Trends and Recommendations: Homicides in Medical Settings

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Introduction

A hospital is supposed to be one of the safest places in America. However, when violence does come through the doors, it tends to arrive in a form the building was not designed to stop. The person holding the weapon is often a patient, an ex-partner, a grieving family member, or, occasionally, someone on the payroll. The motive is rarely robbery. It is usually more personal.

Research on homicides inside medical settings is lacking. What exists tends to focus on a narrow subset of the problem—specifically, the small number of health care workers who deliberately kill their patients (the so-called angels of death).[1] The broader picture, including who kills whom and why across the full range of health care environments, has not been mapped.

The wider literature on workplace violence in health care fills in some of the gaps. Assaults, threats, and other forms of aggression against clinical staff climbed over the past decade and surged during the COVID-19 pandemic.[2] The most volatile settings are emergency departments, psychiatric units, geriatric floors, and any waiting area where people in pain encounter delays they did not expect. Short staffing, poor communication, and limited information all compound the risk. Most of the perpetrators in that literature are patients or their relatives, and the violence ranges from verbal abuse to physical and sexual assault.[3]

What sets a medical environment apart is its overlapping roles. A hospital is a workplace, a crisis center, and a quasi-public building. Doors stay open. Visitors come and go. The people inside are rarely at their best. Those overlapping pressures make prevention uniquely hard.

In this brief, we try to close the evidence gap. To do so, we draw on the Violence Project's Database of Medical Homicides, which covers 280 homicides that took place inside US medical settings between 2000 and 2025.[4] We describe the broad patterns, treat active shooter incidents as a distinct subset (defined, per federal guidance, as one or more people actively engaged in killing or attempting to kill others in a populated area), and offer a set of prevention recommendations aimed at health care leaders, clinical supervisors, hospital security teams, and threat assessment professionals.

Homicides in medical settings

Across the 25 years covered by the database, 280 homicides occurred inside medical settings, resulting in 326 deaths. Incidents took place in almost every state, but California, Florida, and Texas carried the heaviest burden. November was the single most common month. Fridays (18.2 percent) and Tuesdays (19.6 percent) were the most common days of the week. More than a third of incidents (34.9 percent) happened before noon, followed by afternoon (28.9 percent), night (23.0 percent), and evening (13.2 percent).

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Most of these events were small in scale. In 92.5 percent of cases, only one person was killed. Fatalities per incident ranged from one to four and injuries from zero to nine. The overwhelming majority (77.9 percent) happened indoors, and nearly all (96.8 percent) occurred in buildings where access was effectively unrestricted. Urban facilities accounted for 56.1 percent of events, suburban facilities for 32.1 percent, and rural facilities for 11.8 percent.

Firearms were the leading weapon, used in 52.8 percent of cases. Hands and fists came next at 21.1 percent, followed by knives (9.3 percent) and poisoning (5.7 percent). Situationally, domestic incidents were the single biggest category at 34.6 percent. Mental health crises accounted for another 15 percent. Escalating disputes made up 9.6 percent. Retaliation accounted for 7.5 percent.

Victims were almost evenly split by gender (50.3 percent female), with a mean age of 50.5 years and a range from newborn to 100. Nearly half (43.9 percent) were patients. Another 4.9 percent were family members of patients. And 40.2 percent were employees of the facility where they died, meaning that 4 out of every 10 people killed in a medical setting were there to work.

Perpetrators

Perpetrators in this dataset were older than perpetrators of homicide in general. Their mean age was 43, with a range from 18 to 95. The vast majority were male, but 13.1 percent were female, a higher share than in most homicide datasets. Race distribution was 59.2 percent White, 28.1 percent Black, and 7.1 percent Hispanic.

Their relationships to the victim and to the setting varied considerably. Current patients were the largest group (36.7 percent). Partners of employees or patients together made up another 28.8 percent. Medical personnel accounted for 8.7 percent, strangers for 9.5 percent, family and friends of patients for 6.8 percent, and current or former staff for another 6.5 percent combined.

More than half of perpetrators (57.5 percent) showed warning signs before the incident. Many had documented risk histories: 37.1 percent had a prior criminal record, 30.4 percent had a history of violence, 36.4 percent had a documented mental health history, 12.9 percent had a substance use problem, and 38.9 percent had a history of suicidality.

Patterns varied sharply by subgroup. Among the 36 female perpetrators, firearms were less common (38.9 percent) and hands (16.7 percent) and poisoning (25 percent) were more common. Incidents with female perpetrators were more often domestic (44 percent) or involved higher rates of medical negligence (16 percent). Most female perpetrators were White (71 percent). Many were patients themselves (22.9 percent), but others were medical personnel (20 percent) or the domestic partner or family member of a patient (31.4 percent combined).

Patient perpetrators (sample size = 97) stood out as a distinct profile. They killed mostly with their hands (53.6 percent), followed by firearms (22.7 percent) and knives (10.3 percent). Their incidents were heavily driven by mental health factors (46 percent) and unresolved disputes (20.6 percent). Of the perpetrators, 67.0 percent displayed warning signs before the attack, and 90 percent were male.

Active shooters in medical settings

Active shooter incidents represent a small but consequential portion of this problem. The database contains 33 cases across the 25-year window, representing 11.8 percent of all homicides in medical settings. The rate of active shootings in medical settings is higher than the rate in schools or houses of worship—the two public-facing environments that are the most closely studied in the active shooter literature.

Every perpetrator in the active shooter subset was male. Race distribution was 52 percent White, 32 percent Black, 12 percent Hispanic, and 4 percent Asian (n = 1). All used firearms. Five incidents involved assault weapons.

The motivational picture is also distinct. Mental health factors drove 39.3 percent of cases. Retaliation, most often against a specific clinician perceived to have wronged the perpetrator, drove another 25 percent.

Domestic grievances drove 21.4 percent. Of the active shooters, 30.3 percent died by suicide at the scene, and another 27.3 percent were killed by responding officers. Three out of four active shooter cases (75.8 percent) showed warning signs in advance. Most incidents began in the afternoon (46.9 percent) or morning (31.3 percent).

Victims mirrored the broader dataset but with a heavier stranger share. Patients accounted for 25 percent. Strangers also accounted for 25 percent. Medical personnel made up 15.6 percent. Former patients, partners of employees, and domestic partners filled out the rest.

Perpetrators in this subset had more extensive criminal histories than other medical-setting killers. Of the active shooters, 76 percent had a prior record, and 42 percent had a documented mental health history. And the lethality was much greater. On average, an active shooter event in a medical setting killed 1.61 people and injured 1.52. A non-active-shooter event killed 1.04 and injured 0.13. The injury gap reveals that active shootings leave a wake of wounded survivors.

Example cases

Each case in the following list represents a different form of violence inside medical settings, and each carries a different warning for prevention:

- **Clinician as predator.** A physician administered morphine without orders to at least two patients, both of whom died. He later bragged about the killings and called himself the "Angel of Death." He had been fired from a previous hospital after administrators concluded he needed more basic nurse training. On the day of one killing, he told a coworker the victim was "going to die today."
- **Patient kills medical staff, Case 1.** After being told she could not skip the pharmacy line, a woman returned with a gun in her purse and killed the pharmacy worker. Two months earlier, she had pulled a machete-style knife on another patient. Weeks after that incident, she had slapped a nurse across the face.
- **Patient kills medical staff, Case 2.** A man entered the medical center where his back surgeon practiced, fatally shot the doctor, and turned the gun on himself. He blamed the surgeon for back pain that had never gone away. Neighbors later told investigators he had been in a downward spiral for months, growing reclusive and unable to refill his prescriptions. He had recently thrown a chair at a doctor. The facility had banned him.
- **Patients kill each other, Case 1.** A psychiatric patient murdered his 22-year-old roommate. Years earlier, he had killed the psychiatrist treating him for schizophrenia. He was found guilty but not criminally responsible for that first killing; he had said he believed the psychiatrist wanted to die.
- **Patients kill each other, Case 2.** A man strangled another patient to death during a mental health episode. He had been committed to the state hospital after an earlier attempted-murder case ended in an insanity acquittal. The night before the killing, he told another patient, "I'm going to kill someone."
- **Patients kill each other, Case 3.** A woman at an alcohol and drug rehabilitation facility woke before dawn, unscrewed a metal pipe from a nearby bathroom, and beat her roommate to death with it. She had been hearing voices and fighting with imaginary people for days. The victim had begged staff to move her to another room.
- **Domestic partner homicide, Case 1.** A man entered his wife's place of employment, shot her in an execution-style ambush, and then killed himself. Two months earlier, she had called the police and reported that he was threatening to attempt suicide by cop. His guns had been removed from the home. The day before the killing, they had been returned.
- **Domestic partner homicide, Case 2.** A woman called the police after a domestic dispute with her partner. Officers arrived at the hospital where she worked and waited. When her partner arrived, he shot and killed one of the officers. The night before, he had threatened to come to the hospital.

- **Family homicide, Case 1.** A mother repeatedly induced illness in her son by poisoning his feeding tube with salt. Unexplained spikes in his sodium levels eventually caused brain swelling and death. Treating physicians had requested prior medical records from outside hospitals. She had refused to provide them. Later, doctors admitted they had been suspicious from the start but felt they needed more evidence.
- **Family homicide, Case 2.** A man shot and killed his mother in her intensive care unit room. He had been battling a drug problem for years. After disappearing for several days, he came home enraged to learn that his wife could not afford the mortgage and that the family faced eviction. He then drove to the hospital.

These cases span at least six distinct forms of violence: the medical professional as predator, the retaliatory attack on a clinician, patient-on-patient killings inside psychiatric and rehabilitation units, intimate partner ambush at a staff member's workplace, filicide through medical neglect or active harm, and crisis-driven family killings on the inpatient floor. No single prevention strategy covers all of them.

Implications for prevention

Medical environments have a violence profile unlike almost any other public setting. The threats tend to be relational, not opportunistic. They grow out of emotional crisis, intimate relationships, and the access dynamics peculiar to health care. Prevention has to be tailored to that reality. Four patterns deserve particular attention:

1. Domestic violence shows up at the hospital.

Intimate partner violence is one of the biggest drivers of lethal violence in medical settings, both toward patients and toward staff. Hospitals are predictable places. Partners and ex-partners know the schedules, the buildings, and the entrances. They can usually walk in without raising suspicion. When they arrive with a plan, the consequences can be deadly.

2. Mental health crises are central, not peripheral.

Emergency departments and psychiatric units are, by design, the places where acute mental health crises end up. Suicidal ideation, psychosis, severe agitation, and intoxication-driven instability all concentrate in these rooms. The high rate of perpetrator suicide after a homicide in this dataset is consistent with the broader literature connecting homicide and suicide in crisis contexts.[5]

3. Active shooter risk is unusually elevated.

Hospitals experience a higher rate of active shooter events than schools or houses of worship do. Most of those events are planned, and most involve a personal connection to the facility, the staff, or a patient. In addition, most are preceded by warning signs that someone inside the institution saw first.

4. Opportunistic crime is rare.

Robberies, gang-related homicides, and drug-market disputes account for only a small fraction of killings inside health care settings. As a result, the strategies for preventing general community violence will not be fully applicable to medical settings.

Prevention strategies for medical settings

Because the risks are relational and driven by crises, prevention efforts should focus on spotting warning behavior early, communicating across the systems that hold the relevant information, and controlling access in a way that improves safety without hindering hospital operations.

1. Universal de-escalation and suicide prevention training

Every staff member who comes into contact with the public should be trained in behavioral crisis recognition, verbal and nonverbal de-escalation, suicide risk identification, and safe response to volatile individuals. Note that receptionists, security officers, transport workers, and housekeeping staff should all receive this training, not just clinicians and nurses. In many cases in the dataset, the first employee to detect that something was wrong was not a medical provider.

2. **Identification and separation of high-risk individuals**

   Facilities should implement structured protocols to flag patients with documented histories of violence and active restraining orders, as well as those who display severe agitation, psychosis, or intoxication-driven aggression. Those patients should be placed in low-stimulus or secured environments where possible, assigned staff trained in behavioral crisis management, flagged in electronic health records with specific behavioral alerts, and managed through coordinated safety plans that are communicated across shifts and departments.

3. **Coordinated use of Extreme Risk Protection Orders**

   Health care providers are often the last point of contact before lethal violence. They see what family members and employers do not. Clinicians and hospital legal teams should know how to initiate or support Extreme Risk Protection Orders for patients presenting a credible threat of harm to self or others, coordinate with local law enforcement when legal thresholds are met, and document threatening statements in a way that supports legal intervention later.

4. **Confidential reporting and threat recognition systems**

   Staff need an easy, confidential channel to report threatening patient behavior, concerning changes in a colleague's behavior or mental state, domestic violence concerns that affect staff safety, and gaps in physical security. These systems work only if they are nonpunitive, if the response is fast, and if staff can see that their concerns are taken seriously. Reporting systems that punish or ignore the reporter will, over time, train staff to stay quiet.

5. **Routine, trauma-informed screening for intimate partner violence**

   Intake should include structured, private screening for current or historical intimate partner violence, stalking, and coercive control; unsafe home environments; and safety concerns involving children or other dependents. Screening should be paired with warm referrals to social work, legal advocacy, and local shelter systems. It should be repeated when the clinical context changes, particularly during pregnancy, psychiatric admission, or instances of unexplained injuries.

6. **Layered access design**

   Hospitals do not need to become fortresses. Instead, a layered access model can make movement progressively more restricted deeper into the building so that unusual behavior stands out earlier. In practice, layered access can mean having a single public entry after hours, credentialed access to staff-only areas, active visitor management, locked and buzz-in units for inpatient care, and wearable duress alarms for staff in the highest risk roles. The goal is to make unusual movement visible.

   No prevention plan will catch every case. But medical settings have one advantage that most public environments do not: a person's warning signs, such as their pain, their grievance with an ex-partner, or their diagnosis, are often detectable before that person becomes dangerous.

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