Chapter I
BACKGROUND AND SCOPE

On April 16, 2007, one student, senior Seung Hui Cho, murdered 32 and injured 17 students and faculty in two related incidents on the campus of Virginia Polytechnic Institute and State University ("Virginia Tech"). Three days later, Virginia Governor Tim Kaine commissioned a panel of experts to conduct an independent, thorough, and objective review of the tragedy and to make recommendations regarding improvements to the Commonwealth's laws, policies, procedures, systems and institutions, as well as those of other governmental entities and private providers. On June 18, 2007, Governor Kaine issued Executive Order 53 reaffirming the establishment of the Virginia Tech Review Panel and clarifying the panel's authority to obtain documents and information necessary for its review. (See Executive Order 53 (2007), Appendix A.)

Each member of the appointed panel had expertise in areas relevant to its work, including Virginia's mental health system, university administration, public safety and security, law enforcement, victim services, emergency medical services, and the justice system. The panel members and their qualifications are specified in the Foreword to this report. The panel was assisted in its research and logistics by the TriData Division of System Planning Corporation (SPC).

In June, the governor appointed the law firm of Skadden, Arps, Slate, Meagher & Flom, LLP, as independent legal counsel to the panel. A team of their lawyers provided their services on a pro bono basis. Their advice helped enormously as they identified the authority needed to obtain key information and guided the panel through many sensitive legal areas related to obtaining and protecting information, public access to the panel and its work, and other issues. Their advice and counsel were invaluable.

The governor requested a report be submitted in August 2007. The panel devoted substantial time and effort from early May to late August to completing its review and preparing the report. All panel members served pro bono. The panel recognizes that some matters may need to be addressed more fully in later research.

SCOPE

The governor's executive order directed the panel to answer the following questions:

1. "Conduct a review of how Seung Hui Cho committed these 32 murders and multiple additional woundings, including without limitation how he obtained his firearms and ammunition, and to learn what can be learned about what caused him to commit these acts of violence.

2. "Conduct a review of Seung Hui Cho's psychological condition and behavioral issues prior to and at the time of the shootings, what behavioral aberrations or potential warning signs were observed by students, faculty and/or staff at Westfield High School and Virginia Tech. This inquiry should include the response taken by Virginia Tech and others to note psychological and behavioral issues, Seung Hui Cho's interaction with the mental health delivery system, including without limitation judicial intervention, access to services, and communication between the mental health services system and Virginia Tech. It should also include a review of educational, medical and judicial records documenting his

condition, the services rendered to him, and his commitment hearing.

3. "Conduct a review of the timeline of events from the time that Seung Hui Cho entered West Ambler Johnston dormitory until his death in Norris Hall. Such review shall include an assessment of the response to the first murders and efforts to stop the Norris Hall murders once they began.

4. "Conduct a review of the response of the Commonwealth, all of its agencies, and relevant local and private providers following the death of Seung Hui Cho for the purpose of providing recommendations for the improvement of the Commonwealth's response in similar emergency situations. Such review shall include an assessment of the emergency medical response provided for the injured and wounded, the conduct of post-mortem examinations and release of remains, on-campus actions following the tragedy, and the services and counseling offered to the victims, the victims' families, and those affected by the incident. In so doing, the panel shall to the extent required by federal or state law: (i) protect the confidentiality of any individual's or family member's personal or health information; and (ii) make public or publish information and findings only in summary or aggregate form without identifying personal or health information related to any individual or family member unless authorization is obtained from an individual or family member that specifically permits the panel to disclose that person's personal or health information.

5. "Conduct other inquiries as may be appropriate in the panel's discretion otherwise consistent with its mission and authority as provided herein.

6. "Based on these inquiries, make recommendations on appropriate measures that can be taken to improve the laws, policies, procedures, systems and institutions of the Commonwealth and the operation of public safety agencies, medical facilities, local agencies, private providers, universities, and mental health services delivery system."

In summary, the panel was tasked to review the events, assess actions taken and not taken, identify lessons learned, and propose alternatives for the future. Its assignment included a review of Cho's history and interaction with the mental health and legal systems and of his gun purchases. The panel was also asked to review the emergency response by all parties (law enforcement officials, university officials, medical responders and hospital care providers, and the Medical Examiner). Finally, the panel reviewed the aftermath—the university's approach to helping families, survivors, students, and staff as they dealt with the mental trauma and the approach to helping the university itself heal and function again.

METHODOLOGY

The panel used a variety of research and investigatory techniques and procedures, with the goal of conducting its review in a manner that was as open and transparent as possible, consistent with protecting individual privacy where appropriate and the confidentiality of certain records where required to do so.

Much of the panel's work was done in parallel by informal subgroups on topics such as mental health and legal issues, emergency medical services, law enforcement, and security. The panel was supplemented by SPC/TriData and Skadden staff with expertise in these areas. Throughout the process, panel members identified documents to be obtained and people to be interviewed. The list of interview subjects continued to grow as the review led to new questions and as people came forth to give information and insights to the panel.

From the beginning, the concept was to structure the review according to the broad timeline pertinent to the incidents: pre-incident (Cho's history and security status of the university); the two shooting incidents and the emergency response to them; and the aftermath. This helped ensure that all issues were covered in a logical, systematic fashion.

Openness –The panel's objective was to conduct the review process as openly as possible while maintaining confidential aspects of the police investigation, medical records, court records, academic records, and information provided in confidence. The panel's work was governed by the Virginia Freedom of Information Act, and the requirements of that act were adhered to strictly.

Requests for Documents and Information – An essential aspect of the review was the cooperation the panel received from many institutions and individuals, including the staff of Virginia Tech, Fairfax County Public School officials and employees, the families of shooting victims, survivors, the Cho family, law enforcement agencies, mental health providers, the Virginia Medical Examiner, and emergency medical responders, as well as numerous public agencies and private individuals who responded to the panel's requests for documents and information.

Notwithstanding some difficulties at the outset, the Executive Order of June 18, 2007, and the work of our outside counsel ultimately allowed the panel to obtain copies of, review, or be briefed on all records germane to its review. In this regard, however, a few matters should be noted. First, as explained more fully in the body of the report, the university's Cook Counseling Center advised the panel that it was missing certain records related to Cho that would be expected to be in the center's files.

Second, due to the sensitive nature of portions of the law enforcement investigatory record and due to law enforcement's concerns about not setting a precedent with regard to the release of raw information from investigation files, the panel received extensive briefings and summaries from law enforcement officials about their investigation rather than reviewing those files directly. These included briefings by campus police, Blacksburg Police, Montgomery County Police, Virginia State Police, FBI, and U.S. Bureau of Alcohol, Tobacco, Firearms and Explosives (ATF). The first two such briefings were conducted in private because they included protected criminal investigation information and some material that was deemed insensitive to air in public. Most of the information received in confidence was subsequently released in public briefings and through the media. Although the panel did not have direct access to criminal investigation files and materials in their entirety, the panel was able to validate the information contained in these briefings from the records it did have access to from other sources and from discussions with many of the same witnesses who spoke to the criminal investigators. The panel believes that it has obtained an accurate picture of the police response and investigation.

Finally, with respect to Cho's firearms purchases, the Virginia State Police, the ATF, and the gun dealers each declined to provide the panel with copies of the applications Cho completed when he bought his weapons or of other records relating to any background check that may have occurred in connection with those purchases. The Virginia State Police, however, did describe the contents of Cho's gun purchase applications to members of the panel and its staff.

Virginia Tech Cooperation – An essential aspect of the review was the cooperation of the Virginia Tech administration and faculty. Despite their having to deal with extraordinary problems, pressures, and demands, the university provided the panel with the records and information requested, except for a few that were missing. Some information was delayed until various privacy issues were resolved, but ultimately all records that were requested and still existed were provided. University President Charles Steger appointed a liaison to the panel, Lenwood McCoy, a retired senior university

official. Requests for meetings and information went to him. He helped identify the right people to provide the requested information or obtained the information himself. The panel sometimes requested to speak to specific individuals, and all were made available. Many of the exchanges were monitored by the university's attorney, who is a special assistant state attorney general. Overall, the university was extremely cooperative with the panel, despite knowing that the panel's duty was to turn a critical eye on everything it did.

Interviews – Many interviews were conducted by panel members and staff during the course of this review—over 200. A list of persons interviewed is included in Appendix B. A few interviewees wanted to remain anonymous and are not included. Panel members and staff held numerous private meetings with family members of victims and with survivors and their family members.

One group of interviews was to obtain first-hand information about the incidents from victims and responders. This included surviving students and faculty, police, emergency medical personnel and hospital emergency care providers, and coordinators. The police used hundreds of personnel from many law enforcement agencies for their investigation, and the panel did not have nor need the resources to duplicate that effort. Rather, the panel obtained the benefit of much of the investigative information from the law enforcement agencies. Interviews were conducted with survivors, witnesses, and responders to validate the information received and to expand upon it.

To further evaluate the actions taken by law enforcement, the university, and emergency medical services against state and national standards and norms, panel members and staff also conducted interviews with leaders in these fields outside the Virginia Tech community, from elsewhere in Virginia and from other states. The panel also solicited their expert opinions on how things might have been done better, and what things were done well that should be emulated.

Interviews were conducted to understand Cho's history, including his medical and mental health treatment during his early school and university years, and his interactions with the mental health and legal systems. This included interviews with the Cho family, Cho's high school staff and faculty, staff and faculty at the university, many of those involved with the mental health treatment of Cho within and outside the university (including the Cook Counseling Center and his high school counseling), and members of the legal community who had contact with him. The assistance of attorney Wade Smith of Raleigh, NC, was important in dealing with the Cho family. He helped obtain signed releases from the family and arranged an interview with them. Various experts in mental health were consulted on the problems with the mental health and legal system within Virginia that dealt with Cho. They also provided insight on ways to identify and help such individuals in other systems.

In evaluating the aftermath—the attempt to mitigate the damage done to so many families, members of the university community, and the university itself—many interviews were conducted with family members of the victims, survivors and their families, people interacting with the families and survivors, and others. The family members were extended opportunities to speak to the panel in public or private sessions, as were the injured and some other survivors. For these groups, everyone who requested an interview was given one. Not all wanted interviews. Some wanted group interviews. Some were ready to speak earlier or later than others. To the best of the panel's knowledge, and certainly its intent, all were accommodated. The panel learned a great deal about the incident and also confronted directly the indescribable grief and loss experienced by so many. From families and survivors, the panel learned about the positive aspects of the services provided after April 16 and also about the many perceived problems with those services. The panel also considered the many issues that the family members asked to be included in the investigation. This input

was invaluable and substantially improved this report.

Most of the formal interviews were conducted by one or two panel members, often with one or two TriData staff present. Some were conducted solely by staff. Generally, they were conducted in private. No recordings or written transcripts were made. All those interviewed were told that the information they provided might be used in the report but if they wished, they would not be quoted or identified. These steps were taken to encourage candor and to protect remarks that were provided with the caveat that they not be attributed to the speaker. The panel believes it was able to obtain more candid and useful information using this approach. Panel members and staff had many informal conversations with colleagues in their fields to obtain additional insights, generally not in formal settings.

Literature Research – Especially toward the beginning of the review but continuing throughout, much research was undertaken on various topics through the Internet and through information sources suggested by panel members and by individuals with whom the panel came into contact. Many useful references were submitted to the panel by the general public and experts.

Public Meetings – A key part of the panel's review process was a series of four public meetings held in different parts of the Commonwealth to accommodate those who wished to contribute information. The first meeting was held in Richmond at the state capitol complex, followed by meetings at Virginia Tech, George Mason University, and the University of Virginia. This facilitated input from the public and officials of various universities on issues they all cared deeply about. Several other universities offered facilities besides those chosen, including some out of state. Each university site was fully supported by their leadership, public relations department, event planning staff, and campus police. The Virginia State Police provided added protection at the meetings. (The agendas of the public meetings are given in Appendix C.)

In addition to the primary speakers, every public meeting included time for public comment. In some cases the people testifying were representatives of lobbying groups, organizations, and associations, but the panel also heard from victims, family members of victims, independent experts, and concerned citizens. There was even one instance of a cameraman who put his camera down and testified. Generally, the public presenters were expected to restrict themselves to a few minutes, and most did not abuse the opportunity. At one meeting, more people wanted to speak than time available, even though the meeting was extended an hour. Those not able to present information still had the opportunity to submit it to the panel through letters, e-mails, or phone calls, and many did.

Web Site and Post Office Box – Shortly after the panel was formed, its staff created a web site that was used both to inform the public and to receive input from the public. It proved to be very valuable. There was a minimum of spam or inappropriate inputs. The web site was used to post announcements of public meetings and to post presentations made or visual aids used at meetings. More than 400,000 "hits" were recorded, with 26,000 unique visitors. The web site also was advertised as a vehicle for anyone to post information or opinions. As of August 9, 2007, more than 2,000 comments were posted from experts in various fields as well as the general public, victims, families of victims, and others as follows:

Parents (self-identified)	251
General public	1,547
Educators	91
EMS	8
Students	48
Law enforcement officers	18
Family members of victims	12
Health professionals	102
Virginia Tech staff	2
Total	**2,079**

Most persons who submitted information to the web site appeared sincere about making a

contribution. Some lobbying groups on issues such as gun control, carrying guns on campus, and the influence of video games on young people clearly urged their members to post comments.

A post office box also was opened for the public to address comments directly to the panel. The number of letters received was much smaller than the number of e-mails but generally with a high percentage of relevancy, especially from experts, families, and victims.

Telephone Calls and E-Mails – Some information was received directly by panel members or staff through phone calls or e-mails. Much of this information was received by one panel member or staff member and was shared with others when thought important.

Panel Interactions – The members of the Virginia Tech Review Panel engaged on a personal level, participating in the majority of interviews conducted and exchanging many e-mails and phone calls among themselves and with the panel staff. The panel was impeded by the FOIA rules that did not allow more than two members to meet together or speak by phone without it being considered a public meeting.

FINDINGS AND RECOMMENDATIONS

The panel's findings and recommendations are provided throughout the report. Recommendations regarding the methodology used by the panel are presented in Appendix D; they were put in an appendix to avoid having the procedural issues distract the reader from the heart of the main issues.

The findings and related recommendations in this report are of two kinds. The first comes from reviewing actions taken in a time of crisis: what was done very well, and what could have been done better. Almost any crisis actions can be improved, even if they were exemplary.

The second type of finding identifies major administrative or procedural failings leading up to the events, such as failing to "connect the dots" of Cho's highly bizarre behavior; the missing records at Cook Counseling Center; insensitivity to survivors waiting to learn the fates of their children, siblings, or spouses; and fundraising that appeared opportunistic.

To help in understanding the events, the report begins in Chapter II with a description of the setting of the Virginia Tech campus and its preparedness for a disaster. In Chapter III, a detailed timeline serves as a reference throughout the report—the succinct story of what happened, starting with Cho's background, his treatment, and then proceeding to the events of April 16 and its aftermath. The events are elaborated in subsequent chapters.