud. The case of Catherine May Woods and Gwendoline Gayle Graham is such a case. Society struggles to make sense of nurses who murder patients and this is linked to deep fears of the dark side of human beings. The reaction of the public is well argued in the court hearing the case of Wagner et al:

... Wagner and the other three aides murdered patients they found tiresome. "It is only a small step from the murder of the incurably ill to the murder of those who appear to be incurably sick and from there to the murder of bothersome, cheeky patients," Kloyber told the court. "The next step is simply the killing of a patient whose life doesn't seem to be worth anything. That brings us to the euthanasia practised in the Third Reich. This door should never, never be opened again," said the prosecutor... (*The Toronto Star*, 1991a, p.22).

Otherness

Otherness is a pervasive discourse in the public reaction to the murder of patients by nurses. Society has to try to make sense of murder by health professionals. In some cases, an attempt is made to distinguish and separate medical murder from our own society. An example from the texts is the following commentary on

These are peculiarly un-English murders, if George Orwell was right in describing our ideal Sunday newspaper murder as the tale of a middle-class solicitor living an intensely respectable life in the suburbs preferably in a semi-detached house which allows the neighbours to hear suspicious sounds through the walls. In Orwell's view, the solicitor, either chairman of the local Conservative Party branch or a leading nonconformist and strong temperance advocate, goes astray through cherishing some guilty passion for his secretary. His crime, which usually involves poison in the sponge cake or Bovril, is planned with the utmost detail and cunning, and his downfall comes only through some tiny, unforeseeable slip. Orwell died, of course, before the Moors murders or the senseless thuggery of today's casual killings. But the point of his essay was, I think, that the old domestic poisoning drama was quintessentially British, the product of a stable society in which the murderer agonized over adultery and finally chose murder instead. The sort of murders we liked to read about had strong serious emotions behind them.... The notion of a nurse getting rid of the patient entrusted to her for care, some wheezing old man who asks for the bedpan too often, is an abomination, more like the

awful affectless murder which Pamela Hansford Johnson described in her account of the Moors trial... (Amiel, 1989).

Part of the response of the public to nurses who murder patients is resentment. The public resents these nurses – irrespective of whether they are mentally ill or not – having access to any advantage, perk, allowance, creature comfort or other benefit in life. This discourse contributes to, or reflects, public dissatisfaction with a system that allows the criminal to prosper at the expense of the victim but most of all it is about maintaining otherness. The following extract illustrates this resentment:

...the woman called "the angel of death" is stacking up savings which have already reached £25,000. For she is "earning" at least £40 a week doing jobs around Rampton Hospital. In five years, she will have saved more than the total amount of compensation paid to her victims' families. That is not just an insult to them - it offends all decency and justice. It may be all right for prisoners to get a few pounds a week to prepare them for life outside. But what Allitt is receiving is simply disgraceful. It must stop... (*Daily Mirror*, 2005, p.6).

It is easy for people to dismiss Allitt because she appears on the face of it to have little in the way of redeeming features. However, that is not always so and in many cases, serial killers are intelligent, charming and engaging and in the case of these individuals it is much more difficult to sustain the discourse of otherness and aberrance. This creates a difficulty for those in the circle of people immediately affected by the murder of the patient because of the dissonance between the obvious 'nice guy' image and behaviour that is so far removed from the norm. For those who are further removed, how the murderer is perceived will depend to a large extent on the construction placed on the individual by the media, just as I have shown in the case of Allitt.

There are examples of cases where the media has believed the person was a normal, noble nurse acting in the patient's best interests in helping them out of this world in order to ease their suffering. As the facts emerge and it becomes apparent that the person has been murdering patients with malice aforethought, the media discourses change to shape the views of the public. An example of such a case is the French case of Christine Malevre. She was regarded positively by the French media initially:

...A French nurse who admitted helping about 30 elderly terminal patients to die says she was only carrying out their requests. "I listened to these patients. I

helped them...It's true I couldn't stand their suffering, these patients who moan, who look at you with eyes that beg you," she said ... Malevre, suspended from her job at a hospital in Mantes-la-Jolie west of Paris, was placed under formal investigation July 8 for the deaths, but there have been numerous calls for leniency. "I've been criticized for being too (sic) human...But in this job, you can't be too human." ... "when you know that medicine can't do anything more, must you let the patients suffer, not respond to their requests? (AP, 1998a).

However, by 2003 the situation was somewhat different:

...An appeals court on Wednesday confirmed the conviction of a former nurse in the deaths of six patients between 1997 and 1998, and increased her original sentence from 10 years in prison to 12...testimony showed that in the case of Malevre, the nurse never consulted with dying patients or their families before ending the patients' lives...' (Souchard, 2003).

The media attitude had hardened as it became clear that what was involved was murder; it was killing that could not be regarded as consensual euthanasia but at the time, even consensual euthanasia would have still amounted to murder. In all probability, however, it would have attracted much greater leniency. In such circumstances the discourse of otherness takes hold.

Another key feature of the discourse of otherness is that of bizarreness of the behaviour as a barometer of the public reaction. For example, in the treatment of the case of Graham and Woods, there was as much coverage of their lesbian relationship as there was of the fact that they had murdered several patients. Put another way, the emphasis is on the pact with Graham's lesbian lover as much as on the smothering of five old patients.

A former nursing-home aide was found guilty Wednesday of smothering five incapacitated patients in a pact with her lesbian lover... (The Associated Press, 1989, p.10).

I have noted elsewhere that the response of the public to murder of patients by nurses is very much mediated by the media. This was patently so in the case of Genevieve Jones. The approach adopted by the media to portraying cases of nurses who murder patients is interesting. In 'Deadly Medicine', a docudrama about the Jones case, rather than examine the facts of the matter, the approach taken is to depict the doctor as a victim. Jones becomes effectively incidental to the plot while Holland's role is

cleaned up. It seems that even in relation to murder the marginalisation of nursing relative to medicine is visible.

The mind-boggling case of convicted baby killer Genene Jones is the subject of tonight's NBC docudrama, but the nurse who was suspected in as many as 30 other mysterious infant deaths in Central Texas is not the focus...Although Holland is the focus of the movie and was on the set when it was filmed, she says she was not involved with creating either the book or the movie. The book, which focuses equally on Jones and Holland, was written from public records. The movie is a fictionalization of the book, with a shift in focus to Holland as a victim of Jones's criminal activity. Among the fictionalizations is moving the hospital where Holland and Jones first worked together from San Antonio to Austin, changing Kerrville to Langford and changing some characters' names. Also made up is an implied romantic friendship between Holland and Kerr County District Attorney Ron Sutton (played by Stephen Tobolowsky)... (Holloway, 1991, p.10).

Family/friends of Victims - response

To have a member of one's family die is a tragedy. To have a member of one's family wilfully killed by a nurse who is entrusted with their care is shattering. Relatives of victims of nurses who murder patients frequently respond to the revelation of murder with grief but in addition, with shock, horror and dismay for the fact of the breach of trust. It shifts the loss to a different order of suffering. The bodies of texts that construct this discourse of dismay are filled with texts that exemplify it. This US text when reporting the Allitt case includes the entirely predictable responses of the parents of her victims.

Beverley Allitt, 24, flanked by seven guards, paid little notice as several enraged parents moved toward the dock shouting "Bastard!" and "You ought to hang..." (Associated Press, 1993, p.17)

and

The reactions of families of the victims were variable but understandable. Harry Watson, whose eight-week-old grandson Liam was murdered, said: "As long as she is locked away for the rest of her natural life, that will be enough." But Belinda King, whose son Christopher was attacked when he was five weeks old, said: "She can rot in hell..." (R. Kellaway & J. Millbank, 2004, p.8).

It is possible to dismiss this as the usual anger that a parent will experience in reaction to the loss of a child. However, this reaction is not confined to situations where the victims are children., as the following text reveals:

The family were "devastated" when it became clear her mother had been one of Geen's victims. Mrs Blencowe, 47, said: "You put so much trust in people. You put your relatives in their care. "I could not believe someone had done something to make mum more poorly when they should have been making her better..." (BBC News, 2006).

Anger is the strongest emotion expressed by family members of the victims and this is generally expressed in terms of the sense of betrayal. It shows through in almost every text relating to the relatives responses to the nurses who murder.

Victim's widow rages at nurse who killed for kicks: The widow of one of kill-for-kicks nurse Benjamin Geen's victims last night said she hoped the monster would "rot in hell..." (Wickham, 2006a, p.4).

The media, of course, seek to take a 'human interest' angle on these stories which tends to revolve around the victims. This takes the form of looking at the relatives as people and giving them shape and form. For example, the following extract illustrates very clearly the ways in which the media can cobble together extracts from the relatives to set up a view of the offending nurse. In the case of the relatives of the victims of Charles Cullen, they reacted with predictable responses but those responses give an indication of the ways in which nurses who kill patients are viewed. The media seem to be heavily into catalogues in this genre of reporting. Here, in this text about the Cullen case, it is the relatives' turn. It is a rather long extract, but that is because there were many victims and their families deserve to be heard as they poignantly set out the extent of the harm he has done.

'Dolores Stasienco, daughter of Giacomino J. Toto: "Sometimes, he probably believed he was an angel of mercy. Let us correct him: He was an angel from the deepest depths of Hell." Debra Yetter Medina, granddaughter of Mary Natoli: "I want you to die tomorrow so that you can meet God tomorrow because, guess what? There ain't no door out of Hell, baby." Suzy Yengo, daughter of John W. Yengo Sr.: "You are not just a murderer, you are a thief. You stole the last days of my father's life." David Agoada, son of Frances Agoada: "I think our medical system has a disease and you're part of that disease." Mary Burke, daughter of Pasquale M. Napolitano: "He probably told you a joke or two as you were injecting his life sentence, Mr. Cullen." Lucille Gall, sister of the Rev. Florian J. Gall: "There isn't closure for the families. You just have to deal with it. I don't think there ever will be closure." William Stoecker, husband of Eleanor Stoecker, on Cullen's reaction to the victims: "Cullen's reaction was cold, so cold. How can anyone be so cold? The closure is that he's finally going to be put away." Philip Mugavero, grandson of Lucy

Mugavero: "I suspected Mr. Cullen wouldn't react. I don't believe he has the courage to address the victims..." (The Associated Press, 2006a).

As is commonly the case, the family of the victims take what solace they can from the conviction of the perpetrator. There is a definite discourse around the process of the trial. The families desperately need their day in Court and they need to see that the nurse accused of murdering their family member is convicted specifically of the murder of that person. For most families, it seems that even though they may never think that even the harshest penalty is adequate, closure is contingent up conviction.

At least two of the victims' families sat through the trial. "My mother can finally rest in peace," said Jan Hunderman, daughter of victim Marguerite Chambers. "The scars will always be there, but it helps knowing the truth." Linda Engman, daughter of victim Mae Mason, said she was thrilled with the verdict. "I wish we had the death penalty," she said... (Perlman, 1989d, p.29).

Cullen, according to his lawyer, apparently wanted to explain to the families of his victims but seemed put off by their anger and the hostility of patient rights groups. It seems to be a surprise to Cullen that the families should be so angry.

Cullen's public defender, Johnnie Mask Jr., said Cullen hoped to one day be able to explain to each family why he killed their loved ones. But Cullen, whose closely cropped hair has changed from gray to white since he first appeared in court, has not explained further. In fact, from later in 2004 until last week, he tried to get out of attending his own sentencing. Mask explained in an interview in December that it was unlikely Cullen would ever explain himself publicly, largely because victims rights groups have gotten involved in the case. "They have become very hostile to Mr. Cullen," Mask said. Cullen, who wears bulletproof vests to his court appearances, on Friday dropped his effort to avoid appearing in court... (Mulvihill, 2006).

Relatives of victims of nurses that murder patients find the conduct of such nurses incomprehensible and are likely to be unforgiving, as in the cases of Kristin Gilbert in the USA and Roger Andermatt in Switzerland. Saying sorry does not assuage the families to any great extent either because the families of victims of nurses who murder patients are not comforted by the expressed remorse of those nurses. The bodies of texts constituting this discourse reinforce a sense of being insulted by what the relatives consider to be platitudes.

a sister of one of the serial killer's victims likened her to "a disease and a pestilence" deserving of execution... (Mashberg, 2001, p.1).

"I wanted to save the patients suffering and free from them hopelessness," he told the court. "I knew I was violating laws, but I felt I was right." Letter said he now sees his actions as "catastrophically wrong." "Now I know that I not only am guilty toward the dead, but toward their survivors," he said. A lawyer for relatives of the alleged victims was unimpressed by Letter's statement. "To talk of compassion in this case is something that the relatives find deeply insulting and cynical," said Wilhelm Seitz, who represents relatives of 11 of the patients who died... (Pohl, 2006).

Similar comments can be found from relatives of victims in virtually every case. Whether it is a child or an elderly person, there are family members who will grieve their passing and find the fact that their family member was killed by a member of the caring profession to be completely incomprehensible. It will obviously be more difficult to come to terms with than had their family member died of natural causes. It is more difficult to come to terms with than even a random drive-by shooting on the street. The relatives struggle to get past the fact that the nurse should be caring for the patient, not killing them.

Perhaps it this sense of deprivation and betrayal, with its attendant anger, that drives the relatives to take civil action against the nurses who murder. They seek compensation. The discourses suggest that they do this more to punish the offender (who they generally think has been treated much too gently by the system) than for self-enrichment. Most commonly, however, the litigation is against the employing organisation because they will have money in their pockets via their public liability insurance and families often hold the health service accountable for a nurse employed by the hospital to murder their relative. The murderer will of course, be a nurse who may be lowly paid and/or have no assets that would justify the expense of litigation – in legal parlance, a man (sic) of straw. Sometimes civil litigation is taken because the nurse has unsuccessfully attempted to murder someone and the person has been left permanently disabled. This was true in the Allitt case and the family successfully sued for £2.1 million to cover the child's consequent special needs (Waites, 1999, p.1). Civil action was also taken against Orville Lynn Major:

Orville Lynn Majors' convictions for murdering six patients provides a psychological advantage, but no legal edge, to families suing Vermillion County Hospital, an attorney said. Eric Frey of Terre Haute, who represents more than 60 families of patients, said the criminal trial's testimony and prominent media coverage served to inform people whose relatives died during a spike in deaths in the hospital's intensive care unit in the mid-1990s.

"I think observing this trial gave a lot of them information they never had, and I think that's been very helpful," Frey said Monday. "The ones who didn't hear it probably have learned a lot from what they've read." He said that should inspire more people to press forward with their civil complaints against the hospital, its doctors and the hospital's former owner, Vermillion County government. "Now we can get down to the business of hopefully getting them some compensation," he said... (Huppke, 1999).

Civil litigation in cases involving nurses who have murdered patients has occurred in the majority of the countries identified but it is particularly characteristic of the US response of relatives. This is consistent with the failures of organisations to respond to such matters that I discuss elsewhere in this work. They hold hospitals and aged care residential facilities accountable for enabling the murder of their loved ones.

A lawsuit filed this week accuses Rosedale Manor of negligence when it hired Brian K. Rosenfeld, the 33-year-old nurse charged with murdering Mrs. Watts last July. Rosenfeld was hired a few months before Mrs. Watts died. He had left a trail of problems at other nursing homes, the suit alleges, and was even fired by Rosedale eight years earlier for mistreating patients... (Nohlgren & Journey, 1991a, p.1).

and in the same case less than a year later:

Robert and Joyce DeRemer sued Sunshine Village Nursing Home on Monday, asking for punitive damages in the 1987 poisoning of their aunt, Hazel DeRemer. ...the relatives allege that Sunshine was negligent in hiring Rosenfeld, because he was "notorious throughout Pinellas County nursing home circles for his abusive behavior toward patients." Sunshine "failed to properly investigate or otherwise verify Rosenfeld's background, criminal record, propensities," the suit alleges. Sunshine officials did not return a telephone call... (Nohlgren, 1992a, p.3).

The texts reveal many other examples of the families taking civil action in connection with the murder of a family member by a nurse. Another example of relatives of a victim of a nurse who murdered patients taking legal action was that of Justin W. Martin. The family sued the employing nursing home for negligence in hiring and supervising Martin (B. Braun, 1997, p.10). Richard Angelo was also the subject of a civil suit by the family of a victim. Milton Poultney's family filed suit for \$20 million for a negligent, wrongful death, and medical malpractice suit against Good Samaritan Hospital (PR Newswire, 1988).

Joseph Dewey Akin was charged with the murder of Mr Price. Ultimately he pleaded guilty to intentional manslaughter but the point here is that the Price family brought a \$15 million civil suit in which he was named as a defendant. Another woman named Odessa Barber also brought suit against Akin (McIntosh, 1992a, p.1). In some cases individuals who did not succumb to the ministrations of the nurse subsequently commenced civil actions against Akin, but it is the sequence of events in a third case brought by a third victim, Bambi Plumlee, where he had failed in his attempt to murder this patient, that I have included here because by any standards, it is an interesting case.

'Mr. Akin, a doctor and an Atlanta hospital were named in a 1990 lawsuit charging that Mr. Akin injected a patient with a near-lethal dose of medication at the hospital's emergency room. Bambi Plumlee, the plaintiff in the suit, charged that she had gone to Physicians and Surgeons Community Hospital on Jan. 28, 1988, suffering from an allergic reaction to medication. Mrs. Plumlee said the doctor had already released her when Mr. Akin, her nurse, suggested a mild medication to treat allergic reactions. The doctor agreed, and Mr. Akin prepared the medication while they talked, she said. "The second it went into my hand I knew something was wrong, and when it hit my heart I felt like I blew up," Mrs. Plumlee said. "I started screaming, 'You've killed me, you've killed me,' and then I passed out."

Mrs. Plumlee said the doctor did not see what drug Mr. Akin allegedly injected. Neither Mr. Akin nor the doctor named in the suit was ever served with the court action, so the hospital remained as the only defendant. It never responded or presented a defense, and in February a Fulton County judge awarded Mrs. Plumlee \$750,000 - money she says she does not expect to collect. (McIntosh & Montgomery, 1991, p.1).

Among the bodies of texts relating to the murder of patients by nurses and the reaction the families, the texts constitute a discourse of justice. Whether the families feel that justice is achieved in the outcome of the case seems to have a significant bearing on whether they have any sense of closure. For some, this is the case. The relatives in the case of Kristin Gilbert were reported as saying they felt that justice had been done when she was sentenced to life in prison without possibility of release. Even though some had been hoping she would get the death penalty, they were satisfied with the sentence. As the mother of one of the victims put it, "...Now, I can go to the cemetery and feel good that vengeance has been done..." (Gorlick, 2001). The texts rarely express the desire for vengeance so expressly. The sentiments with respect to the preference for the death penalty are not so unusual. Another case where those sentiments were expressed was that of van Oort (AP, 2003d). I describe the

discourse around the sense of failure on the part of the hospital or organisational administrations in these cases elsewhere in this work but it has to be said that, whilst it is very common for people to blame the hospital, the families do not always consider the hospital or organisation to have failed. In the Kristen Gilbert case, it was reported that:

...Even families of some of Gilbert's victims view the hospital positively. "To me, the majority of the people there were really kind and considerate and devoted to their job," said Claire J. Jagodowski, whose late husband, Stanley Jagodowski, went into cardiac arrest 15 minutes after Gilbert was seen entering his room with a needle... (AP, 2001f).

Relatives of the victims of nurses who murder patients react in ways that vary largely according to the perceptions of the actions of the nurse. Few would be as positive as the son of the victim in the Kanner case, however.

Amberik's adult son, Jerrod Amberik, pleaded with the judge to release Kanner on probation, saying she was a devoted friend and caregiver whose friendship with his mother "was almost on a sister level." "She doesn't deserve to be taken away," Jerrod Amberik said, his eyes welling... (Nichols, 2004b, p.1).

Although there was a key difference between the cases of Kanner and Pavia in so far as Kanner was considered to be guilty of murder for profit and to remove the inconvenient wife whereas Pavia was considered to have committed authentic euthanasia, the one thing they had in common was that in each case, the victim's family were among their staunchest defenders.

Dawson's son, Kenneth Dawson, said Pavia should never have been charged with murder and believed she acted out of compassion. He said his mother was beyond help before arriving at the hospital... (AP, 2003f).

I have considered here the reactions of the families of the victims in these cases of murder of patients by nurses and it is obvious that the responses fall into a fairly narrow and predictable spectrum of reactions. Now I want to consider the reaction of the family and friends of the nurses themselves for it is difficult to imagine how they must feel when a member of their family who has been practising as a nurse – that most trusted of professions - caring for people in the most vulnerable of positions, suddenly turns out to be a serial murderer.

Family/friends of Perpetrators - response

In most cases, the initial response on the part of relatives of the nurse charged with murder is to maintain their belief that their family member is innocent of the charges. This is precisely what one would expect and the bodies of text around the murder of patients by nurses afford many examples of texts that constitute this discourse. It would be almost inconceivable for a family to react in other way. Cases that contribute to this discourse include that of Geen, Salisbury, Mori, and of course, many others. In analysing cases of murder by nurses it is essential to recognise that there are many more victims than just those who are killed. It is possible that even these nurses are themselves victims of damaging childhoods. However, it is the families of the nurses that I really have in mind here.

What parent would not want to believe that their child was incapable of the deeds they had allegedly committed such as those of Anthony Geen (*Daily Post*, 2006, p.13), of Barbara Salisbury (*The Sentinel*, 2005, p.19), and of Kristen Gilbert (Gorlick, 2001) whose father was shattered after attending the sentencing hearing of his daughter where the choices were between life imprisonment and the death sentence.

Kristen Gilbert's father cried Thursday as he told jurors his family will be devastated if his 33-year-old daughter is executed for murdering her patients at a veterans hospital. "How do you deal with the death of a child," Richard Strickland said, unable to restrain his tears. "To have her life end under these circumstances would be unbelievable..." (Gorlick, 2001)

For Daisuke Mori's mother, completely unable to accept that he was guilty, the trial must have been an ordeal but she watched all of it:

Mori's mother, who watched the whole of her son's trial from the spectators' gallery, still believes in his innocence, claiming scientific reexamination of the evidence would exonerate him... (Kurita, 2005b).

The family – parents, siblings etcetera – do not stop loving their family member because that person is accused of murder. Even when the family is sure of the nurse's guilt they may not withdraw their support from their family member but it is unlikely that a family could understand how their relative could have become a murderer.

Sometimes, they may take solace in religion. In the Rosenfeld case, there was an element of this. His father said:

"He also has another judgment day - in heaven," said his father, Lewis Rosenfeld..."I felt sorry for the victims and their families...I don't know where Brian went wrong," Rosenfeld said... (Leisner, 1992).

There are within the body of texts relating to the murder of patients by nurses some texts that constitute a discourse around the place of the family in the proceedings. For example, the family of victims of Barbara Salisbury hint at their status as political pawns in the bureaucratic response to the affair.

But a spokesman for Salisbury's family said that though they welcomed the investigation they had serious concerns about the way it was being put together. He said: "Why is the investigation team to be made up of 75% of hospital staff? Surely this cannot be seen to be open or fair if the majority have a vested interest. "Will all the senior nurses who gave evidence at the trial be included in and questioned by the investigation - as we understand they may not." At the time of the investigation we feel the relatives of the deceased patients were still grieving and vulnerable... (P. Smith, 2005).

This is not a particularly strident discourse but it crops up where the families of the nurses who murder consider that their relative is not getting a fair hearing. There are other examples where the family is not particularly supportive of their family member. For example, when the daughter of Gene Jones was interviewed she was asked if she thought her mother was guilty. She replied by saying that she did not know if she had done it (the murder), but she sure as hell was capable of it. It was hardly a vote of confidence.

Finally, there is a question as to whether family members are safe from the homicidal activity of nurses who murder patients. The discourse around this is not strident either but there enough texts to raise it as an issue for the immediate relatives.

'Prosecutors argued Thursday that Glenn Gilbert's grand jury testimony that his former wife tried to poison him helps prove that she intended to kill her patients with overdoses of the drug epinephrine. They want the jury to hear a transcript of that testimony, but don't want to put him on the stand. (Gorlick, 2001)

Conclusion

It is appropriate that in this last of the chapters in which I analyse the data, it is the responses to the phenomenon of murder of patient by nurses that are the focus. The discourses around the responses of health service provider organisations; regulatory bodies, the nursing profession and other health professions; the family and friends of the victims; and the public have been canvassed in this chapter. To summarise those responses briefly, the discourses imply that the health service organisations respond when and if they are made to respond, but in all other cases their response is that of the ostrich – or as expressed in the Genene Jones case, a conscious choice for judicious silence. For the regulatory bodies such as nurses, boards, so long as the health service organisations adopt a policy of judicious silence, the boards have no role to play and thus do not have to respond. The virtual silence of the nursing profession may not be judicious, but it is no less a silence for that small fact. Aside from an occasional, usually defensive and always very quiet demurrer, the profession has nothing to say about those of their number who murder patients. In contrast, the family and friends of victims may have a lot to say in the immediate aftermath of the murder of their relative or friend. They soon fall silent, however, whether that be because they feel justice is done when the offending nurse is sentenced or because the media lose interest after the conviction and sentencing. There is little acknowledgement anywhere of the enduring pain and suffering of those relatives closest to the victims which may account for the level of civil litigation against offenders and the health services that host them. Finally there is the public who, like the families and friends, rise up in high dudgeon in the immediacy of the case and for so long as the media sustains the coverage. These are the responses to murder of patients by nurses as revealed by the data.

As has been the case in the preceding chapters, the data has been primarily drawn from the media. However, in the case of the responses of the nursing profession, more of the data was to be found in the professional nursing literature. In this Chapter, I have had, inescapably, to address all six of the elements of discourse analysis because its content is riven by the pathways of power; it is permeated by the knowledges embodied in different professions and entities; it is a product of competing contexts wherein the world of nurses and medicine and hospitals and caring is separated and distinct from the world of the public who venture into that

other world when they are at their most vulnerable. These contexts generate texts that constitute discourses that are diverse and bring to the fore the subjectivity of the responders. All of these elements have been explicated in this Chapter and at its end is the sense that all parties hold the murder of patients by nurses completely at arm's length unless they are so closely and directly affected by a specific case as to be compelled to have it within their contemplation. I believe they do not want to know about it. It is simply too threatening.

Chapter 9

Extraordinary nurses, extraordinary deeds, ordinary places.

Introduction

The title of this final chapter encapsulates the central thesis that emerges from this discursive study. Nurses who commit murder on their patients are the exception. They are not the rule – there are not murderers lurking around every corner of the hospital corridor and thus, the social construction of nurses who murder as other, although often exaggerated, does have a rational base. It should be borne in mind, though, that the nurses included in this study murdered at least one thousand and possibly as many as two thousand patients.

The crimes of these nurses are heinous and shocking. Their dramatisation in the media paradoxically desensitises the public and imbues its members with a sense of immunity in much the same way as war, mutilation and killing is accommodated in households via the television. The medium keeps the phenomenon one step removed and thus it does not intrude on one's sense of security.

The places in which these crimes are committed are ordinary. The nurses who commit the crimes are extraordinary. I do not use the word here in its positive sense. By extraordinary, I mean that these nurses are outside the realm of ordinary nurses. They are out of the ordinary. The occurrence of the murder of a patient or patients by a nurse seems to be independent of the standard of care in the particular facility. It can occur in good facilities as much as in poor facilities. The commission of these crimes stands as testament to the power that the murderers can wield in ordinary places. It points to the ease with which these extraordinary nurses are able to inhabit the spaces that ordinary nurses consider to be places of care, nurture and safe harbour. These are places where patients, families, professionals and administrators

are all at risk of being sucked into the maelstrom of devastation that inevitably attends the revelation of murderous activities on the part of a nurse.

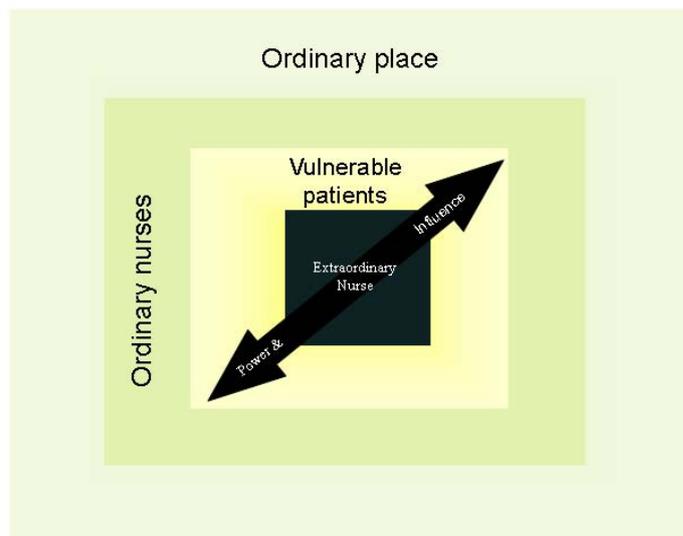


Fig 7.1 Circumstances of Murder Committed by Nurses on Patients

In this concluding chapter, I speculate about the significance of the findings for patients, nurses and society. Before doing so, however, I make some contextualising comments about the chapter. Classically, a thesis ends with a conclusion that summarises the methods, findings and conclusions of the study. I therefore, quite properly, re-state the research question (or questions) and detail the answers to those questions as revealed by the study. The questions that this study set out to answer were:

How do the various discourses surrounding murder committed by nurses on patients in the course of their work shape the definition and treatment of these crimes?

and

How have these meanings come about?

Each of the extensive data chapters of this thesis sheds light on various aspects of these questions such that it is possible to do so. The constructions that I have identified are just that – constructions – for this is a work that is informed by postmodernist thought. Accordingly, no more is claimed for its postulations than

their possibility. In keeping with the discursive nature of this work, I should also point out that this is a conclusion only insofar as I report the conclusions that I have reached in relation to the discourses that have emerged in the course of this study and proffer, to the extent that it is possible, answers to the research questions. It is, of course, a conclusion in the sense that it constitutes the end of this dissertation. Equally, and again in keeping with its postmodern nature, it is not a conclusion. It is a waypoint rather than an endpoint. It is a point in the evolution of our understandings of the phenomenon of murder of patients by nurses. With this caveat, I sum up the answers to these two research questions as revealed by the data. In so doing, I also reaffirm that this has been a methodical research exercise as well as a search for new substantive understandings.

Murderers	Profiles differ. Differences noticed and accentuated after suspicions are raised or after the fact.	
Victims	The very old, the very young, the very ill and physically or mentally disabled people.	<u>Collateral victims</u> Family, friends, communities, colleagues, the team and the organisation.
Places	Intensive Care, Coronary Care, Emergency, Residential Aged Care, Community	Systems failures, 'loyalty' within the team, poor support for whistle blowers.
Opportunities	Working alone - even for short periods, ease of employment – change jobs when suspicions aroused.	Intravenous access, physically weak patients.
Methods of Murder	Lethal injection, suffocation, abuse.	
Evidence	Primarily circumstantial, patterns of suspicious deaths and work rosters, or confessions	Various deals taken to secure a conviction. Turning evidence and confessing to lesser crimes.
Punishment	Life in prison with varying times of non parole.	social

Table 7.1 Summary of Murder Committed by Nurses on Patients

Methods

To answer the research questions, it is necessary to locate them in the context of the methodology of this study which is a discursive analysis of the phenomenon of murder of patients by nurses. By definition, a discursive analysis is rambling, expatiate and digressive, but it is also reasoned, reflexive and interpretive (Hardy &

Phillips, 2002, p.85). I explain in Chapter 4 the approach that I adopt. This involves engaging throughout the analysis of the data, and indeed, this entire work, in a reflexive process intended to maintain the integrity of the work and to maintain insight into the extent to which I exercise my own construction of the phenomenon as author.

Throughout this work, I emphasise the interplay of six factors in two triads – text, discourse and context on the one hand, and power, knowledge and subjectivity on the other. I endeavour to unify these two triads by elucidating all six factors in the phenomenon of murder of patients by nurses. In pursuit of answers for these questions, a mass of texts is mined in an effort to discern the discourses that reveal the understandings and meanings that this phenomenon holds among the public and the profession. Through this, I seek to identify the conditions that make it possible for nurses to murder patients. I point out in Chapter 4 that the methodology of the study is influenced by the work of Foucault and other discourse theorists and that is evident in this concluding chapter.

Limitations of the Study

This study sheds some light on the phenomenon of murder of patients by nurses. However, in spite of the fact that many thousands of articles are examined, the overwhelming majority of these are drawn from newspapers. This is not by choice; it is simply the case that the professional literature is virtually silent on the subject. The significance of this is that news reports tend to be mediated through the lens of the editor. They convey discourses but they also distort and shape and mediate those discourses. It has to be acknowledged that there is a preponderance of US and UK literature which may account for the proportion of US and UK cases. Australia, by contrast, had virtually no cases and it is hard to believe that there could be quite such a disparity between cultures that are not so dissimilar.

Another limitation of the study is the fact that it relies almost exclusively on those cases where the offender is charged and convicted of murder. There may be other cases of nurses charged with other crimes that are relevant to this study but they are not considered here. The study is intentionally restricted to convictions for murder.

As is the case with many qualitative studies, the point of this work is to give shape to the phenomenon of murder of patients by nurses but it can only be said to provide insight into the understandings of murder of patients by nurses during the period of the study. Moreover, the study is limited to those texts that are in the English language. Thus, where reports are of cases that occurred in non-English speaking countries, I have to accept the English language texts at face value. If they are at odds with reports in the native language of that country, or if they are deficient in relevant details, I have no way of rectifying or even of knowing if this is so.

Extraordinary nurses

During the 1990's Taylor explored the notion of ordinariness in nursing (Taylor, 1994). She describes the quality of ordinariness in nurses that is appreciated by patients, families and the general public. Being ordinary makes nurses approachable, empathetic and like other people, much more so than members of the medical profession. Thus, ordinary nurses are held in positive regard. It is difficult to distinguish extraordinary nurses who murder patients from ordinary nurses who do not, however. The data suggest that it is unlikely that there is any one profile of the individual that can be said to be typical of nurses who murder patients. The diversity of the defendants illustrates the variety of individuals who engage in this practice. Some are clearly extremely intelligent; others are not. Some are young, some are older, some are male, some are female, some are gay, some are straight, some are senior nurses, some are mere assistants, but all are able to murder patients.

There is a pattern of emotional deprivation in childhood, just as there is with the general population of serial murderers but no reports suggest that all nurses who have a pattern of emotional deprivation in childhood inevitably go on to murder patients (or anybody else, for that matter). Newspaper reports refer to behaviours that are indicative of the manipulator, attention seeker or trouble maker but the very dark side of these nurses is only exposed after the fact and in the media. After charges are laid, the media portrays the murderous nurse (who does not present as particularly different to the ordinary nurse) as markedly other. Much space is given to describing abnormal acts and creating a sense of incredulity that the murderer is a nurse. The media actively works to construct the nurse who murders as other. The profession

distances itself from these nurses who are soon described as former nurses or as assistants in nursing. The profession of nursing, by and large, fails to acknowledge that the murders took place in caring environments led by and supervised by registered nurses.

I have so far characterised these nurses as extraordinary nurses as compared with ordinary nurses, with the key parameter being otherness. This same dichotomy appears in a discourse around bad nurses and good nurses. Foucault would identify this as a dividing practice. This dichotomy of bad and good nurses is grounded in otherness and is an expression of subjectivity. Throughout this study the discourses around nurses who murder patients have cast up examples of the ways in which the bad nurses are aberrant and deviant, and can therefore be distinguished as 'other'. They are different from good nurses. Good nurses are the stereotypical nurses who soothe fevered brows, minister to the sick, do good deeds after the fashion of Florence Nightingale and Mother Theresa, and deserve and receive our unreserved trust. Good nurses – who are of course ordinary nurses – would not contemplate murdering a patient. It would run counter to all of the tenets of the nursing profession. Bad nurses – or extraordinary nurses – might well murder patients because they are likely to be aberrant in every conceivable way. They are also incredibly rare, of course, and there are many ways of setting them apart from good, normal, ordinary nurses. The discourses contain extensive examples of the ways in which they are set apart. They are monsters. They are evil angels. They are black angels. They have nasty habits and nasty relationships. They exert power over good, ordinary nurses. They are manipulative and threatening. They lie, they steal, they cheat and treat everyone badly. They are uncaring and cruel. They are often psychotic, always personality disordered. Every nurse is aware of bad, extraordinary nurses but most nurses are quite confident that they would recognise such a nurse in the unlikely event that they should ever be confronted with one as a colleague. That is as well since members of the public trust the good, ordinary nurses to root out the bad, extraordinary nurses. That these nurses should be so easily identifiable is reassuring for the public who are at some time or another likely to be the consumers of health services. It enables them to retain their trust and confidence in good, ordinary nurses.

This situation is compounded by a further set of conditions that relate to the construction of nursing in the minds of the public. There is a discontinuity in the perception of nursing knowledges. It is clear from this study that the public draws little if any distinction between the categories and levels of preparation among nurses. Nothing in the literature located during this study suggests that medical knowledge does not dramatically empower the medical profession. However, there is no suggestion that nursing knowledge brings with it any corresponding empowerment. This construction of nursing has serious implications in the context of this study. With respect to the medical profession, there is a clear understanding in the minds of the public that the medical practitioner has undertaken many years of study and practice to hold a license to practice medicine. There are processes in place to ensure that it is the case and the public, at least until this year in the case of Australia, has been confident that a medical practitioner will have genuine qualifications. With respect to nurses, the public conception that a nurse is a nurse is a nurse implies that there is no discrimination of ability on the basis of qualification. The patient will be as relaxed about an assistant in nursing performing a procedure as they will about a registered nurse doing it. They trust their nurse. It is for this reason that the study includes nurses at every level from the assistant in nursing to the registered nurse. The public may find some consolation in the fact that nurses at every level from assistant to specialist registered nurse have been convicted of the murder of patients.

Knowledge and power are at the very least, two sides of the one coin. For the likes of Foucault, they are inseparable. When the public thinks in terms of nurses and their knowledges, they do not think in terms of registered nurses, enrolled nurses, assistants in nursing, nurses' aides, Category 1 nurses, Category 2 nurses, licensed vocational nurses, nurse practitioner, etcetera. For the general public, a nurse is a nurse is a nurse, irrespective of educational background, training or experience. A nurse is the person who takes care of you. This means that it is the epithet of 'nurse' that attracts the trust of the patient. The media compounds this by a failure on its part to discriminate among the various levels of nursing qualification as evidenced by its frequent generic use of the term 'nurse'. These are further reasons why this study includes levels at every level from assistant to registered nurse.

Extraordinary deeds

Extraordinary nurses commit extraordinary deeds. The extraordinary deeds of interest to this study are those involving the murder of patients. This study casts some light on these deeds which are, to the maximum extent that is possible, ignored by the public and the profession of nursing. The first question that springs to mind is why these nurses murder patients. The first clue to the answer lies in the motives claimed or attributed for murder by nurses. Discounting compassion as a defence, these motives include sexual thrill; the derivation of pleasure from the ability to exercise the power of life and death; revenge; theft; and most commonly, the thrill killing scenario involving the creation of a situation of medical emergency where the nurse gets to play the hero – the ‘super-nurse’ – and gains considerable attention. It is arguable that any murder involves the exercise of power and it may be that the motive for all of these murders can be explained as an exercise of the power of life and death. If these are the motives for murdering patients, then we can go some way towards understanding why these murders occur. Attention and power are key factors. Serial murderers tend to achieve celebrity status because of media exposure and the attention of researchers so this may contribute to motivation. It will be evident that these motives provide only a superficial explanation for why nurses murder patients.

Having canvassed the question of why these murders occur, the next question to be contemplated is how they occur. A part of the answer to this question is how the patient is murdered. The overwhelming majority are by lethal injection but other methods include suffocation, torture and abuse, and beating to death. With the exception of suffocation, these other methods of killing are generally associated with single murders which often involve a loss of control and questionable intent. The primary threat is lethal injection.

It is helpful to be able to say something of why and how these murders occur. However, one would expect that these extraordinary deeds would be swiftly detected and would attract equally swift retribution. However, this study shows that it is extremely difficult to secure a conviction of a nurse who murders because the case is almost always circumstantial. One thing that does work in favour of a successful prosecution is a confession and, among the cases included in this study, over half of

the offenders confessed. Many of them subsequently retracted their confessions but once uttered, the confession provides a good deal of guidance for an investigator and even if retracted, a conviction can often be secured as a consequence of the original confession.

The discourses uncovered in this study contain significant commentaries on the difficulty of obtaining convictions and much of this revolves around the difficulty of obtaining hard evidence on which to ground a case. Nurses are, in this era of evidence based practice, far more attuned to the need for evidence in all domains of practice than was hitherto the case. Essentially, when an investigation commences, the investigators have to tread warily because of the presumption of innocence. Only when they have sufficient evidence to lay charges – when they have what is often referred to as ‘probable cause’ – can they begin to pursue the investigation more aggressively. The presumption of innocence effectively obstructs justice in many of these cases and frustrates investigators whose cases so often fail for lack of evidence. This leads to a denial of justice for the families of many of the victims of nurses who murder. For most of these families it is not enough that the nurse who murdered their family member is given a life sentence for the murder of some other victim. They want to know that there has been justice on behalf of their own family member. These failures of the legal system tempt us to think that the presumption of innocence should be waived in such cases.

Such temptations are to be resisted. In giving precedence to the presumption of innocence, it does seem that the law works to protect the interests of the offender against those of their victim and the prosecutor. However, the legal system has evolved this position for very sound reasons and, as this study shows, there are sufficient cases of innocent nurses being wrongly accused for this to be an essential feature of the system. The *sequelae* of shattered lives and derailed careers cannot be ignored.

Among the cases in this study where extraordinary nurses have been convicted, their activities have generally become so brazen that the position of the ordinary nurses working with them becomes untenable. Bearing in mind that nurses work as teams, suspicions about the behaviour of the extraordinary nurse are likely to emerge in the

face of escalating behaviour and when they do, they will create a significant dilemma for the ordinary nurses. They have to decide as individuals what they will do with their suspicions. If they choose to share them with the team, they can then decide as a team. More commonly, they keep them to themselves for fear that others may not share their view. There are various sanctions within teams for behaviour that may be perceived as disruptive, or worse still, disloyal. Loyalty is a key issue here because often the extraordinary nurse manipulates team members to command their loyalty. This creates a slippery slope for the ordinary nurses because loyalty can be corrupted to complicity. However, ordinary nurses can take solace from the fact that, although they are slow on the uptake, they are almost always the whistleblower in those cases where conviction is achieved. The time between suspicion and action creates the space for further casualties and the extraordinary nurse will capitalise on that space. It is for this reason that those who blow the whistle will not be spared the castigation that will inevitably be sprayed across the organisation when the activities of the extraordinary nurse are exposed.

There are other dimensions to the extraordinary deeds of these extraordinary nurses. For example, the claims that I am making relate to nurses who murder multiple patients. It is not one extraordinary deed but almost invariably multiple murders for which they are responsible and in some cases, very many murders. The fact that the killing trajectory of some of the nurses in this study spanned many years – as many as 16 years in the case of Charles Cullen – implies an ease with which the murder of patients can be achieved that might well infuse us with a sense of deep shock. All nurses have ready access to the means of murdering patients. Their colleagues are unlikely to entertain suspicions in the absence of a pattern of unusual deaths. Even in the presence of such a pattern, they are unlikely to report any suspicions that they do harbour – at least not in time to prevent any further murders. If the individual moves on, nothing is likely to ever come to light – and in general, employers are very helpful to such nurses who choose to move on. All of these factors contribute to the ease with which a nurse may murder a patient.

Ordinary places

There is no doubt that murder of patients by nurses is complex. An important factor in understanding this phenomenon is the space in which such murders occur. We need to understand where these murders take place. There is nothing special about the locations of the murders that gave rise to the cases in this study. These murders all occur in the workplaces of nurses. They occur in the acute care (where patients have intravenous access), the nursing homes and aged care units, mental health and paediatric units. That is to say, these murders are committed in ordinary places that care for the most vulnerable of patients. We need to understand what enables the creation of a workplace as a crucible for murder by nurses.

For a nurse to murder one or more patients, there are certain prerequisites. It is clear from the cases that they require access to the most vulnerable of patients. They also need access to the means of murder. They need to have the opportunity to kill the patient and in most cases, this will require time alone with the patient. These three core requirements are readily satisfied by any area in which nurses work because all areas have some patients who are vulnerable; all nurses have access to the means of murder to a greater or lesser extent; and the nature of nursing work ensures that nurses spend time alone with patients. For a nurse to continue murdering patients in their workplace for any length of time requires some additional elements. It requires that colleagues do not become suspicious or, if they do, that they keep their suspicions to themselves. It requires that the extraordinary nurse is sufficiently careful not to create a pattern of unusual deaths that point to their involvement. Once again, none of these are unusual features of a nurse's ordinary workplace but I want to explore each element in a little more depth.

Who nurses murder is important in understanding the phenomenon. These extraordinary nurses only murder vulnerable patients. Vulnerability in this context is the inability to resist the murderous ministrations of the extraordinary nurse. Almost all patient care areas in hospitals provide opportunity for access to vulnerable patients. Whether the patients are vulnerable because of acute illness or because they are elderly and frail or demented, or whether they are afflicted with some mental illness or other or if they are babies or young children, the fact will remain that they are vulnerable. It is vulnerable patients who provide the victims for nurses who

murder. The most likely victims will be elderly patients but an unconscious person, a baby or a mentally ill person may be equally at risk. So too those with technologically induced vulnerability such as those with intravenous access *in situ*. Selection is usually random. These nurses are opportunistic murderers so almost all patients have an equal chance if they are sufficiently vulnerable. However extraordinary nurses appear to gravitate toward areas with the greatest concentration of vulnerable patients.

Thus, in any workplace a nurse is likely to be able to access a vulnerable victim. All nurses have access to a multiplicity of means of murder so I will spend no more time on this prerequisite. All nurses also get to spend time alone with patients so this prerequisite is also satisfied. Consequently, all of the prerequisites for a nurse to murder one patient will almost invariably be satisfied in any workplace. For a nurse to continue killing, they have to then avoid suspicion and in particular, the establishment of a discernible pattern. Neither of these requirements seems difficult to achieve but where it is not then conviction is likely to follow, judging by the cases encountered in this study. In the case of avoiding suspicion, the findings of this study show that nurses appear to be extremely reluctant to contemplate the possibility that a colleague might be a murderer, but even where they harbour such suspicions, they will be even more reluctant to disclose them. Thus, in most cases the killing trajectory of an extraordinary nurse will be protracted well beyond the time one might expect.

Where suspicions arise in relation to the activities of an extraordinary nurse, the findings of this study show that the nurse is far more likely to be encouraged by the administrators of the facility to move on than to be reported either to nurse regulators or the police. The fact that a nurse who is murdering patients may just move on is highly significant in the context of a claim that such nurses may murder in any workplace. Charles Cullen, for example, was able to move through at least ten facilities in sixteen years and in each facility he found a place to murder, and he could not be regarded as atypical among the extraordinary nurses.

In almost all of the cases included in this study, those employed in the workplace where the murders are committed are shocked by the discovery of a murderer in their

midst and by the fact that a murder could be committed in their place of work. In this review of the characteristics of a workplace that enables extraordinary nurses to murder patients, such factors as access to vulnerable patients and to the means of killing, the reticence of nurses to suspect their colleagues of murder, the reticence of colleagues to report such suspicions, and the enablement of workplace mobility are all significant in increasing the likelihood of an extraordinary nurse being able to operate in a particular workplace. The reality is, however, that the particular workplace is the ordinary workplace where nurses 'pull together' and 'look after' each other. Thus the ordinary workplace of nurses can be a dangerous place for the vulnerable patient and it is incumbent on nurses to understand the space that permits extraordinary nurses to murder patients.

Discussion

It is my view that the research questions of this study are inherently interesting to the nursing profession and the consumers of nursing services. For me this is, of itself, a sufficient justification for this work. However, there is a more compelling reason for this study. I highlight a substantial number of cases that involved the charging and/or conviction of nurses for the murder of patients. Recent developments in nursing include increased opportunities for independent practice. Given the record of medicine in terms of recorded murder, and particularly in the recent past an examination of medical murder in the field of nursing is of more than passing interest. The public ranks nursing as its most trusted profession. They do not expect their nurses to murder them or their loved ones.

The public can rest assured that most nurses will not murder them. However, the argument that only a miniscule proportion of nurses ever murder patients may be of little persuasive value, given that a significant proportion of those who encounter the nursing profession do so from a position of vulnerability. Patients are entitled to be confident that they receive care in organisations and sub-units of organisation in which they will be protected by nurses and other health professionals from all forms of abuse of which murder is an extreme example. It does seem that, although most nurses do not murder patients, a significant proportion of nurses – possibly even a

majority – work in places where murder could take place and go undetected for an intolerable length of time.

I have already explored in some depth the ways in which nurses contribute to the possibility of their workplaces playing host to extraordinary nurses, thereby creating the space for the murder of patients. Hospital nursing has traditionally been characterised by an ethos of teamwork. Professions themselves emanated from guilds and have continued to display many of the features of a secret society. Nursing has brought its traditions with it as it has developed into a profession. There are bonds within nursing forged through difficult times with many shared experiences in circumstances that are often both trying and confronting. It is asking a lot of nurses to report suspicions of their colleagues. It is asking for a fundamental change in culture. Nurses need to be able to rely on each other and to trust each other. However, if this culture of teamwork permits the murder of patients, then it may be that the modus operandi of nursing has surfaced as a problem that now needs to be problematized in the Foucauldian sense. This means alternative ways of doing nursing may need to be identified. If it now falls to ordinary nurses to protect patients against these extraordinary nurses who murder patients, and to do so by reporting suspicions, there would be a significant change to the profession and it would come only at a cost.

Health service organisations also contribute to the possibility of the workplaces of nurses becoming the space for the murder of patients. by assisting nurses who they suspect of being extraordinary to move on to other workplaces. The findings show this to be a common reaction by organisations where a nurse was suspected of murdering patients. It is, in the organisation's view, less damaging to keep quiet. At one level, this is understandable although not to be condoned, particularly in the case of private organisations. These attitudes are driven by policies associated with economic rationalism wherein the chief driver of operational decisions is the bottom line. Thus, staff who are inadequately qualified or who are otherwise ill-equipped for the job they are hired to do (as in the case of 17 year old Shermike Rainey and 19 year old Justin W.Martin) may be employed because they are cheaper than better qualified staff. Decisions of this nature reflect a total disregard for the qualifications and knowledges of nursing. I have already commented on attitudes of this nature

among the public who are uninformed on these matters, but there is no excuse for any such ignorance on the part of those engaged in the administration of health care services and the employment of nurses. In their case, it is a question of pure expedience. The decisions are purely about the cheapest option for the facility and probably this is very effective in the short term. It does nothing for their patients, however, and it only takes one Justin W. Martin to ruin an organisation so this can be a somewhat myopic basis for decisions.

It becomes even more myopic when the extraordinary nurse is apprehended, charged and convicted as the actions of the organisation are placed under the closest of scrutiny. There is an almost automatic tendency with the media reports of such cases to castigate the organisation for all of its faults. When the scrutiny is close enough, even the best of organisations is likely to be shown to have blemishes. This was so in the case of Kristen Gilbert where the Veterans Administration hospital for which she worked was reported to have all manner of deficits, few of which were ever substantiated.

The same close scrutiny will expose the decisions of the administration because the first question that arises is, how can a hospital or health service possibly have a nurse on staff that murders patients. Inevitably it is perceived as a failure of the organisation's systems. This has resulted in the sacking of many of those who find themselves in charge of organisations in such circumstances. I have characterised these consequences as collateral damage but it is neither the only nor even the most serious form of collateral damage wrought by these extraordinary nurses who murder patients. Often, they take their colleagues with them. There are a number of examples within the cases included in this study of nurses who failed either to report the murderous activities of a nurse in their workplace, or to report the abusive activities of such a nurse that led to the death of a patient, or failed to intercede to assist an abused patient where the abuse led to the patient's death. In such circumstances the victim loses their life amid much pain and suffering, the organisation is damaged, the family of the victim is damaged, the implicated nurses are damaged (including those implicated simply by association) and the regulators appear inadequate. There are no winners.

There is no excuse for nurse regulatory authorities to be less than assiduous in pursuing any reported suspicions of this nature. However, these bodies too have been found wanting when it comes to dealing with nurses suspected of murdering patients. I will make some further comments about the regulatory authorities but first, given the implications of this for the nursing profession, I want to make some comments about professions generally in the 21st Century.

Traditionally, the ‘true professions’ were considered to be law and medicine. They were held in great esteem and were privileged in many ways. The hallmark of a true profession was self-regulation. This literally makes a profession a law unto itself and is taken extremely seriously by the particular profession. Self-regulation places upon a profession the responsibility to determine its standards of ethical conduct and the penalties for any breach of those standards. It entitles the profession to determine the penalties for those breaches and to conduct a hearing when a complaint is made in relation to a member of the profession to determine whether that complaint is upheld or dismissed. If they determine it is upheld, the profession has responsibility for determining and imposing any applicable penalty. The powers of the self-regulating profession include the right to expel any member on specified grounds. Self-regulation also subsumes a right to be the profession’s gatekeeper (which serves to limit numbers, thus determining supply and demand) and a right to monopoly practice.

It is obvious why self-regulation would be highly prized by any profession. However, it can mean that the profession becomes arrogant and/or loses touch with the society that bestows upon it the right of self-regulation. In recent years, the ‘true professions’ have had their challenges. Many other occupational groups have sought professional status. At the same time, there has been a significant diminution in the status of professions generally in the eyes of the publics they serve. Two sets of related factors have contributed to this lowered standing. Firstly, the knowledge explosion, education and associated technology have made knowledge – including specialist knowledge – readily accessible to the majority of people. The second set of factors pertains to the conduct of the professions themselves. In many cases, their conduct has been perceived to be lamentable and the actions of their self-regulatory mechanisms in response to complaints about that conduct have been woefully

inadequate, or to put it perhaps slightly more objectively, those responses have not lived up to the expectations of their public. This results in pressure on government to intercede, and this usually translates into at least some external intervention and regulation of the profession.

Both the legal profession and the medical profession now enjoy diminished standing with the public they serve. The evolution of medical negligence as a legal action and the exponential expansion of successful actions by plaintiffs, the knowledge explosion, ready access to medical information, new and improved forensic technologies for the detection of murder, the diminution in the standing of professions generally and the highly commercialised nature of medicine today have all contributed to the removal of the medical profession from their pedestal. This has been accompanied by a reduction in the level of trust of the medical profession. The detection and convictions of a number of medical practitioners as serial murderers has served to further erode the public trust in the medical profession. Scandals pointed to the need for greater monitoring and supervision of medical practitioners and provoked the introduction of a whole new discourse of clinical governance. That is, the profession was perceived as incapable of self-regulation. This phenomenon has occurred in most Western developed countries and is evidenced by the emergence of statutory frameworks for standards of practice in health services that include mechanisms for monitoring the practice of all health professionals but primarily, that of medical practitioners.

The diminution in the standing of professions and so far as this study is concerned, of medicine in particular, can be regarded as a Foucauldian discontinuity (Canguilhem, 1994): it represents a change in the practices of the discipline. This is as true for medicine as it is for law. The question that arises here is whether this discontinuity matters. Does it matter if society collectively does not trust medical practitioners? I would contend that, in the context of this study, it matters a great deal. When doctors were held in the highest esteem and the public placed them on a pedestal, they were trusted absolutely by that same public. The level of trust coupled with the vulnerability engendered by the sick role and dependency through ignorance (which might otherwise be explained as skewed power relations due to social and knowledge differentials) constituted a set of conditions that enabled doctors to murder patients

with a high level of impunity. The risk of being detected was minimal. Clinical governance can help to reduce the possibilities for medical practitioners to murder patients, at least in high numbers. It is unlikely that a Harold Shipman could go undetected for 30 years now in the UK or Australia. The discontinuity is evident in the emergence of clinical governance. If Foucault were still alive, I suspect the irony of clinical governance would not be lost on him because it represents a reversal of the panoptical gaze; a turning upon themselves of the gaze that has for so long been trained by them on the recipients of their medical ministrations. Nevertheless, clinical governance is heavily reliant on statistical patterns so medical murder on a lesser scale is still perfectly feasible. The diminution of trust in the doctor-patient relationship, however deleterious it may be to the quality of care, is highly likely to further reduce the possibility of the doctor murdering the patient.

However, this study is not about murder committed by the medical profession. It is about murder committed by nurses and it is this that I seek to explain. The nursing profession has not lost the trust of the public it serves. As has been shown elsewhere in this dissertation, nurses are at the top of the 'most trusted professions' list. Thus, patients are unlikely to be alert to the possibility that their nurse might be seeking to murder them. The same set of conditions that previously enabled medical practitioners to murder their patients with impunity - trust coupled with the vulnerability engendered by the sick role and dependency through ignorance - continues to obtain in the case of nurses. Thus, it is possible that the murder of patients is now potentially more easily achieved by nurses than medical practitioners.

The maintenance by the public of their trust in good, ordinary nurses is highly utilitarian insofar as the provision of health care services is concerned. It enables the process of caregiving to proceed with a minimum of disruption. The continuing public perception of nurses as caregivers who hold little power in the healthcare hierarchy serves to consolidate their position as a trusted ally in the patient's encounters with the generally foreign world of the health care system. Thus, for patients, at least in one sense, these are largely positive features that enable them to endure often difficult times. The negative aspect is that, in the event that they encounter an extraordinary nurse who wants to murder patients in the unit where they

are receiving care, these attitudes ensure that they remain vulnerable to the hazard of that nurse.

For the profession of nursing, these may not be such positive features either because it means that the profession does not have to confront and deal with the problem of extraordinary nurses who murder patients unless the problem crops up in their workplace. Here, context comes to the fore because nurses are actors within a defined space. Within that space they are the determinants of conduct and culture. If the profession is absolved from the responsibility of having to deal with the problem of nurses who murder patients, that is a serious problem in nursing because clearly there are many contexts in which such actions are possible. On the basis of the findings of this study, and as I have argued in this Chapter, it is possible for such actions to occur in any nurse's workplace. That means that the workplace of every nurse has at least the potential to be a space in which nurses may murder patients.

There is within the profession of nursing another emerging discontinuity but it is confusing insofar as it involves the erosion of an existing dividing practice but it is real and tangible in its consequences. This is the propensity of nursing generally to blur the boundaries between the levels of nursing. For example, workforce shortages have led to the expansion of the capacity of enrolled nurses in Australia to administer medications. Having blurred the boundaries, registered nurses are beginning to engage in a discourse of rhetoric around the perceived diminution of differences between the levels of nursing. This is dangerous ground indeed for the profession because it imports a failure on the part of registered nurses to understand the qualitatively different skills and abilities of the registered nurse as compared with the enrolled nurse. If one takes into account the supervisory role of the registered nurse over the enrolled nurse, and considers the disastrous events that can occur where the registered nurse fails to adequately exercise that supervisory control, any acknowledgement by registered nurses that they fail to understand this responsibility needs to be addressed swiftly. At least four of the most disturbing cases in this study were attributable to failures of this nature where enrolled nurses or nurse's aides were permitted to dominate the workplace and gain access to vulnerable patients. This is a matter of power relations and the importance of these relations is starkly demonstrated in the cases to which I am referring. I want to explore the issues of

both vulnerability and the exercise of power but before doing so, I want to make some comments about the regulators of nursing.

Whilst it is understandable that the public may indulge in a degree of complacency with respect to the level of nursing qualification and knowledge that a nurse may hold, the regulators of nursing have no business sharing this construction. In those jurisdictions wherein occurred the cases included in this study, the discourses suggest that the regulators of nursing have failed in one of their key obligations in not dispelling the public ignorance around the preparation of nurses. Governments have acknowledged the importance of the expertise of a registered nurse by locating their preparation in universities. It is incumbent upon regulators to ensure that the public understands the levels of preparation of those who hold themselves out as nurses. This is not the only failure of the regulators, however. One of the stronger discourses that has emerged in this study implies the failure of nurse regulatory authorities to act appropriately in the face of allegations of murder of patients by nurses. This is so with respect both to investigating allegations and dealing with nurses shown to have failed in their professional obligations to patients.

I have alluded to the issue of vulnerable patients on several occasions already in this chapter so I will not labour the point further beyond noting that in this study the patterns of places where murder of patients by nurses occurs coincided with the places where other forms of abuse of patients are reported. Nurses work in groups or teams. They need to be aware both of the dynamics of their team and of the consequences of allowing the development and continuation of workplaces where abuse of power forms part of the culture. These are the spaces that make fertile ground for the murder of patients. The cases revealed many such workplaces. Many of the participants in those workplaces claimed no knowledge of the murders that were being committed there. Others harboured suspicions but remained quiet. Still others participated in a proactive code of silence and worst of all, some actively assisted the murderer.

In light of the findings of this study, it seems likely that some of the recent developments in the way the nursing workforce is deployed in Australian health services may exacerbate the problem of workplaces that play host to nurses who

murder. The increasing casualisation of the workforce – that is, the presence of staff who are employed on a casual basis – ensures that there is a greater turnover of staff with diminished familiarity between staff. Staff also move between facilities and organisations and they have significantly enhanced mobility of employment. Staff shortages also mean that employers are forced to be less fussy than they might otherwise choose to be about the staff they employ. There is a trickle down effect in such circumstances because the permanent staff have a vested interest in not upsetting the casual staff who may choose not to return if they do not like their experience of working in a given unit.

A discursive analysis of this nature is not generally a catalyst for specific recommendations, and of course the discourses cannot be construed as evidence for the contentions of this study. However, so persistent and consistent are the discourses identified, and so serious is the subject matter, that I would seek the readers indulgence as I tentatively proffer a number of recommendations consistent with this analysis that could constitute the next steps in the evolution of our knowledge of this phenomenon and that may afford the genesis of debate and public airing of these issues.

Recommendations

The recommendations from this study are directed to averting the risk of the creation of workplaces that are crucibles for the murder of patients by nurses. There will always be extraordinary nurses and they will from time to time succeed in murdering patients. Our efforts should be directed toward truncating their killing trajectories and finding constructive ways to limit the harm they cause within and without the team. Given the foregoing discussion and the findings emanating from this study, the recommendations flowing from it fall into several categories. There are those recommendations that involve issues of policy and there are recommendations that ordinary nurses can put into practice in order to minimise the possibility of an extraordinary nurse ever passing unnoticed in their workplace. The final category of recommendations relates to those questions that lie beyond the scope of a study of this nature but need to be asked and answered with respect to the murder of patients by nurses.

Policy

- Governments recognise the importance of the knowledges of nursing and the relationship between levels of qualification, education and the quality of care which extends to the prevention of the murder of patients. This would involve the allocation of adequate funding to universities and hospitals for the education and employment of the required numbers of nurses with the requisite education.
- Governments and health care agencies do not rely solely on 'top-down' strategies for quality control such as clinical governance to avoid the murder of patients by nurses.
- Policy makers will give credence and support to 'bottom up' projects that concentrate on workplace values, attitudes and cultures alongside of the top down approaches.
- Nurse regulatory authorities set in place dedicated projects for the education of the public about the various levels of nursing qualification and knowledge.

Practice

Nurses in teams are facilitated to develop a series of critical questions designed to challenge the team to critically reflect on the current status quo and understand the forces that inhibit or support change. These questions might include:

- Is it possible that a patient could be murdered in this workplace?
- How would I/we know if it was happening:
- What would I/we do?
- What effect might this have on the team?
- What needs to change and how can I/we change it?

Research

This study points to a range of areas that would sustain further investigation. The following areas are of critical importance in further developing understanding of the place in which murder of patients by nurses occurs:

- research into workplace environments and the dynamics of professions are fertile grounds for investigating the place of murder. The political nature of

the issue and the obvious need for democratic change leads the researcher towards critical social studies and action research investigations of the status quo and the influence of power in clinical environments.

- Throughout this study there have been recurrent hints and implications that nurses who commit just one murder would never be detected. I have no evidence for this because if such cases exist, they do go undetected. That is the paradox of this question. Almost all cases in this study involved nurses who were serial murderers and they were generally detected because of the pattern of their murders. The possibility of single murders of patients by nurses should not be ignored as the broader implications of the murder of patients by nurses are explored.

Conclusion

This study is complete in the sense that I have reached the end of this thesis. I have, throughout its long life, sought to retain perspective on this phenomenon of murder committed by nurses on patients. I know, perhaps better than anyone, that it involves only a tiny proportion of nurses. Even so, such a sustained encounter with a dark side of nursing, and the knowledge that this small number of cases involves the unnecessary deaths of well over a thousand patients, has the capacity to challenge one's view of nursing. I hope that I have generated knowledge that will allow nursing to acknowledge and confront this element of human frailty and failing. At the very least, I hope that I have started a conversation among nurses that nurses need to have, and I hope that I have offered a portal to the further exploration of the phenomenon.

Finally as I draw this thesis to an end I will close with a haunting question for which there are no answers but many pointers in this study. It is a question that needs to be asked, but more importantly, it is a question that needs to be answered:

How many nurses are getting away with murder?

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