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Campus Security 2010:
Rapid-Response Crisis Management and
Future Models of Campus Policing


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A. AN OVERVIEW OF THE VIRGINIA TECH REPORT


- This is the report of the Virginia Tech Review Panel appointed by Governor Kaine on April 19, 2007 and Executive Order No. 53 (2007), June 18, 2007.


- The report includes 11 chapters and 14 appendices.

Chapters (147 pages)

I. Background and Scope
II. University Setting and Security
III. Timeline of Events
IV. Mental Health History of Seung Hui Cho (and related Virginia mental health laws)
V. Information Privacy Laws
VI. Gun Purchase and Campus Policies
VII. Double Murder at West Ambler Johnson (first incident)
VIII. Mass Murder at Norris Hall (second incident)
IX. Emergency Medical Services Response
X. Office of the Chief Medical Examiner
XI. Immediate Aftermath and the Long Road to Healing

Appendices

A. Executive Order 53 (2007)
B. Individuals Interviewed
C. Public Meetings Agenda
D. Recommendations on Review Methodology (included in this synopsis as Attachment A)
E. Va Tech Guidelines for Choosing Alerting System.
F. Active Shooter Excerpt- University of Virginia Emergency Response Plan
G. Guidance Letters on FERPA, HIPPA Interpretation, US Dept of Education
H. Explanation of FERPA and HIPPA Laws
I. Federal and Virginia Gun Purchaser Forms
J. Virginia Form for Involuntary Commitment or Incapacitation
K. Articles on Mixture of Guns and Alcohol on Campus
M. Red Flags, Warning Signs and Indicators
N. A Theoretical Profile of Seung Hui Cho

Synopsis of Virginia Tech Review Panel Report (08/07) by Charles F. Carletta  -1 -
B. SUMMARY OF KEY FINDINGS [Report, p. 1-3]

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.
C. BRIEF CHAPTER REVIEWS AND COMMENTARY

The outline for each chapter is presented first. Comments of possible interest to the reader are bulleted. The Review Panel’s recommendations are provided in Part D of this report, a separate document.

CHAPTER I. BACKGROUND AND SCOPE

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- Process information.

CHAPTER II. UNIVERSITY SETTING AND SECURITY

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- Suggest that you read this chapter in its entirety.
- Interesting info about VA Tech’s police department (VTPD): an accredited police force; the police chief reports to a university vice president. Review Panel asks whether the department’s mission statement – which emphasizes support of academic mission and a peaceful/orderly community -- places “minimizing disruption” ahead of “acting on the side of precaution.” [p. 13]
- Academic buildings at VT did not have card readers or guards at entry; classrooms do not have locks.
- Existing, and upgrades to, campus alerting systems are discussed; VT is installing a unified, multimedia messaging system (Specs are in Appendix E of the Report).
- VT Emergency Response Plan does not address shootings (See University of Virginia’s plan in Appendix F of the Report).
- University response groups – Policy and Resources (Operating) – are described. The Policy group is chaired by the President; it does not include a member of the campus police.
- There was no Threat Assessment Team at VT.
- See Key Findings: University Setting and Security (below).
- See Chapter II Recommendations.
KEY FINDINGS: UNIVERSITY SETTING AND SECURITY [pp. 17-19]

The Emergency Response Plan of Virginia Tech was deficient in several respects. It did not include provisions for a shooting scenario and did not place police high enough in the emergency decision-making hierarchy. It also did not include a threat assessment team. And the plan was out of date on April 16; for example, it had the wrong name for the police chief and some other officials.

The protocol for sending an emergency message in use on April 16 was cumbersome, untimely, and problematic when a decision was needed as soon as possible. The police did not have the capability to send an emergency alert message on their own. The police had to await the deliberations of the Policy Group, of which they are not a member, even when minutes count. The Policy Group had to be convened to decide whether to send a message to the university community and to structure its content.

The training of staff and students for emergencies situations at Virginia Tech did not include shooting incidents. A messaging system works more effectively if resident advisors in dormitories, all faculty, and all other staff from janitors to the president have instruction and training for coping with emergencies of all types.

It would have been extremely difficult to "lock down" Virginia Tech. The size of the police force and absence of a guard force, the lack of electronic controls on doors of most buildings other than residence halls, and the many unguarded roadways pose special problems for a large rural or suburban university. The police and security officials consulted in this review did not think the concept of a lockdown, as envisioned for elementary or high schools, was feasible for an institution such as Virginia Tech.

It is critical to alert the entire campus population when there is an imminent danger. There are information technologies available to rapidly send messages to a variety of personal communication devices. Many colleges and universities, including Virginia Tech, are installing such campus-wide alerting systems. Any purchased system must be thoroughly tested to ensure it operates as specified in the purchase contract. Some universities already have had problems with systems purchased since April 16.

An adjunct to a sophisticated communications alert system is a siren or other audible warning device. It can give a quick warning that something is afoot. One can hear such alarms regardless of whether electronics are carried, whether the electronics are turned off, or whether electric power (other than for the siren, which can be self-powered) is available. Upon sounding, every individual is to immediately turn on some communication device or call to receive further instructions. Virginia Tech has installed a system of six audible alerting devices of which four were in place on April 16. Many other colleges and universities have done something similar.

No security cameras were in the dorms or anywhere else on campus on April 16. The outcome might have been different had the perpetrator of the initial homicides been rapidly identified. Cameras may be placed just at entrances to buildings or also in hallways. However, the more cameras, the more intrusion on university life.

Virginia Tech did not have classroom door locks operable from the inside of the room. Whether to add such locks is controversial. They can block entry of an intruder and compartmentalize an attack. Locks can be simple manually operated devices or part of more sophisticated systems that use electromechanical locks operated from a central security point in a building or even university-wide. The locks must be easily opened from the inside to allow escape from a fire or other emergency when that is the safer course of action. While adding locks to classrooms may seem an obvious safety feature, some voiced concern that locks could facilitate rapes or assaults in classrooms and increase university liability. (An attacker could drag someone inside a room at night and lock the door, blocking assistance.) On the other hand, a locked room can be a place of
refuge when one is pursued. On balance, the panel generally thought having locks on classroom doors was a good idea.

Shootings at universities are rare events, an average of about 16 a year across 4,000 institutions. Bombings are rarer but still possible. Arson is more common and drunk driving incidents more frequent yet. There are both simple and sophisticated improvements to consider for improving security (besides upgrading the alerting system). A risk analysis needs to be performed and decisions made as to what risks to protect against.

There have been several excellent reviews of campus security by states and individual campuses (for example, the states of Florida and Louisiana, the University of California, and the University of Maryland). The Commonwealth of Virginia held a conference on campus security on August 13, 2007.

The VTPD and BPD were well-trained and had conducted practical exercises together. They had undergone active shooter training to prepare for the possibility of a multiple victim shooter.

The entire police patrol force must be trained in the active shooter protocol, because any officer may be called upon to respond.

It was the strong opinion of groups of Virginia college and university presidents with whom the panel met that the state should not impose required levels of security on all institutions, but rather let the institutions choose what they think is appropriate. Parents and students can and do consider security a factor in making a choice of where to go to school.

Finally, the panel found that the VTPD statement of purpose in the Emergency Response Plan does not reflect that law enforcement is the primary purpose of the police department.

CHAPTER III. TIMELINE OF EVENTS

| Chapter contents: | Pre-Incidents: Cho’s History |
|                  | The Incidents                  |
|                  | Post-Incidents                  |

- A detailed reconstructed timeline, starting with Cho’s birth in 1984 to the Governor’s declaration of a state-wide day of mourning August 20, 2007.
- The minute-by-minute compilation for April 16 is a good measure of how quickly and simultaneously events happen in a situation like this.
- There are no key findings or recommendations in Chapter III.

CHAPTER IV. MENTAL HEALTH HISTORY OF SEUNG HUI CHO

| Chapter Contents: | PART A – MENTAL HEALTH HISTORY |
|                  | Early Years |
|                  | Elementary School in Virginia |
|                  | Middle School Years |
|                  | High School Years |
|                  | College Years |
|                  | Cho’s Hospitalization and Commitment Proceedings |
|                  | After Hospitalization |
|                  | Missing the Red Flags |
• Part A is essentially an ex-post case study; worth reading by the medical/counseling professionals.
• Key milestones in Cho’s odyssey are summarized in Chapter III Timeline.
• Counseling Center responses/protocols are worth analysis; some balls were dropped.
• Note that VT had a “care team” but that it failed “to connect the dots” – see “Missing the Red Flags” and key findings below.
• Appendix M summarizes Red Flags, Warning Signs and Indicators.
• Part B is quite specific to the Commonwealth of Virginia
• See also Chapter IV Recommendations.

MISSING THE RED FLAGS [p. 52]

The Care Team at Virginia Tech was established as a means of identifying and working with students who have problems. That resource, however, was ineffective in connecting the dots or heeding the red flags that were so apparent with Cho. They failed for various reasons, both as a team and in some cases in the individual offices that make up the core of the team.

Key agencies that should be regular members of such a team are instead second tier, nonpermanent members. One of these, the VTPD, knew that Cho had been cautioned against stalking—twice, that he had threatened suicide, that a magistrate had issued a temporary detention order, and that Cho had spent a night at St. Albans as a result of such detention order. The Care Team did not know the details of all these occurrences.

Residence Life knew through their staff (two resident advisors and their supervisor) that there were multiple reports and concerns expressed over Cho’s behavior in the dorm, but this was not brought before the Care Team. The academic component of the university spoke up loudly about a sullen, foreboding male student who refused to talk, frightened classmate and faculty with macabre writings, and refused faculty exhortations to get counseling. However, after Judicial Affairs and the Cook Counseling Center opined that Cho’s writings were not actionable threats, the Care Team’s one review of Cho resulted in their being satisfied that private tutoring would resolve the problem. No one sought to revisit Cho’s progress the following semester or inquire into whether he had come to the attention of other stakeholders on campus.

The Care Team was hampered by overly strict interpretations of federal and state privacy laws (acknowledged as being overly complex), a decentralized corporate university structure, and the absence of someone on the team who was experienced in threat assessment and knew to investigate the situation more broadly, checking for collateral information that would help determine if this individual truly posed a risk or not. (The interpretation of FERPA and HIPAA rules is discussed in a later chapter.)
There are particular behaviors and indicators of dangerous mental instability that threat assessment professionals have documented among murderers. A list of red flags, warning signs and indicators has been compiled by a member of the panel and is included as Appendix M.

KEY FINDINGS – CHO’S COLLEGE YEARS TO APRIL 15, 2007 [pp. 52-53]

The lack of information sharing among academic, administrative, and public safety entities at Virginia Tech and the students who had raised concerns about Cho contributed to the failure to see the big picture. In the English Department alone, many professors encountered similar difficulties with Cho—non-participation in class, limited responses to efforts to personally interact, dark writings, reflector glasses, hat pulled low over face. Although to any one professor these signs might not necessarily raise red flags, the totality of the reports would have and should have raised alarms.

Cho’s aberrant behavior of pathological shyness and isolation continued to manifest throughout his college years. He shared very little of his college life with his family, had no friends, and engaged in no activities outside of the home during breaks and summer vacations. While he was an adult, he was a member of the household and receiving parental support, but he did not hold a job to help earn money for college. Unusual by U.S. standards, a high, sometimes exclusive focus on academics is common among parents from eastern cultures.

Cho’s roommates and suitemates noted frequent signs of aberrant behavior. Three female residents reported problems with unwanted attention from Cho (instant messages, text messages, Facebook postings, and erase board messages). One of Cho’s suitemates combined many of these instances of concern into a report shared with the residence staff. The residence advisors reported these matters to the hall director and the residence life administrator on call. These individuals in turn, communicated by e-mail with the assistant director of Judicial Affairs.

Notwithstanding the system failures and errors in judgment that contributed to Cho’s worsening depression, Cho himself was the biggest impediment to stabilizing his mental health. He denied having previously received mental health services when he was evaluated in the fall of 2005, so medical personnel believed that their interaction with him on that occasion was the first time he had showed signs of mental illness. While Cho’s emotional and psychological disabilities undoubtedly clouded his ability to evaluate his own situation, he, ultimately, is the primary person responsible for April 16, 2007; to imply otherwise would be wrong.

CHAPTER V. INFORMATION PRIVACY LAWS

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- The chapter addresses federal and state law concerning “four categories of information that may be useful in evaluating and responding to a troubled student:”
  - Law enforcement records
  - Court records
  - Medical information and records
  - Educational records
The laws are discussed in the context of Cho’s conduct leading to the shootings.

Note that most of this info was probably compiled by the law firm of Skadden, Arps, Slate, Meagher & Flom L.L.P., who provided assistance to the Review Panel.

See Chapter V Recommendations. Most of the recommendations are directed to state and national authorities and the “need for amendment and clarification” of privacy laws. One (V-5) is specifically directed to universities.

Even though the chapter takes a measured and somewhat restrained view, this quote is auspicious: [p. 63]

The widespread perception is that information privacy laws make it difficult to respond effectively to troubled students. This perception is only partly correct. Privacy laws can block some attempts to share information, but even more often may cause holders of such information to default to the nondisclosure option—even when laws permit the option to disclose. Sometimes this is done out of ignorance of the law, and sometimes intentionally because it serves the purposes of the individual or organization to hide behind the privacy law. A narrow interpretation of the law is the least risky course, notwithstanding the harm that may be done to others if information is not shared. Much of the frustration about privacy laws stems from lack of understanding. When seen clearly, the privacy laws contain many provisions that allow for information sharing where necessary.

CHAPTER VI. GUN PURCHASE AND CAMPUS POLICIES

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- Much of this chapter deals with Cho’s purchase of two firearms from registered gun dealers with no problem, despite his mental history.

- Only a portion of the chapter deals with guns on campus, and this is in the context of Virginia universities law: [p. 74]

Virginia universities and colleges do not seem to be adequately versed in what they can do about banning guns on campus under existing interpretations of state laws. The governing board of colleges and universities can set policies on carrying guns. Some said their understanding is that they must allow anyone with a permit to carry a concealed weapon on campus. Others said they thought guns can be banned from buildings but not the grounds of the institution. Several major universities reported difficulty understanding the rules based on their lawyers’ interpretation. Most believe they can set rules for students and staff but not the general public.

- Regarding Virginia Tech and Mr. Cho: [p. 74]

Virginia Tech, with approval of the state Attorney General’s Office, had banned guns from campus altogether. Virginia Tech has one of the tougher policy constraints of possessing guns on campus among schools in Virginia. However, there are no searches of bags or use of magnetometers on campus like there are in government offices or airports. Cho carried his weapons in violation of university rules, and probably knew that it was extremely unlikely that anyone would stop him to check his bag. He looked like many others.
• See **Chapter VI Recommendations.** Most of the recommendations are directed to changes in Virginia law, including passage of legislation that clearly establishes the right of every higher education institution to regulate the possession of firearms on campus as it pleases. One (VI-6) is directed to universities.

**CHAPTER VII. DOUBLE MURDER AT WEST AMBLER JOHNSTON**

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• This chapter reconstructs, in detail, the shootings at West Ambler Johnson (WAJ) – the first of the day. It describes the events leading up to the shootings in Norris Hall, and the police and university actions taken in response.

• Note that police and EMS response to the scene was very fast (4 minutes and 6 minutes).

• It is instructive that *no one* reported, or remembered, seeing Cho at any time during his odyssey around campus on April 16.

• The report is critical of the decision not to pursue alternatives to the initial lead [pp. 79-80].

• This chapter discusses the delayed alert to the university community, and the decision not to close the campus, in some detail [p. 80-84]. Lessons to be gleaned.

• The "false alarm" incident on campus the previous August is described in some detail [pp. 80-81]. This is worth a look: VT administrators may felt that it caused a dangerous incident at that time, and this may have contributed to their caution on April 16. Many lessons to be gleaned here.

• Key findings are reported below. See **Chapter VII Recommendations.**

**KEY FINDINGS – WEST AMBLER JOHNSTON** [pp. 86-87]

Generally the VTPD and BPD officers responded to and carried out their investigative duties in a professional manner in accordance with accepted police practices. However, the police conveyed the wrong impression to the university Policy Group about the lead they had and the likelihood that the suspect was no longer on campus.

The police did not have the capability to use the university alerting system to send a warning to the students, staff, and faculty. That is, they were not given the keyword to operate the alerting system themselves, but rather they had to request a message be sent from the Policy Group or at least the associate vice president for University Relations, who did have the keyword. The police did have the authority to request that a message be sent, but did not request that be done. They gave the university administration the information on the incident, and left it to the Policy Group to handle the messaging.

The university administration failed to notify students and staff of a dangerous situation in a timely manner. The first message sent by the university to students could have been sent at least an
hour earlier and been more specific. The university could have notified the Virginia Tech community that two homicides of students had occurred and that the shooter was unknown and still at large. The administration could have advised students and staff to safeguard themselves by staying in residences or other safe places until further notice. They could have advised those not en route to school to stay home, though after 8 a.m. most employees would have been en route to their campus jobs and might not have received the messages in time.

Despite the above findings, there does not seem to be a plausible scenario of university response to the double homicide that could have prevented a tragedy of considerable magnitude on April 16. Cho had started on a mission of fulfilling a fantasy of revenge. He had mailed a package to NBC identifying himself and his rationale and so was committed to act that same day. He could not wait beyond the end of the day or the first classes in the morning. There were many areas to which he could have gone to cause harm.

CHAPTER VIII. MASS MURDER AT NORRIS HALL

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- This chapter reconstructs, in detail, the mass killings at Norris Hall. It describes the events and the police and university actions taken in response.
- It is important to note that, due to the WAJ incident, there were many police and EMS personnel, as well as a command center, already on campus; the first police response came in 3 minutes.
- Note the way Cho’s bomb threat was handled [p. 89]; most university personnel have no idea how to handle one of these. Similarly, some students saw the chained doors, but did not report their observations [p. 90].
- The chapter reports the actions in the various classrooms and hallways in detail [pp. 90-94] as well as the police response [pp. 94-95] and university messaging [pp. 95-97]; once shooting started, actions were prompt, but shooting was over in 11 minutes.
- Key findings are reported below. See Chapter VIII Recommendations.

KEY FINDINGS – NORRIS HALL [pp. 98-99]

Overall, the police from Virginia Tech and Blacksburg did an outstanding job in responding quickly and using appropriate activeshooter procedures to advance to the shooter’s location and to clear Norris Hall.

The close relationship of the Virginia Tech Police Department and Blacksburg Police Department and their frequent joint training saved critical minutes. They had trained together for an active shooter incident in university buildings. There is little question their actions saved lives. Other campus police and security departments should make sure they have a mutual aid arrangement as good as that of the Virginia Tech Police Department.
Police cannot wait for SWAT teams to arrive and assemble, but must attack an active shooter at once using the first officers arriving on the scene, which was done. The officers entering the building proceeded to the second floor just as the shooting stopped. The sound of the shotgun blast and their arrival on the second floor probably caused Cho to realize that attack by the police was imminent and to take his own life.

Police did a highly commendable job in starting to assist the wounded, and worked closely with the first EMTs on the scene to save lives.

Several faculty members died heroically while trying to protect their students. Many brave students died or were wounded trying to keep the shooter from entering their classrooms. Some barricading doors kept their bodies low or to the side and out of the direct line of fire, which reduced casualties.

Several quick-acting students jumped from the second floor windows to safety, and at least one by dropping himself from the ledge, which reduced the distance to fall. Other students survived by feigning death as the killer searched for victims.

People were evacuated safely from Norris Hall, but the evacuation was not well organized and was frightening to some survivors. However, being frightened is preferable to being injured by a second shooter. The police had their priorities correct, but they might have handled the evacuation with more care.

CHAPTER IX. EMERGENCY MEDICAL SERVICES RESPONSE

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<td>EMS Incident Command System</td>
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<td>Hospital Response</td>
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<td>Key Findings</td>
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- This chapter reconstructs, in detail, the EMS response to the shootings at West Ambler Johnston and the mass killings at Norris Hall, including communications, triage, transport, and hospital operations. This a very thorough analysis with comparison to benchmarks. This should be useful for mass casualty incident planning.
- Note that VaTech’s Rescue Square is a student volunteer organization.
- The Review Panel (see Finding #17) is generally complementary to the EMS response, but notes several flaws, including different communications frequencies and the absence of an emergency operations center (EOC) on campus.
- See Chapter IX Recommendations. Most recommendations address coordinated, unified mass casualty planning, incident management procedures, disaster drills, and management of casualties.

KEY FINDINGS: POSITIVE LESSONS [p. 121]
- The EMS responses to the West Ambler Johnston residence hall and Norris Hall occurred in a timely manner.
- Initial triage by the two tactical medics accompanying the police was appropriate in identifying patient viability.
The application of a tourniquet to control a severe femoral artery bleed was likely a lifesaving event. Patients were correctly triaged and transported to appropriate medical facilities.

The incident was managed in a safe manner, with no rescuer injuries reported.

Local hospitals were ready for the patient surge and employed their NIMS ICS plans and managed patients well.

All of the patients who were alive after the Norris Hall shooting survived through discharge from the hospitals.

Quick assessment by a hospitalist of emergency department patients waiting for disposition helped with preparedness and patient flow at one hospital.

The overall EMS response was excellent, and the lives of many were saved.

EMS agencies demonstrated an exceptional working relationship, likely an outcome of interagency training and drills.

KEY FINDINGS: AREAS FOR IMPROVEMENT

All EMS units were initially dispatched by the Montgomery County Communications Center to respond to the scene; this was contrary to the request.

There was a 4-minute delay between VTRS monitoring the incident (9:42 a.m.) on the police radio and its being dispatched by police (9:46 a.m.).

Virginia Tech police and the Montgomery County Communications Center issued separate dispatches. This can lead to confusion in an EMS response.

BVRS was initially unaware that VTRS had already set up an EMS command post. This could have caused a duplication of efforts and further organizational challenges. Participants interviewed noted that once a BVRS officer reported to the EMS command post, communications between EMS providers on the scene improved.

Because BVRS and VTRS are on separate primary radio frequencies, BVRS reportedly did not know where to stage their units. In addition, BVRS units were reportedly unaware of when the police cleared the building for entry.

Standard triage tags were used on some patients but not on all. The tags are part of the Western Virginia EMS Trauma Triage Protocol. Their use could have assisted the hospitals with patient tracking and record management. Some patients were identified by room number in the emergency department and their records became difficult to track.

The police order to transport the deceased under emergency conditions from Norris Hall to the medical examiners office in Roanoke was inappropriate. The lack of a local EOC and fully functioning RHCC may lead to communications and operational issues such as hospital liaisons being sent to the scene. If each hospital sent a liaison to the scene, the command post would have been overcrowded.

A unified command post should have been established and operated based on the NIMS ICS model.

Failure to open an EOC immediately led to communications and coordination issues during the incident.

Communications issues and barriers appeared to be frustrating during the incident.

CHAPTER X. OFFICE OF THE CHIEF MEDICAL EXAMINER

Chapter contents: Legal Mandates and Standards of Care
Death Notification
Events
Issues
Key Findings
Recommendations
A Final Word
• While much of this chapter focuses on processes internal to the ME process, the university’s role, and problems, in dealing with death notifications and the families are also detailed.

• The chapter provides a very detailed reconstruction of Roanoke ME actions on April 16-18 [pp. 124-127] as well as the autopsy process [pp. 127-129] and family treatment [pp. 129-131]. The section on family treatment should be carefully reviewed.

• VaTech established a family assistance center (FAC) at the Inn at Virginia Tech the next day (11 am on April 17), but as noted in Finding #20, “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.”

• Key Findings are presented below. See **Chapter IX Recommendations**, especially those addressing the family assistance center (V-3, V-4, and V-5).

**KEY FINDINGS - POSITIVE LESSONS** [pp.131-132]

The part of the OCME disaster plan related to postmortem operations functioned as designed. The internal notification process as well as staff redeployments allowed the surge in caseload generated by the disaster to be handled appropriately as well as existing cases and other new cases that were referred to the OCME from other events statewide.

Thirty-three positive identifications were made in 3 days of intense morgue operations. The contention that the OCME was slow in completing the legally mandated tasks of investigation is not valid.

Crime scene operations with law enforcement were effective and expedient.

Cooperation with the Department of Forensic Services for fingerprint and dental comparison was good.

The OCME performed their technical duties well under the pressures of a high-profile event.

**KEY FINDINGS – AREAS FOR IMPROVEMENT** [p.132]

The public information side of the OCME was poor and not enough was done to bring outside help in quickly to cover this critical part of their duties. The OCME did not dedicate a person to handle the inquiries and issues regarding the expectations of the families and other state officials. This failure resulted in the spread of misinformation, confusion for victim survivors, and frustrations for all concerned.

The inexperience of state officials charged with managing a mass fatality event was evident. This could be corrected if state officials include the OCME in disaster drills and exercises.

The process of notifying family members of the victims and the support needed for this population were ineffective and often insensitive. The university and the OCME should have asked for outside assistance when faced with an event of this size and scope.

Training for identification personnel was inadequate regarding acceptable scientific identification methods. This includes FAC personnel; Virginia funerals directors; behavioral health, law enforcement, public health, and public information officials; the Virginia Dental Association; and hospital staffs.
Adequate training for PIOs on the methods and operations of the OCME was lacking. This training had been given to two Health Department public information officers prior to the shootings. However, since neither was available, information management in the hands of an inexperienced public information officer proved disastrous. This in turn, allowed speculation and misinformation, which caused additional stress to victims’ families.

No one was in charge of the family assistance center operation. Confusion over that responsibility between state government and the university added to the problem. Under the current state planning model, the Commonwealth’s Department of Social Services has part of the responsibility for family assistance centers. The university stepped in to establish the center and use the liaisons, but they were not knowledgeable about how to manage such a delicate operation. Moreover, the university itself was traumatized.

CHAPTER XI. IMMEDIATE AFTERMATH AND THE LONG ROAD TO HEALING

| Chapter contents: | First Hours  
| Actions by Virginia Tech  
| Meetings, Visits, and Other Communications with Families and with the Injured  
| Ceremonies and Memorial Events  
| Volunteers and Onlookers  
| Communications with the Medical Examiner’s Office  
| Department of Public Safety  
| Key Findings  
| Recommendations |

- This chapter addresses the run-out from the events of April 16.
- The Review Panel comes to this conclusion about the immediate response [p. 136]:

After Cho committed suicide and the scene was finally cleared by the police to allow EMS units to move in, the grim reports began to emerge. The numbers of dead and injured rose as each new report was issued. Parents, spouses, faculty, students, and staff scrambled for information that would confirm that their loved ones, friends, or colleagues were safe. They attempted to contact the university, hospitals, local police departments, and media outlets, in an attempt to obtain the latest information.

Chaos and confusion reigned throughout the campus in the immediate aftermath. Individuals and systems were caught unaware and reacted to the urgency of the moment and the enormity of the event. There was an outpouring of effort to help and to provide for the safety of everyone. Responders scrambled to offer solace to the despairing and to meet emergency needs for medical care and comfort to the injured. These initial spontaneous responses helped to stabilize some of the impact of the devastation as it unfolded.

Grief-stricken university leaders, faculty, staff, and law enforcement worked together to monitor the rapidly changing situation and set up a location where families could assemble. Some family members arrived not knowing whether their child, spouse, or sibling had been taken to a hospital for treatment for their wounds, or to a morgue. University officials designated The Inn at Virginia Tech as the main gathering place for families.

- Actions by Virginia Tech section bear a very close read. Most colleges place much emphasis on emergency response and immediate management of the incident. Long term
care and follow-up at most campuses will get overwhelmed without some careful planning about sustained response.

- One of the continuing challenges was the fact that a crime had been committed; those shot were crime victims; and there are public protocols for dealing with families of crime victims. As seen in incidents such as 9/11, the families of victims become a continuing and powerful force long after the incident.
- This chapter has much more to say about the family assistance center (FAC), pp. 139-142.
- Key Findings are presented below. See Chapter XI Recommendations, all of which are relevant. While XI-11 refers to universities in Virginia, the same can be said about those in many states.

KEY FINDINGS – AFTERMATH [pp. 145-146]

Mass fatality events, especially where a crime is involved, present enormous challenges with regard to public information, victim assistance, and medical examiner’s office operations. Time is critical in putting an effective response into motion.

Discussions with the family members of the deceased victims and the survivors and their family members revealed how critical it is to address the needs of those most closely related to victims with rapid and effective victim services and an organized family assistance center with carefully controlled information management. Family members of homicide victims struggle with two distinct processes: the grief associated with the loss of a loved one and the wounding of the spirit created by the trauma. Together they impose the tremendous burden of a complicated grieving process.

Post traumatic stress is likely to have affected many dozens of individuals beginning with the men and women who were in the direct line of fire or elsewhere in Norris Hall and survived, and the first responders to the scene who dealt with the horrific scene.

While every injured victim and every family member of a deceased victim is unique, much of what they reported about the confusion and disorganization following the incident was similar in nature.

Numerous families reported frustration with poor communications and organization in the university’s outreach following the tragedy, including errors and omissions made at commencement proceedings.

A coordinated system-wide response to public safety is lacking. With the exception of the Virginia community College System, which immediately formed an Emergency Preparedness Task Force for its 23 institutions, the response of the state-supported colleges and universities has been uncoordinated. To the panel’s knowledge, there have been no meetings of presidents and senior administrators to discuss such issues as guns on campus, privacy laws, admissions processes, and critical incident management plans. The independent colleges and universities met collectively with members of the panel, and the community colleges have met with panel members two times. The presidents of the senior colleges and universities declined a request to meet with members of the panel June 26, saying it was “not timely” to do so.

The presenter wishes to thank David S. Haviland, Professor Emeritus, Rensselaer Polytechnic Institute, Troy, New York for his research and assistance in the preparation of these written materials.

Synopsis of Virginia Tech Review Panel Report (08/07) by Charles F. Carletta
VT Report Recommendation | Your Campus Status and Next Steps
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**CHAPTER II. UNIVERSITY SETTING AND SECURITY: EMERGENCY PLANNING**

**II-1** Universities should do a risk analysis (threat assessment) and then choose a level of security appropriate for their campus. How far to go in safeguarding campuses, and from which threats, needs to be considered by each institution. Security requirements vary across universities, and each must do its own threat assessment to determine what security measures are appropriate.

**II-2** Virginia Tech should update and enhance its Emergency Response Plan and bring it into compliance with federal and state guidelines.

**II-3** Virginia Tech and other institutions of higher learning should have a threat assessment team that includes representatives from law enforcement, human resources, student and academic affairs, legal counsel, and mental health functions. The team should be empowered to take actions such as additional investigation, gathering background information, identification of additional dangerous warning signs, establishing a threat potential risk level (1 to 10) for a case, preparing a case for hearings (for instance, commitment hearings), and disseminating warning information.

**II-4** Students, faculty, and staff should be trained annually about responding to various emergencies and about the notification systems that will be used. An annual reminder provided as part of registration should be considered.

**II-5** Universities and colleges must comply with the Clery Act, which requires timely public warnings of imminent danger. “Timely” should be defined clearly in the federal law.

**CHAPTER II. UNIVERSITY SETTING AND SECURITY: CAMPUS ALERTING**

**II-6** Campus emergency communications systems must have multiple means of sharing information.

**II-7** In an emergency, immediate messages must be sent to the campus community that provide clear information on the nature of the emergency and actions to be taken. The Initial messages should be followed by update messages as more information becomes known.
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<tr>
<th>VT Report Recommendation</th>
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<tr>
<td>II-8 Campus police as well as administration officials should have the authority and</td>
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<td>capability to send an emergency message. Schools without a police department or senior</td>
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<td>security official must designate someone able to make a quick decision without</td>
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<td>convening a committee.</td>
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<td>CHAPTER II. UNIVERSITY SETTING AND SECURITY: POLICE ROLE AND TRAINING</td>
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<td>II-9 The head of campus police should be a member of a threat assessment team as well</td>
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<td>as the emergency response team for the university. In some cases where there is a</td>
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<td>security department but not a police department, the security head may be appropriate.</td>
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<td>II-10 Campus police must report directly to the senior operations officer responsible</td>
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<td>for emergency decision making. They should be part of the policy team deciding on</td>
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<td>emergency planning.</td>
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<td>II-11 Campus police must train for active shooters (as did the Virginia Tech Police</td>
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<td>Department). Experience has shown that waiting for a SWAT team often takes too long.</td>
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<td>The best chance to save lives is often an immediate assault by first responders.</td>
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<td>II-12 The mission statement of campus police should give primacy to their law</td>
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<td>enforcement and crime prevention role. They also must to be designated as having a</td>
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<td>function in education so as to be able to review records of students brought to the</td>
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<td>attention of the university as potential threats. The lack of emphasis on safety as the</td>
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<td>first responsibility of the police department may create the wrong mindset, with the</td>
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<td>police yielding to academic considerations when it comes time to make decisions on,</td>
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<td>say, whether to send out an alert to the students that may disrupt classes. On the</td>
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<td>other hand, it is useful to identify the police as being involved in the education role</td>
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<td>in order for them to gain access to records under educational privacy act provisions.</td>
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<td>CHAPTER IV. CHO’S MENTAL HEALTH HISTORY</td>
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<tr>
<td>IV-1 Universities should recognize their responsibility to a young, vulnerable</td>
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<td>population and promote the sharing of information internally, and with parents, when</td>
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<td>significant circumstances pertaining to health and safety arise.</td>
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<td>IV-2 Institutions of higher learning should review and revise their current policies</td>
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<td>related to— a) recognizing and assisting students in distress b) the student code of</td>
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<td>conduct, including enforcement c) judiciary proceedings for students, including</td>
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<td>enforcement d) university authority to appropriately intervene when it is believed a</td>
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<td>distressed student poses a danger to himself or others</td>
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<td>IV-3 Universities must have a system that links troubled students to appropriate medical and counseling services either on or off campus, and to balance the individual's rights with the rights of all others for safety.</td>
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<td>IV-4 Incidents of aberrant, dangerous, or threatening behavior must be documented and reported immediately to a college's threat assessment group, and must be acted upon in a prompt and effective manner to protect the safety of the campus community.</td>
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<td>IV-5 Culturally competent mental health services were provided to Cho at his school and in his community. Adequate resources must be allocated for systems of care in schools and communities that provide culturally competent services for children and adolescents to reduce mental-illness-related risk as occurred within this community.</td>
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<td>IV-6 Policies and procedures should be implemented to require professors encountering aberrant, dangerous, or threatening behavior from a student to report them to the dean. Guidelines should be established to address when such reports should be communicated by the dean to a threat assessment group, and to the school's counseling center.</td>
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<td>IV-7 Reporting requirements for aberrant, dangerous, or threatening behavior and incidents for resident hall staff must be clearly established and reviewed during annual training.</td>
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<td>IV-8 Repeated incidents of aberrant, dangerous, or threatening behavior must be reported by Judicial Affairs to the threat assessment group. The group must formulate a plan to address the behavior that will both protect other students and provide the needed support for the troubled student.</td>
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<td>IV-9 Repeated incidents of aberrant, dangerous, or threatening behavior should be reported to the counseling center and reported to parents. The troubled student should be required to participate in counseling as a condition of continued residence in campus housing and enrollment in classes.</td>
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<td>IV-10 The law enforcement agency at colleges should report all incidents of an issuance of temporary detention orders for students (and staff) to Judicial Affairs, the threat assessment team, the counseling center, and parents. All parties should be educated about the public safety exceptions to the privacy laws which permit such reporting.</td>
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<td>IV-11 The college counseling center should report all students who are in treatment pursuant to a court order to the threat assessment team. A policy should be implemented to address what information can be shared with family and roommates pursuant to the public safety exceptions to the privacy laws.</td>
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<td>IV-12 The state should study what level of community outpatient service capacity will be required to meet the needs of the commonwealth and the related costs in order to adequately and appropriately respond to both involuntary court-ordered and voluntary referrals for those services. Once this information is available it is recommended that outpatient treatments services be expanded statewide.</td>
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Note: Recommendations IV-13 through IV-24 are specific to Virginia Code and are not included.

CHAPTER V. INFORMATION PRIVACY LAWS
Note: See Report pp. 69-70 for additional text for recommendations V-1 through V-4, and V-6.

V-1 Accurate guidance should be developed by the attorney general of Virginia regarding the application of information privacy laws to the behavior of troubled students.

V-2 Privacy laws should be revised to include “safe harbor” provisions.

V-3 The following amendments to FERPA should be considered: FERPA should explicitly explain how it applies to medical records held for treatment purposes. FERPA should make explicit an exception regarding treatment records.

V-4 The Department of Education should allow more flexibility in FERPA’s “emergency” exception.

V-5 Schools should ensure that law enforcement and medical staff (and others as necessary) are designated as school officials with an educational interest in school records. This FERPA-related change does not require amendment to law or regulation. Education requires effective intervention in the lives of troubled students. Intervention ensures that schools remain safe and students healthy. University policy should recognize that law enforcement, medical providers, and others who assist troubled students have an educational interest in sharing records. When confirmed by policy, FERPA should not present a barrier to these entities sharing information with each other.

V-6 The Commonwealth of Virginia Commission on Mental Health Reform should study whether the result of a commitment hearing (whether the subject was voluntarily committed, involuntarily committed, committed to outpatient therapy, or released) should also be publicly available despite an individual’s request for confidentiality.

CHAPTER VI. GUN PURCHASE AND CAMPUS POLICIES Note: See Report p. 76 for additional text for recommendations VI-1 through VI-4.

VI-1 All states should report information necessary to conduct federal background checks on gun purchases.

VI-2 Virginia should require background checks for all firearms sales, including those at gun shows.
### Attachment A

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<tr>
<td>VI-3 Anyone found to be a danger to themselves or others by a court-ordered review should be entered in the Central Criminal Records Exchange database regardless of whether they voluntarily agreed to treatment.</td>
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<td>VI-4 The existing attorney general’s opinion regarding the authority of universities and colleges to ban guns on campus should be clarified immediately.</td>
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<td>VI-5 The Virginia General Assembly should adopt legislation in the 2008 session clearly establishing the right of every institution of higher education in the Commonwealth to regulate the possession of firearms on campus if it so desires. The panel recommends that guns be banned on campus grounds and in buildings unless mandated by law.</td>
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<td>VI-6 Universities and colleges should make clear in their literature what their policy is regarding weapons on campus. Prospective students and their parents, as well as university staff, should know the policy related to concealed weapons so they can decide whether they prefer an armed or arms-free learning environment.</td>
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### CHAPTER VII. DOUBLE MURDER AT WEST AMBLER JOHNSTON

| VII-1 In the preliminary stages of an investigation, the police should resist focusing on a single theory and communicating that to decision makers. |
| VII-2 All key facts should be included in an alerting message, and it should be disseminated as quickly as possible, with explicit information. |
| VII-3 Recipients of emergency messages should be urged to inform others. |
| VII-4 Universities should have multiple communication systems, including some not dependent on high technology. Do not assume that 21st century communications may survive an attack or natural disaster or power failure. |
| VII-5 Plans for canceling classes or closing the campus should be included in the university’s emergency operations plan. It is not certain that canceling classes and stopping work would have decreased the number of casualties at Virginia Tech on April 16, but those actions may have done so. Lockdowns or cancellation of classes should be considered on campuses where it is feasible to do so rapidly. |

### CHAPTER VIII. MASS MURDER AT NORRIS HALL

<p>| VIII-1 Campus police everywhere should train with local police departments on response to active shooters and other emergencies. |</p>
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<td>VIII-2</td>
<td>Dispatchers should be cautious when giving advice or instructions by phone to people in a shooting or facing other threats without knowing the situation. This is a broad recommendation that stems from reviewing other U.S. shooting incidents as well, such as the Columbine High School shootings. For instance, telling someone to stay still when they should flee or flee when they should stay still can result in unnecessary deaths. When in doubt, dispatchers should just be reassuring. They should be careful when asking people to talk into the phone when they may be overheard by a gunman. Also, local law enforcement dispatchers should become familiar with the major campus buildings of colleges and universities in their area.</td>
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<td>VIII-3</td>
<td>Police should escort survivors out of buildings, where circumstances and manpower permit.</td>
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<td>VIII-4</td>
<td>Schools should check the hardware on exterior doors to ensure that they are not subject to being chained shut.</td>
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<td>VIII-5</td>
<td>Take bomb threats seriously. Students and staff should report them immediately, even if most do turn out to be false alarms.</td>
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**CHAPTER IX. EMS RESPONSE**

| IX-1                     | Montgomery County, VA should develop a countywide emergency medical services, fire, and law enforcement communications center to address the issues of interoperability and economies of scale. |
| IX-2                     | A unified command post should be established and operated based on the National Incident Management System Incident Command System model. For this incident, law enforcement would have been the lead agency. |
| IX-3                     | Emergency personnel should use the National Incident Management System procedures for nomenclature, resource typing and utilization, communications, interoperability, and unified command. |
| IX-4                     | An emergency operations center must be activated early during a mass casualty incident. |
| IX-5                     | Regional disaster drills should be held on an annual basis. The drills should include hospitals, the Regional Hospital Coordinating Center, all appropriate public safety and state agencies, and the medical examiner’s office. They should be followed by a formal postincident evaluation. |
| IX-6                     | To improve multi-casualty incident management, the Western Virginia Emergency Medical Services Council should review/revise the Multi-Casualty Incident Medical Control and the Regional Hospital Coordinating Center functions. |
| IX-7                     | Triage tags, patient care reports, or standardized Incident Command System forms must be completed accurately and retained after a multi-casualty incident. They are instrumental in evaluating each component of a multi-casualty incident.
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<tr>
<td>IX-8 Hospitalists, when available, should assist with emergency department patient dispositions in preparing for a multi-casualty incident patient surge.</td>
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<td>IX-9 Under no circumstances should the deceased be transported under emergency conditions. It benefits no one and increases the likelihood of hurting others.</td>
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<td>IX-10 Critical incident stress management and psychological services should continue to be available to EMS providers as needed.</td>
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**CHAPTER X. OFFICE OF THE CHIEF MEDICAL EXAMINER**

X-1 The chief medical examiner should not be one of the staff performing the postmortem exams in mass casualty events; the chief medical examiner should be managing the overall response.

X-2 The Office of the Chief Medical Examiner (OCME) should work along with law enforcement, Virginia Department of Criminal Justice Services (DCJS), chaplains, Department of Homeland Security, and other authorized entities in developing protocols and training to create a more responsive family assistance center (FAC).

X-3 The OCME and Virginia State Police in concert with FAC personnel should ensure that family members of the deceased are afforded prompt and sensitive notification of the death of a family member when possible and provide briefings regarding any delays.

X-4 Training should be developed for FAC, law enforcement, OCME, medical and mental health professionals, and others regarding the impact of crime and appropriate intervention for victim survivors.

X-5 OCME and FAC personnel should ensure that a media expert is available to manage media requests effectively and that victims are not inundated with intrusions that may increase their stress.

X-6 The Virginia Department of Criminal Justice Services should mandate training for law enforcement officers on death notifications.

X-7 The OCME should participate in disaster or national security drills and exercises to plan and train for effects of a mass fatality situation on ME operations.

X-8 The Virginia Department of Health should continuously recruit board-certified forensic pathologists and other specialty positions to fill vacancies within the OCME. Being understaffed is a liability for any agency and reduces its surge capability.

X-9 The Virginia Department of Health should have several public information officers trained and well versed in OCME operations and in victims services. When needed, they should be made available to the OCME for the duration of the event.
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<tr>
<td>X-10 Funding to train and credential volunteer staff, such as the group from the</td>
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<td>Virginia Funeral Director's Association, should be made available in order to</td>
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<td>utilize their talents. Had this team been available, the</td>
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<td>family assistance center could have been more</td>
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<td>effectively organized.</td>
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<td>X-11 The Commonwealth should amend its</td>
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<tr>
<td>Emergency Operations Plan to include an emergency support function for mass</td>
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<tr>
<td>fatality operations and family assistance. The new ESF should address roles</td>
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<td>and responsibilities of the state agencies. The topics of family assistance and</td>
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<td>notification are not adequately addressed in the National Response Plan (NRP) for the</td>
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<td>federal government and the state plan that mirrors the NRP also mirrors this weakness.</td>
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<tr>
<td>Virginia has an opportunity to be a national leader by reforming their EOP to this</td>
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<td>effect.</td>
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<td>CHAPTER XI. IMMEDIATE AFTERMATH AND LONG ROAD TO HEALING</td>
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<tr>
<td>XI-1 Emergency management plans should include a section on victim services that</td>
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<tr>
<td>addresses the significant impact of homicide and other disaster-caused deaths on</td>
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<td>survivors and the role of victim service providers in the overall plan. Victim service</td>
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<td>professionals should be included in the planning, training, and execution of crisis</td>
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<td>response plans. Better guidelines need to be developed for federal and state response</td>
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<td>and support to local governments during mass fatality events.</td>
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<td>XI-2 Universities and colleges should ensure that they have adequate plans to stand</td>
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<td>up a joint information center with a public information officer and adequate staff</td>
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<td>during major incidents on campus. The outside resources that are available (including</td>
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<td>those from the state) and the means for obtaining their assistance quickly should be</td>
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<td>listed in the plan. Management of the media and of self-directed volunteers should be</td>
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<td>included.</td>
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<td>XI-3 When a family assistance center is created after a criminal mass casualty event,</td>
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<td>victim advocates should be called immediately to assist the victims and their families.</td>
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<td>Ideally, a trained victim service provider should be assigned to serve as a liaison to</td>
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<td>each victim or victim's family as soon as practical. The victim service should help</td>
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<td>victims navigate the agencies at the FAC.</td>
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<td>XI-4 Regularly scheduled briefings should be provided to victims' families as to the</td>
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<td>status of the investigation, the identification process, and the procedures for</td>
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<td>retrieving the deceased. Local or state victim advocates should be present with the</td>
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<td>families or on behalf of out-of-state families who are not present so that those</td>
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<td>families are provided the same up-to-date information.</td>
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<tr>
<td>VT Report Recommendation</td>
<td>Your Campus Status and Next Steps</td>
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<tr>
<td>XI-5  Because of the extensive physical and emotional impact of this incident, both short- and long-term counseling should be made available to first responders, students, staff, faculty members, university leaders, and the staff of The Inn at Virginia Tech. Federal funding is available from the Office for Victims of Crime for this purpose.</td>
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<tr>
<td>XI-6  Training in crisis management is needed at universities and colleges. Such training should involve university and area-wide disaster response agencies training together under a unified command structure.</td>
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<td>XI-7  Law enforcement agencies should ensure that they have a victim services section or identified individual trained and skilled to respond directly and immediately to the needs of victims of crime from within the department. Victims of crime are best served when they receive immediate support for their needs. Law enforcement and victim services form a strong support system for provision of direct and early support.</td>
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<tr>
<td>XI-8  It is important that the state's Victims Services Section work to ensure that the injured victims are linked with local victim assistance professionals for ongoing help related to their possible needs.</td>
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<tr>
<td>XI-9  Since all crime is local, the response to emergencies caused by crime should start with a local plan that is linked to the wider community. Universities and colleges should work with their local government partners to improve plans for mutual aid in all areas of crisis response, including that of victim services.</td>
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<tr>
<td>XI-10 Universities and colleges should create a victim assistance capability either inhouse or through linkages to county-based professional victim assistance providers for victims of all crime categories. A victim assistance office or designated campus victim advocate will ensure that victims of crime are made aware of their rights as victims and have access to services.</td>
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<tr>
<td>XI-11 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.</td>
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</table>
VIRGINIA TECH GUIDELINES FOR CHOOSING ALERTING SYSTEM

The successful system would provide:

- Multi-modal communications;
  - text messaging (preferably using true Short Message Service [SMS] protocol)
  - Instant Messaging (IM)
  - e-mail
  - web posting
  - voice communication to cellular or land line based extensions (including ability to fax)

- Flexibility in “registering” or “subscribing” users;
  - ability to pre-load based on existing directory data with both APIs and online mechanisms for batch or manual updates

- Robust, but distributed data centers, i.e. more than one location; ability to send alerts even if event impacts vendor’s facility

- Robust, but dispersed messaging; concern is with saturation of communications channels (Part of “Lessons Learned” from 9/11 and previous incident in Blacksburg on first day of Fall Semester 2006; “too much, too soon” will quickly overwhelm cellular and land line telephony systems)

- The vendor would have to be flexible in terms of contracting, and willing to collaborate on further developing the product’s features to meet specific needs identified by Virginia Tech.
INFORMATION PRIVACY LAWS

[This summary was prepared by Skadden, Arps for the Virginia Tech Review Panel]

All Law Enforcement Agencies

- Upon request, must disclose basic criminal incident information (such as a description of the crime and the date it occurred) about felony crimes.
- Upon request, must release the name and address of anyone arrested and charged with any crime.
- Upon request, must release all records about an incident that was not a crime. However, the agency must remove all personal information such as social security numbers.
- Upon request, may release information from investigative files. Law enforcement agencies typically adopt a policy against disclosure.

Universities and Campus Police Departments

- Must keep a publicly-available log that lists all crimes. The log must give the time, date, and location of each offense, as well as the disposition of each case.
- Must disclose the name and address of people arrested for felonies and misdemeanors involving assault, battery, or "moral turpitude."

Juvenile Law Enforcement Records

- Records restricted from disclosure. Agencies can release the records to other parts of the juvenile justice system or to parents.
- Officials may release to school principals information about certain offenders who commit serious felonies, arson, or weapons offenses.

Judicial Records

- Generally, court records can be widely shared.
- Juvenile records are tightly restricted. They can only be disclosed outside the juvenile justice system with a court order.
- Records of commitment hearings must be sealed when the subject of the hearing requests it. If sealed, the records can only be accessed through court order.
Commitment hearings must be open to the public, so certain information is not required to be kept in confidence: name of the subject, and the time, date, and location of the hearing.

Medical Information

- Governed by both state and federal law.
- Federal law is the Health Insurance and Portability and Accountability Act of 1996 and the regulations interpreting it. Virginia law is the Virginia Health Records Privacy Act.
- In most respects, the federal and state laws are similar and can be analyzed together.
- Both laws state that health information is private and can only be disclosed for certain reasons.
- HIPAA can pre-empt a state law, making the state law ineffective. This generally occurs when state law is less protective of privacy than federal law.
- The laws apply to all medical providers and billing entities. They define "provider" broadly: doctors, nurses, therapists, counselors, and social workers, as well as HMOs, insurers, and other health organizations are all included in the definition.
- Requires disclosure of records to patients who are the subject of the records.
- Allows disclosure to anyone when a patient fills out a written authorization.
- Allows sharing when it is necessary for treatment.
- Allows disclosure to relatives with permission or in emergency situations.
- Allows disclosure in situations where legislators and rule-makers have concluded that privacy is outweighed by other interests. For example, providers may disclose in certain situations when an individual presents an imminent threat to the health and safety of individuals and the public. Providers may also disclose information to law enforcement when necessary to locate a fugitive or suspect.
- Providers may disclose information when state law requires it, such as in mandated reports for domestic violence injuries. If the state law only permits disclosure and does not require it, federal law will invalidate the state law.
- Federal law does not apply to records held by school medical facilities. State law does apply.
Educational Records

- Privacy of educational records is primarily governed by federal law, the Family Educational Rights Privacy Act of 1974, as well as regulations that interpret the law.

- FERPA applies to all educational institutions that accept federal funding, whatever the level. As a practical matter, this means almost all institutions of higher learning as well as public elementary and secondary schools.

- FERPA states that information from educational records is private and can only be disclosed for certain reasons.

- FERPA has a different focus than HIPAA. HIPAA protects all medical information gained in the course of treatment, whether in oral or written form. FERPA applies only to information in student records. Personal observations, including information gained from a conversation with a student, fall outside FERPA.

- Applies to health records maintained at university health clinics. However, it was not drafted to address specific issues of medical information.

- State laws about health records also apply. Disclosure is not permitted when a state law is less protective of health records privacy than FERPA. However, state law can be more protective than FERPA. State law can restrict disclosure that FERPA authorizes.

- Records created and held by law enforcement agencies for law enforcement purposes fall outside of FERPA.

- If a law enforcement agency shares a record with the school, the record that is maintained by the school becomes subject to FERPA. The record kept by the law enforcement agency is not subject to FERPA.

- Authorizes disclosure of any record to parents who claim adult students as dependents for tax purposes.

- Authorizes release to parents when the student has violated alcohol or drug laws and is under 21.

- Authorizes use of information by all school officials designated to have a legitimate educational interest in receiving such information.
• Authorizes disclosure of the final result of a disciplinary proceeding that held that a student violated school policy for an incident involving a crime of violence (as defined under federal law) or a sex offense.

• Allows state law to authorize certain uses in the juvenile justice system.

• Authorizes emergency disclosure to any appropriate person in connection with an emergency, "if the knowledge of such information is necessary to protect the health or safety of the student or other persons."

• This exception is to be narrowly construed.

Government Data Collection and Dissemination Practices Act

• Establishes rules for collection, maintenance, and dissemination of individually-identifying data.

• Does not apply to police departments or courts.

• Agencies that are bound by the Act may only disclose information when disclosure is permitted or required by law. "Permitted by law" to include any official request.

• If an agency requests data from another agency for a function it is legally authorized to perform, the request is official.

• The agency releasing the data must inform individuals when their data is disclosed.
GUIDANCE FROM U.S. DEPARTMENT OF EDUCATION

Disclosure of Information from Education Records to Parents of Students Attending Postsecondary Institutions

Recently many questions have arisen concerning the Family Educational Rights and Privacy Act (FERPA), the federal law that protects the privacy of students’ education records. The Department wishes to clarify what FERPA says about postsecondary institutions sharing information with parents.

What are parents’ and students’ rights under FERPA?

At the K-12 school level, FERPA provides parents with the right to inspect and review their children’s education records, the right to seek to amend information in the records they believe to be inaccurate, misleading, or an invasion of privacy, and the right to consent to the disclosure of personally identifiable information from their children’s education records. When a student turns 18 years old or enters a postsecondary institution at any age, these rights under FERPA transfer from the student’s parents to the student. Under FERPA, a student to whom the rights have transferred is known as an “eligible student.” Although the law does say that the parents’ rights afforded by FERPA transfer to the “eligible student,” FERPA clearly provides ways in which an institution can share education records on the student with his or her parents.

While concerns have been expressed about the limitations on the release of information, there are exceptions to FERPA’s general rule that educational agencies and institutions subject to FERPA may not have a policy or practice of disclosing “education records” without the written consent of the parent (at the K-12 level) or the “eligible student.”

When may a school disclose information to parents of dependent students?

Under FERPA, schools may release any and all information to parents, without the consent of the eligible student, if the student is a dependent for tax purposes under the IRS rules.

Can a school disclose information to parents in a health or safety emergency?

The Department interprets FERPA to permit schools to disclose information from education records to parents if a health or safety emergency involves their son or daughter.

Can parents be informed about students’ violation of alcohol and controlled substance rules?

Attachment C-5
Another provision in FERPA permits a college or university to let parents of students under the age of 21 know when the student has violated any law or policy concerning the use or possession of alcohol or a controlled substance.

*Can a school disclose law enforcement unit records to parents and the public?*

Additionally, under FERPA, schools may disclose information from “law enforcement unit records” to anyone – including parents or federal, State, or local law enforcement authorities – without the consent of the eligible student. Many colleges and universities have their own campus security units. Records created and maintained by these units for law enforcement purposes are exempt from the privacy restrictions of FERPA and can be shared with anyone.

*Can school officials share their observations of students with parents?*

Nothing in FERPA prohibits a school official from sharing with parents information that is based on that official’s personal knowledge or observation and that is not based on information contained in an education record. Therefore, FERPA would not prohibit a teacher or other school official from letting a parent know of their concern about their son or daughter that is based on their personal knowledge or observation.

*How does HIPAA apply to students’ education records?*

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a law passed by Congress intended to establish transaction, security, privacy, and other standards to address concerns about the electronic exchange of health information. However, the HIPAA Privacy Rule excludes from its coverage those records that are protected by FERPA at school districts and postsecondary institutions that provide health or medical services to students. This is because Congress specifically addressed how education records should be protected under FERPA. For this reason, records that are protected by FERPA are not subject to the HIPAA Privacy Rule and may be shared with parents under the circumstances described above.

In all of our programs here at the Department of Education, we consistently encourage parents’ involvement in their children’s education. FERPA is no exception. While the privacy rights of all parents and adult students are very important, there are clear and straightforward ways under FERPA that institutions can disclose information to parents and keep them involved in the lives of their sons and daughters at school.
Experts who evaluate possible indicators that an individual is at risk of harming himself or others know to seek out many sources for clues, certain red flags that merit attention. A single warning sign by itself usually does not warrant overt action by a threat assessment specialist. It should, however, attract the attention of an assessor who has been sensitized to look for other possible warning signs. If additional warning signs are present then more fact-finding is warranted to determine if there is a likelihood of danger.

Some warning signs carry more weight than others. For instance, a fascination with, and possession of, firearms are more significant than being a loner, because possession of firearms gives one the capacity to carry out an attack. But if a person simply possesses firearms and has no other warning signs, it is unlikely that he represents a significant risk of danger.

When a cluster of indicators is present then the risk becomes more serious. Thus, a person who possesses firearms, is a loner, shows an interest in past shooting situations, writes stories about homicide and suicide, exhibits aberrant behavior, has talked about retribution against others, and has a history of mental illness and refuses counseling would obviously be considered a significant risk of becoming dangerous to himself or others. A school threat assessment team upon learning about such a list of warning signs would be in a position to take immediate action including:

- Talking to the student and developing a treatment plan with conditions for remaining in school
- Calling the parents or other guardians
- Requesting permission to receive medical and educational records
- Checking with law enforcement to ascertain whether there have been any interactions with police
- Talking with roommates and faculty
- Suspending the student until the student has been treated and doctors indicate the student is not a safety risk

Following are some warning signs (indicators and red flags) associated with school shootings in the United States. Schools, places of employment, and other entities that are creating a threat assessment capability may want to be aware of these red flags:

**Violent fantasy content** –

- Writings (Stories, essays, compositions),
- Drawings (Artwork depicting violence),
Reading and viewing materials (Preference for books, magazines, television, video tapes and discs, movies, music, websites, and chat rooms with violent themes and degrading subject matter), and role playing acts of violence and degradation.

**Anger problems** –
Difficulty controlling anger, loss of temper, impulsivity,
Making threats

**Fascination with weapons and accoutrements** –
Especially those designed and most often used to kill people (such as machine guns, semiautomatic pistols, snub nose revolvers, stilettos, bayonets, daggers, brass knuckles, special ammunition and explosives)

**Boasting and practicing of fighting and combat proficiency** –
Military and sharpshooter training, martial arts, use of garrotes, and knife fighting

**Loner** –
Isolated and socially withdrawn, misfit, prefers own company to the company of others

**Suicidal ideation** –
Depressed and expresses hopelessness and despair
Reveals suicidal preparatory behavior

**Homicidal ideation** –
Expresses contempt for other(s)
Makes comments and/or gestures indicating violent aggression

**Stalking** –
Follows, harasses, surveils, attempts to contact regardless of the victim's expressed annoyance and demands to cease and desist

**Non-compliance and disciplinary problems** –
Refusal to abide by written and/or verbal rules

**Imitation of other murderers** –
Appearance, dress, grooming, possessions like those of violent shooters in past episodes (e.g. long black trench coats)

**Interest in previous shooting situations** –
Drawn toward media, books, entertainment, conversations dealing with past murders

Attachment D-2
Victim/martyr self-concept –
Fantasy that some day he will represent the oppressed and wreak vengeance on the oppressors

Strangeness and aberrant behavior –
Actions and words that cause people around him to become fearful and suspicious

Paranoia –
Belief that he is being singled out for unfair treatment and/or abuse; feeling persecuted

Violence and cruelty –
A history of using violence to solve problems (fighting, hitting, etc.), abusing animals or weaker individuals

Inappropriate affect –
Enjoying cruel behavior and/or being able to view cruelty without being disturbed

Acting out –
Expressing disproportionate anger or humor in situations not warranting it, attacking surrogate targets

Police contact –
A history of contact with police for anger, stalking, disorderly conduct;
Past temporary restraining orders (or similar court orders),
A jail/prison record for aggressive crimes

Mental health history related to dangerousness –
A history of referral or commitments to mental health facilities for aggressive/destructive behavior

Expressionless face/anhedonia –
An inability to express and/or experience joy and pleasure

Unusual interest in police, military, terrorist activities and materials
Vehicles resembling police cars, military vehicles, surveillance equipment, handcuffs, weapons, clothing (camouflage, ski masks, etc.)

Use of alcohol/drugs –
Alcohol/drugs are used to reduce inhibitions so that aggressive behaviors are more easily expressed
Attachment E

REACTIONS TO EMOTIONAL TRAUMA AND LOSS

In one horrific moment on 9/11/01, we were all exposed to a traumatic assault on our sense of well-being. For many there is also an intense feeling of loss. For some, the emotional reactions to this experience were intense and immediate. For others, the initial reaction was that of “numbness.” Many of the latter group will find the emotional reactions will hit later when they are not expecting it.

What follows is a summary of some of the common stages found in our reactions to grief and loss. Each of us may react a little differently but don’t be surprised to find yourself going through any or all of the stages. Please do not hesitate to seek support if you find yourself having a hard time no matter which “stage” you are going through.

1. **Shock**

Some never go through a prolonged stage of shock and are able to express emotions immediately. Others feel numb and that no emotions or tears come. Sometimes there is denial. Gradually people become aware of what has happened and are able to cry or show other emotions.

2. **Emotional Release**

One begins to feel and to hurt. Many people begin at this point. It is good to cry in grief. If one does not express this emotion, it will be expressed in some other way – on the physical or emotional level. Some people need to be induced to cry. This is particularly true of men, as our culture makes many men feel uneasy to cry.

3. **Preoccupation with the loss**

The person may try to think of other things but find him/herself unable to shift his/her mind from those lost. This can include fear of potential loss of loved ones in the future.

4. **Symptoms of some physical and emotional distresses**

Most common physical distresses are:

- sleeplessness
- tightness in the throat
- choking with shortness of breath
- empty, hollow feeling in the stomach
- lack of muscular power (“everything I lift seems so heavy”)
- digestive symptoms and poor appetite
Attachment E

Most common emotional distresses are:
   a. slight sense of unreality
   b. feeling of emotional distance from people – that no one really cares or understands
   c. sometimes there are feelings of panic
   d. thoughts of self-destruction
   e. desire to run away

These feelings are normal and natural.

5. Hostile Reactions

There is often a disconcerting loss of warmth in relationships and a tendency to respond with irritability and anger. These feelings can be surprising and inexplicable to the survivor and may even be directed toward friends or family members who for various reasons cannot provide the emotional support the person expected.

Anger may be directed towards those seen as responsible for the loss. A danger in the current situation is that some will place blame where it does not belong, blaming those who share some similarity to those actually responsible.

6. Guilt

There is frequently some sense of guilt in grief. People think of the things they felt they should have done but didn't. Those who have survived often feel guilt that they survived and others did not.

7. Depression

Many feel total despair, unbearable loneliness, and hopelessness; nothing seems worthwhile. These feelings may be even more intense for those who live alone or who have little family. These feelings are normal.

8. Withdrawal

Many tend to withdraw from social relationships. Regular routines have been disrupted. Life seems like a bad dream.
9. **Re-entry into relationships**

Time and ventilation of feelings will finally produce a better situation. Eventually light shines through the gloom and the darkness of despair and life comes into clearer focus. The person readjusts to the environment.

10. **Resolution and readjustment to reality**

This gradually comes, but the scar is still there. There are times when cycles of grief will hit the person and there will be emotional outbursts – this is normal. Holidays and anniversaries of the person’s death are particularly difficult times.

**TO MOVE THROUGH THESE TEN STAGES, IT IS NECESSARY TO EXPRESS THE FEELINGS AND PAIN IN THE PROCESS. VENTILATION OF FEELING ALLOWS THE PERSON TO EMERGE WITH INCREASED WARMTH, DEPTH, AND UNDERSTANDING OF ONE’S LIFE SITUATION.**

(Revised from an open source handout from the University of California, Santa Barbara and Rensselaer Polytechnic Institute)
Attachment F

EXAMPLE OF STATUTORY PRIVILEGE OF CONFIDENTIALITY

A. PHYSICIAN – PATIENT PRIVILEGE (CPLR Sec. 4504)
   1. Medical professionals cannot disclose information acquired while
      attending a patient in a professional capacity.
   2. Applies to physicians, dentists, podiatrists, chiropractors, and nurses.
   3. Information obtained must have been necessary for treatment.
   4. Can be waived by patient.
   5. Exceptions:
      a. Health care providers must disclose information that a patient
         under 16 has been the victim of a crime.
      b. Dentists must disclose information necessary to identify their
         patients.
      c. Does not apply to child abuse/neglect cases in Family Court
         (Family Court Act Sec. 1046, Social Services Law Sec. 413
         and 415).
      d. Gunshot and serious knife wounds must be reported (Penal
         Law Sec. 265.23).
      e. Certain types of communicable diseases must be reported
         (Public Health Law Sec. 2101).
      f. Patients addicted to narcotic drugs must be reported (Public
         Health Law Sec. 3372 and 3373).

B. PSYCHOLOGIST – PATIENT PRIVILEGE (CPLR 4507)
   1. Communications between licensed psychologist and patient are privileged
      and treated the same as those between attorney and client and physician
      and patient.
   2. Exceptions:
      a. Does not apply to child abuse/neglect cases in family court (Family
         Court Act Sec. 1046, Social Services Law Sec. 413 and 415).
SOME STEPS TO TAKE TO PROPERLY SHARE CONFIDENTIAL INFORMATION

1. A foundation of regular practiced communication among the parties is essential.
   - Counseling Center
   - Health Center
   - Dean of Students
   - Public Safety
   - Residence Life
   - Appropriate Vice Presidents
   - General Counsel

2. Some questions to ask:
   a. I sent you John Student; has he shown up for his assignment?
      - yes or no?
      - I cannot answer that.