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Lessons Learned from the Virginia Tech Tragedy

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Lessons Learned from the Virginia Tech Tragedy

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Introduction

On April 16, 2007, Seung Hui Cho, a psychologically disturbed student at Virginia Tech, shot to death 32 students and faculty, wounded 17 more, and then killed himself. Three days later, Virginia Governor Tim Kaine appointed a panel to review the events leading up to this tragedy; the handling of the incident by public safety officials, emergency services providers, and the University; and the services subsequently provided to families, survivors, caregivers and the community.

The review panel presented its report to Governor Kaine in August 2007. The report summarizes key findings and includes eleven chapters with 91 recommendations. The panel reviewed several separate but related issues to assess events leading to the mass shootings and the aftermath:

- The life and mental history of Seung Hui Cho, from early childhood to the weeks before April 16
- Federal and state laws governing 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 medicine care immediately following the shootings, both onsite at Virginia Tech and in cooperating hospitals
- The work of the Office of the Chief Medical Examiner-Virginia
- The services provided for surviving victims of the shootings and others injured, the families and loved ones of those injured, members of the community and caregivers
The Virginia Tech Review Panel:

- Gerald Massengill
  - Retired Superintendent, Virginia State Police
- Tom Ridge
  - First U.S. Secretary of Homeland Security and former Governor of Pennsylvania
- Gordon Davies
  - Former Director, State Council of Higher Education-Virginia
- Roger Depue
  - Past Director, FBI National Center for the Analysis of Violent Crime
- Bela Sood, MD
  - Chair, Child and Adolescent Psychiatry, Virginia Commonwealth University
- Diane Strickland
  - Former Judge, Roanoke, VA
- Carroll Ann Ellis
  - Director of the Fairfax County Police Department Victim Services Division
- Marcus Martin, MD
  - Former Chair, Department of Emergency Medicine
  - Assistant Dean, School of Medicine, University of Virginia

The Virginia Tech Review Panel conducted over 200 closed interviews, four public panel meetings, four closed panel meetings, reviewed numerous documents and subsequently made 91 recommendations. The entire report can be reviewed at the Virginia Tech website: [www.governor.virginia.gov/tempcontents/techpanelreport.cfm](http://www.governor.virginia.gov/tempcontents/techpanelreport.cfm).

All of the following information is found in this report: Virginia Tech Review Panel; Mass Shootings at Virginia Tech; Report of the Review Panel presented to Governor Kaine; Commonwealth of Virginia; August 2007.

**History**

Seung Hui Cho was born in Korea in 1984. His mother, father and older sister indicated that Cho had health problems in his early years. At nine months old, Cho developed whooping cough and then pneumonia, and was hospitalized. Doctors told the family that Cho had a hole in his heart (some records report that he had a heart murmur). Before the age of three, doctors conducted further cardiac tests on Cho, likely including an echocardiogram or cardiac catheterization. Cho reportedly sustained emotional trauma related to his illnesses and procedures, and did not like to be touched from that point on. He was generally perceived as medically frail.

Cho was eight years old when he and his family emigrated to the U.S., in 1992. They initially lived in Maryland and then moved to Virginia. In the sixth grade Cho’s teachers noted that he was very withdrawn. Upon the recommendation of his teachers, his parents eventually took him to the Center for Multicultural Human Services (CMHS) for evaluation and counseling, in the summer of 1997. CMHS is a mental health services facility in Northern Virginia that offers psychological evaluations, testing and treatment to low-income, English-limited
immigrants and refugees. His parents told the specialists at CMHS of Cho’s social isolation and unwillingness to discuss his thoughts or feelings. At CMHS, Cho began working with a specialist trained in art therapy as a way of diagnosing and addressing emotional pain and psychological problems. Psychiatrists at CMHS also worked periodically with Cho and his family.

Cho was diagnosed with social anxiety disorder, selective mutism and major depression. Cho’s problems were characterized by social phobia, feelings of inadequacy, poor self-esteem and anger. Considered an underachiever, Cho eventually demonstrated hatred of fellow students, school and his own life in his writings and actions. During middle school, Cho continued to isolate himself from other students. In the spring semester of eighth grade his art therapist observed a new development in his behavior: he began depicting tunnels and caves in his art. The murders at Columbine High School took place in April, 1999; shortly afterwards, Cho wrote a disturbing paper for his English class that expressed generalized thoughts of suicide and homicide. He indicated that “he wanted to repeat Columbine.”

With the assistance of CMHS art therapy, psychiatric medication, and family and teachers who devised and carried out an individualized education plan, Cho graduated from Westfield High School with a 3.5 GPA. Although recommended to attend a smaller college, Cho chose to enter Virginia Tech in the fall of 2003. He had good grades the first year. He initially majored in business information technology; by his junior year he switched his major to English because of an interest in poetry and writing. Over the course of his college years Cho’s actions and conduct included many disturbing incidents, such as: stalking multiple female students; property destruction (burning papers in the dorm room and stabbing the dorm room carpet); intimidation of professors (through acts of disruption in class and verbal attacks); and taking pictures of female classmates under the desk using his cell phone. Cho wrote and presented disturbing papers about violence, killings, crime and darkness. Cho had hoped to publish a book containing his writings but received a rejection letter from the book publisher who had received his proposal.

During the fall of 2005 his worrisome behavior continued; following a stalking incident and interrogation by police in December, Cho sent an instant message to his suitemate stating “I might as well kill myself.” When this was reported to the police, Cho was evaluated by a pre-screener from the New River Valley Community Services Board, who indicated that Cho was imminently dangerous to himself and others. A magistrate issued a temporary detaining order and Cho was transported to Carilion St. Albans Psychiatric Hospital for mental evaluation, which involved an overnight stay of about 15 hours. As part of the legal process for temporary detention and a
commitment hearing, an independent evaluator assessed Cho, concluding that he did not present an imminent danger to himself. A staff psychiatrist at Carilion St. Albans Psychiatric Hospital also reached this conclusion, and recommended outpatient counseling. Collateral information was lacking during those evaluations. The special justice who conducted Cho’s commitment hearing ruled that “Cho presents an imminent danger to himself as a result of mental illness” and ordered outpatient involuntary commitment and treatment. Again, collateral information was absent, as no suitemates, roommates, family members nor Virginia Tech administrators were present at Cho’s commitment hearing. He was released to follow up at Cook Counseling Center on the same day.

An electronic schedule at the Cook Counseling Center at Virginia Tech indicated that Cho kept his appointment that day at 3:00 p.m. The triage report is missing, as well as those from prior telephone triages; the counselor who performed the triage had no independent recollection of Cho. There are no records to indicate that Cho received any treatments at Cook Counseling Center. Cho’s family was unaware of the events in Blacksburg during the fall of 2005, although his behavior worried roommates, resident advisors, teachers and eventually campus police. The parents were unaware that Cho had been committed to St. Albans Hospital or that he had appeared in court before a special justice.

In the spring of 2006, Cho had a hostile encounter with one of his technical writing professors. The trend of disturbing thoughts continued in his writings. A submission for Cho’s fiction workshop class in this semester now seem to foreshadow the events of one year later. In the spring of 2007, during Cho’s senior year, he purchased guns and ammunition, and spent time at the practice range. Two days before the massacre, an Asian male wearing a hooded garment was seen by a faculty member in Norris Hall. One of her students told her that the doors in Norris Hall had been chained; this may have been a practice run. On April 15, Cho called his family, as he usually did on Sunday night; the family reported that conversation was normal, and that Cho said nothing to cause them concern.

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**April 16, 2007 Timeline**

<table>
<thead>
<tr>
<th>Time</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>5:00 AM</td>
<td>Cho awake in dorm room</td>
</tr>
<tr>
<td>6:47 AM</td>
<td>Cho spotted outside WAJ</td>
</tr>
<tr>
<td>7:02 AM</td>
<td>Emily Hilscher enters WAJ</td>
</tr>
<tr>
<td>7:15 AM</td>
<td>Cho shoots two people in 4040 WAJ</td>
</tr>
<tr>
<td>7:17 AM</td>
<td>Cho accesses Harper Hall</td>
</tr>
<tr>
<td>7:20 AM</td>
<td>VTPD receives call about noise in 4040 WAJ</td>
</tr>
<tr>
<td>7:24 AM</td>
<td>VTPD arrive WAJ Room 4040 and find 2 people shot</td>
</tr>
<tr>
<td>7:26 AM</td>
<td>VT rescue squad arrives</td>
</tr>
<tr>
<td>7:30 AM</td>
<td>No suspect is apprehended, shooter is at large</td>
</tr>
<tr>
<td>7:40 AM</td>
<td>VTPD Chief Flinchum is notified by phone</td>
</tr>
</tbody>
</table>
Chief Flinchum notifies VT administration

The Virginia Tech police department was aware of the shooting within five minutes, but they did not notify the Virginia Tech administration for another 37 minutes. Although no suspect was apprehended at West Ambler Johnston Hall, the police knew the shooter was at large and possibly still on campus.

The first class period for April 16 began at 8:00 a.m. and the second at 9:05 a.m. It was not until 9:26—two hours after the initial shooting—that Virginia Tech administrators sent e-mails to campus staff, faculty and students about the dorm shooting. The Virginia Tech campus is very large—roughly 2,600 hundred acres, with 16 different roads, 19 different entryways and about 35,000 students, staff, and faculty. There was concern on the part of Virginia Tech administrators not to create a campus-wide panic, recalling what occurred in August, 2006, when escaped convict William Morva was on the loose after killing a security guard at Montgomery Regional Hospital and a police officer in the Blacksburg area. Therefore, the Virginia Tech president convened a policy group on the morning of April 16 to help determine how to notify people on campus about the shootings. During the 2006 experience, the campus administration had issued an alert that a murderer was on the loose in the vicinity of the campus, apparently causing the inference that students were being held hostage in the student center. News photos of the event show students rushing out of the student center with their hands up while police with drawn automatic weapons and bulletproof vests charged the building. This false alarm creating a highly dangerous situation influenced administrative decisions over issuing an alert in 2007.

Around 9:40 a.m., more than two hours after the WAJ shootings, Cho entered Norris Hall and killed 30 students and faculty before killing himself. He entered several rooms on the second floor of Norris Hall, repeatedly firing point-blank at people. The classrooms in Norris Hall had unlockable wooden doors; desks, tables, and chairs were used to try to barricade doors. Some people used their bodies to barricade doors; others played dead. In one classroom, while a professor tried to hold the door closed, ten students jumped 19 feet out of the window; the professor was killed.
Many police officers, primarily from the Virginia Tech and Blacksburg police department, were on campus following the WAJ shootings. The response by the police department and the Virginia Tech Rescue Squad was rapid. The Virginia Tech Rescue Squad headquarters is located within a couple blocks of Norris Hall; they quickly set up staging areas and informed rescue units to be on standby. They established the command post at rescue headquarters and eventually set up several treatment areas: a minor treatment area, a delayed treatment area and a critical treatment area. All the individuals transported from Norris Hall to hospitals survived. In one case, an individual shot in the groin had a severed femoral artery. Rescue workers used a commercial tourniquet to control the hemorrhage until the individual was transported to the hospital.

**Lessons Learned**

In essence, the lessons learned from the VT tragedy revolve around communication issues. Due to Cho’s selective mutism and resulting social phobia he could or would not communicate effectively with others; similarly, others did not communicate effectively with Cho. The Fairfax school system never communicated with VT. There were communication lapses between VT and Cho’s parents, and vice versa. There was no evidence of communication between Cook Counseling Center and the Center for Multicultural Human Services. Because Cho was committed to involuntary treatment, no information was sent to the Central Criminal Records Exchange (CCRE) denoting mental illness, which could have blocked his gun purchases. In Blacksburg, communications were deficient between faculty, care teams, judiciary affairs, police, Cook Counseling Center and Virginia Tech administration. This was compounded by the lack of collateral information and deficient communication among the special justice, psychiatrists, independent evaluator, community services board pre-screener, Cho’s parents, VT administration, police and the Cook Counseling Center related to the involuntary commitment hearing. The Virginia Tech police department communicated poorly with VT administrators about the status of the gunman; the administrators failed to alert students, faculty, staff about critical incidents and threats to public safety in a timely manner. During the rescue efforts there were communication issues related to information provided to rescue squads, hospitals and families of victims.

Driving some of this miscommunication was the misinterpretation of the Family Educational Rights and Privacy Act (FERPA) of 1974. Many people were unaware of the exception allowing for record release in an
emergency, when disclosure is necessary to protect the health or safety of individuals. Certain health care providers did not realize that they could disclose information about a person who presents an imminent threat to public safety, under Health Insurance and Portability and Accountability Act (HIPAA) of 1996.

**Campus Physical Security Measures**

Following the VT tragedy, many institutions of higher learning have taken additional security measures, including securing dormitory, classrooms and administrative buildings with outside access security locks; installing inside locks for classroom doors; and replacing the handle bars inside doors with flat-panel panic bars. Other screening measures include strategically placing cameras outside buildings entryways; adding entry gates and guards where feasible (particularly in some inner city campuses); using metal detectors; placing sirens/public address systems in locations around campuses; and installing high definition LCD-screen messaging boards at strategic locations around campuses. Institutions are also exploring multimedia communication capabilities to provide immediate clear messages to students, faculty, staff and parents. Other shooting incidents or threats on college campuses since the Virginia Tech events have reinforced the need to take such measures. Institutions are therefore developing an active protocol providing for early notification of dangerous situations, canceling classes, and issuing warnings to be aware of potential danger and remain in a safe location.

**Recommendations**

The VT Review Panel provided 91 recommendations to the Governor. The Governor classified these recommendations into three groups. Group 1 is the set of recommendations that institutions could enact without legislation and put into place as policies. Group 2 includes those recommendations that the Governor could act on primarily without legislation. Group 3 recommendations have to be reviewed by state legislators, recommended as bills and placed into law. During the 2008 Virginia General Assembly, legislators reviewed numerous House and Senate bills related to mental health laws. In essence these bills cover the following:

- Broadening criteria for involuntary commitment
- Expanding commitment for reporting to the CCRE
- Requirements for community services board monitoring of patient compliance in those patients who have been committed to involuntary outpatient treatment
- Allowing of medical record sharing in cases of safety threat
- Broadening authority in the temporary detention order process, including the authority of emergency physicians to contact the magistrate and request the TDO
The VT Review Panel expressed gratitude to the more than 200 people who were interviewed and participated in group discussions, and to Tri Data, a Division of Systems Planning Incorporation and Skadden, Arps, Slate, Meager, and Flom LLP for their assistance in developing the report. The VT Review Panel invited family members of the victims to lend their words of dedication to the report; the panel is honored to share their words of love, remembrance and strength:

“We dedicate this report not solely to those who lost their lives at VT on April 16, 2007, and to those physically and/or psychologically wounded on that dreadful morning, but also to every student, teacher, and institution of learning, that we may all safely fulfill our goals of learning, educating, and enriching humanities stores of knowledge: the very arts and sciences that ennoble us.”