

SUMMARY OF KEY FINDINGS

On April 16, 2007, Seung Hui Cho, an angry and disturbed student, shot to death 32 students and faculty of Virginia Tech, wounded 17 more, and then killed himself.

The incident horrified not only Virginians, but people across the United States and throughout the world.

Tim Kaine, Governor of the Commonwealth of Virginia, immediately appointed a panel to review the events leading up to this tragedy; the handling of the incidents by public safety officials, emergency services providers, and the university; and the services subsequently provided to families, survivors, care-givers, and the community.

The Virginia Tech Review Panel reviewed several separate but related issues in assessing events leading to the mass shootings and their aftermath:

- The life and mental health history of Seung Hui Cho, from early childhood until the weeks before April 16.
- Federal and state laws concerning the privacy of health and education records.
- Cho's purchase of guns and related gun control issues.
- The double homicide at West Ambler Johnston (WAJ) residence hall and the mass shootings at Norris Hall, including the responses of Virginia Tech leadership and the actions of law enforcement officers and emergency responders.
- Emergency medical care immediately following the shootings, both onsite at Virginia Tech and in cooperating hospitals.
- The work of the Office of the Chief Medical Examiner of Virginia.
- The services provided for surviving victims of the shootings and others injured, the families and loved ones of those killed and injured, members of the university community, and caregivers.

The panel conducted over 200 interviews and reviewed thousands of pages of records, and reports the following major findings:

1. Cho exhibited signs of mental health problems during his childhood. His middle and high schools responded well to these signs and, with his parents' involvement, provided services to address his issues. He also received private psychiatric treatment and counseling for selective mutism and depression.

In 1999, after the Columbine shootings, Cho's middle school teachers observed suicidal and homicidal ideations in his writings and recommended psychiatric counseling, which he received. It was at this point that he received medication for a short time. Although Cho's parents were aware that he was troubled at this time, they state they did not specifically know that he thought about homicide shortly after the 1999 Columbine school shootings.

2. During Cho's junior year at Virginia Tech, numerous incidents occurred that were clear warnings of mental instability. Although various individuals and departments within the university knew about each of these incidents, the university did not intervene effectively. No one knew all the information and no one connected all the dots.
3. University officials in the office of Judicial Affairs, Cook Counseling Center, campus police, the Dean of Students, and others explained their failures to communicate with one another or with Cho's parents by noting their belief that such communications are prohibited by the federal laws governing the privacy of health and education records. In reality, federal laws and their state counterparts afford ample leeway to share information in potentially dangerous situations.
4. The Cook Counseling Center and the university's Care Team failed to provide needed support and services to Cho during a period in late 2005 and early 2006. The system failed for lack of resources, incorrect interpretation of privacy laws, and passivity. Records of Cho's minimal treatment at Virginia Tech's Cook Counseling Center are missing.
5. Virginia's mental health laws are flawed and services for mental health users are inadequate. Lack of sufficient resources results in gaps in the mental health system including short term crisis stabilization and comprehensive outpatient services. The involuntary commitment process is challenged by unrealistic time constraints, lack of critical psychiatric data and collateral information, and barriers (perceived or real) to open communications among key professionals.
6. There is widespread confusion about what federal and state privacy laws allow. Also, the federal laws governing records of health care provided in educational settings are not entirely compatible with those governing other health records.
7. Cho purchased two guns in violation of federal law. The fact that in 2005 Cho had been judged to be a danger to himself and ordered to outpatient treatment made him ineligible to purchase a gun under federal law.
8. Virginia is one of only 22 states that report any information about mental health to a federal database used to conduct background checks on would-be gun purchasers. But Virginia law did not clearly require that persons such as Cho—who had been ordered into out-patient treatment but not committed to an institution—be reported to the database. Governor Kaine's executive order to report all persons involuntarily committed for outpatient treatment has temporarily addressed this ambiguity in state law. But a change is needed in the Code of Virginia as well.
9. Some Virginia colleges and universities are uncertain about what they are permitted to do regarding the possession of firearms on campus.
10. On April 16, 2007, the Virginia Tech and Blacksburg police departments responded quickly to the report of shootings at West Ambler Johnston residence hall, as did the Virginia Tech and Blacksburg rescue squads. Their responses were well coordinated.
11. The Virginia Tech police may have erred in prematurely concluding that their initial lead in the double homicide was a good one, or at least in conveying that impression to university officials while continuing their investigation. They did not take sufficient action to deal with what might happen if the initial lead proved erroneous. The police

reported to the university emergency Policy Group that the "person of interest" probably was no longer on campus.

12. The VTPD erred in not requesting that the Policy Group issue a campus-wide notification that two persons had been killed and that all students and staff should be cautious and alert.
13. Senior university administrators, acting as the emergency Policy Group, failed to issue an all-campus notification about the WAJ killings until almost 2 hours had elapsed. University practice may have conflicted with written policies.
14. The presence of large numbers of police at WAJ led to a rapid response to the first 9-1-1 call that shooting had begun at Norris Hall.
15. Cho's motives for the WAJ or Norris Hall shootings are unknown to the police or the panel. Cho's writings and videotaped pronouncements do not explain why he struck when and where he did.
16. The police response at Norris Hall was prompt and effective, as was triage and evacuation of the wounded. Evacuation of others in the building could have been implemented with more care.
17. Emergency medical care immediately following the shootings was provided very effectively and timely both onsite and at the hospitals, although providers from different agencies had some difficulty communicating with one another. Communication of accurate information to hospitals standing by to receive the wounded and injured was somewhat deficient early on. An emergency operations center at Virginia Tech could have improved communications.
18. The Office of the Chief Medical Examiner properly discharged the technical aspects of its responsibility (primarily autopsies and identification of the deceased). Communication with families was poorly handled.
19. State systems for rapidly deploying trained professional staff to help families get information, crisis intervention, and referrals to a wide range of resources did not work.
20. The university established a family assistance center at The Inn at Virginia Tech, but it fell short in helping families and others for two reasons: lack of leadership and lack of coordination among service providers. University volunteers stepped in but were not trained or able to answer many questions and guide families to the resources they needed.
21. In order to advance public safety and meet public needs, Virginia's colleges and universities need to work together as a coordinated system of state-supported institutions.

As reflected in the body of the report, the panel has made more than 70 recommendations directed to colleges, universities, mental health providers, law enforcement officials, emergency service providers, law makers, and other public officials in Virginia and elsewhere.

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