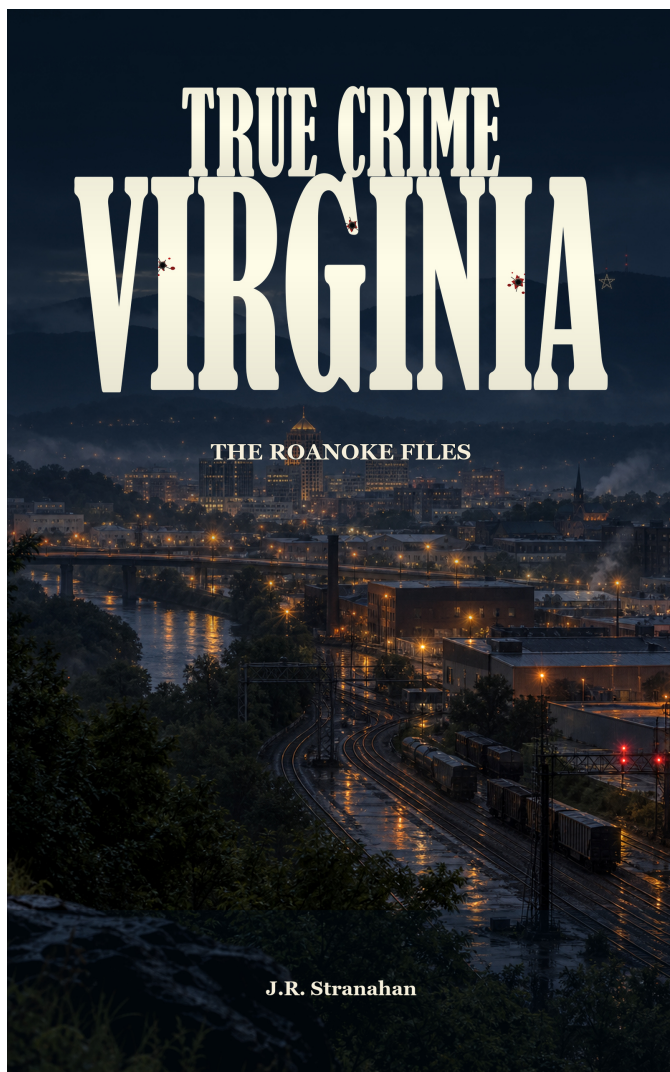


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Thirty-Two Stones

Two places in Blacksburg

The attack at Virginia Tech on April 16, 2007, occurred in two buildings and entered the public record through several different kinds of inquiry. A governor's review panel reconstructed the day and examined institutional systems. State courts later considered wrongful-death claims. The United States Department of Education decided whether the university had met federal campus-warning requirements. Virginia Tech reported changes to its own practices. Each record answered a different question.[VT1][VT3][VT4]

The geography is exact. Virginia Tech is in Blacksburg, in Montgomery County. West Ambler Johnston Hall was a residence hall. Norris Hall was an engineering building across campus. The first attack killed Emily Jane Hilscher and Ryan Christopher Clark. The second killed thirty students and faculty members. The person responsible then killed himself. The stable count is thirty-two people murdered, separate from the perpetrator's death.[VT1]

Those numbers can hide the lives they count. Virginia Tech's remembrance pages describe Hilscher as a freshman in animal and poultry sciences from Woodville, Virginia. She was a horsewoman and an animal lover who intended to become a veterinarian. She had joined the equestrian team that spring and was preparing for another competition.[VT5]

Clark, known to friends as Stack, was a senior from Martinez, Georgia. He had completed work toward degrees in biology, English and psychology while maintaining a 4.0 grade-point average. He played baritone in the Marching Virginians, worked in student programs and served as the resident adviser in West Ambler Johnston. His record at Virginia Tech joined academic work, music and service.[VT5]

The thirty people killed at Norris Hall were Ross Alameddine, Christopher Bishop, Brian Bluhm, Austin Cloyd, Jocelyne Couture-Nowak, Kevin Granata, Matthew Gwaltney, Caitlin Hammaren, Jeremy Herbstritt, Rachael Hill, Jarrett Lane, Matthew La Porte, Henry Lee, Liviu Librescu, G. V. Loganathan, Partahi Lumbantoruan, Lauren McCain, Daniel O'Neil, Juan Ortiz-Ortiz, Minal Panchal, Daniel Perez, Erin Peterson, Michael Pohle Jr., Julia Pryde, Mary Read, Reema Samaha, Waleed Shaalan, Leslie Sherman, Maxine Turner and Nicole White. They included undergraduate and graduate students, instructors and professors. Their fields ranged from languages and international studies to engineering, architecture and biology.[VT1]

The list matters because much of the later record is organized around the man who killed them or the institutions that responded. A responsible account returns the names to the center. It also resists turning an official reconstruction into a scene that no witness could have observed from beginning to end.

The first call

Hilscher entered West Ambler Johnston at 7:02 that morning, according to the residence hall's card record. The shooter's own card recorded his return to Harper Hall at 7:17. The revised panel report therefore placed the first attack between a few minutes after 7:02 and a few minutes before 7:17. It could not supply a more exact time.[VT1]

Nor could the report explain how he entered the residential part of the building. His student mailbox was in a public foyer, but that access did not open the interior residence area at that hour. He may have followed someone through a door or entered while another student left. No witness established the method.[VT1]

The selection of Hilscher also remained unexplained. Investigators found no documented relationship between her and the shooter. He had previously harassed a different woman who lived on the same floor, but the panel found no evidence that connected that history to Hilscher. The

material he later mailed to a television network did not explain the first attack. The report discussed possible theories and rejected certainty. A rehearsal, a diversion, a personal selection and a random opportunity remained speculation.[VT1]

Clark lived next door. The panel presumed that he responded to disturbing sounds and was shot when he came to investigate. The report identified no witness to that sequence. The record supports his presence, his role as resident adviser and the location of the attack. It does not support invented words, a reconstructed decision or a private final thought.[VT1]

Students nearby did not immediately identify what they heard as gunfire. A fall from a loft bed seemed possible. The first call to Virginia Tech police came at 7:20. An officer arrived at West Ambler Johnston at 7:24. Virginia Tech rescue personnel reached room 4040 at 7:29 and found two people with gunshot wounds.[VT1]

Clark could not be resuscitated. Hilscher was taken first to Montgomery Regional Hospital and then to Carilion Roanoke Memorial Hospital. She lived for hours after the attack. The panel concluded that the treatment and transport decisions were appropriate and that the injuries were not survivable. It separately found that neither the university nor the hospitals notified her family before she died. Her family learned she had been harmed through the family of her boyfriend and then struggled to find where she had been taken.[VT1]

The distinction between medical response and family communication recurs throughout the official review. One system can perform a technical task well while another fails the people waiting for information. The panel did not say an earlier call would have allowed Hilscher's family to reach the hospital in time. It said that notification should have been an immediate priority and that the family should not have been left searching without reliable information.[VT1]

A lead and a warning

Police secured West Ambler Johnston, began processing the room and interviewed residents. The building was effectively locked down while the first work continued. No witness supplied a description of the shooter. Bloody footprints and cartridge cases were evidence, but they did not then identify the person who had left them.[VT1]

At 7:40, Virginia Tech Police Chief Wendell Flinchum learned of the shootings. He requested assistance from the Blacksburg Police Department at 7:51 and reached the university executive vice president's office at 7:57. President Charles Steger was notified shortly after eight. At 8:11, Flinchum told Steger that one student was critically wounded, one had died, no weapon had been found and bloody footprints were present. The incident appeared domestic in nature, he said.[VT1]

That impression preceded the lead on which the investigation soon focused. Hilscher's roommate entered West Ambler Johnston at 8:14 and was interviewed after her arrival. She told investigators that Hilscher's boyfriend, Karl Thornhill, usually brought her back on Monday mornings and that he owned firearms. Police began looking for him and his truck. Until that interview, they did not have him as a person of interest.[VT1]

The phrase person of interest was a starting point, not a charge. Investigators had reason to locate the last known person who had been with Hilscher. They did not yet know that the same shooter would attack a second building. Their early theory treated the dormitory shootings as a targeted domestic event and placed the likely person of interest away from campus.

The university's Policy Group met at 8:25 to decide how to notify the campus. At 8:40, Flinchum told Steger that Hilscher's boyfriend was a person of interest and probably off campus. The police continued their investigation and staged emergency response teams. They did not recommend that the university send an alert or cancel classes. Under

the emergency plan then used in practice, the Policy Group controlled release of the warning and only two university officials had the code needed to send it.[VT1]

The record also shows that people with partial information took protective action before the university sent a campuswide message. Blacksburg public schools locked down. The university's Center for Professional and Continuing Education and veterinary college did so independently. Bank-deposit pickups and trash collection were canceled. These decisions do not prove that the whole campus understood a continuing threat. They show that knowledge of the first shooting changed conduct while the official message was still being prepared.[VT1][VT3]

The first campuswide email went out at 9:26, more than two hours after the initial emergency call. It said a shooting incident had occurred at West Ambler Johnston, police were investigating and the university community should be cautious and report anything suspicious. It did not say that one student had died, another had been critically wounded, the shooter was unidentified or the weapon had not been found.[VT1][VT3]

The panel separated an alert from a full physical lockdown. Virginia Tech then had more than a hundred major buildings, many entrances, open roads and paths, and a daytime population comparable to a small city. Police consulted by the panel did not think officers could seal the entire campus quickly. Canceling classes and directing people to remain where they were was more feasible, although any instruction carried risk when the shooter's location was unknown. Sending people outdoors could expose them to danger there. Keeping them inside could place them in the same building as the attacker.[VT1]

Those difficulties did not answer the warning question. The panel found that adults on campus could use accurate information to make choices about their own safety. An earlier message could have reached more people before nine o'clock classes. A clearer message could have told recipients that the violence was serious and unresolved. The report did

not claim that one wording or one closure order would certainly have prevented the Norris Hall attack. It concluded that the possibility of reducing harm justified earlier, explicit notice.[VT1]

By then police had stopped Thornhill on a road away from campus. He cooperated with questions and allowed officers to examine his truck and shoes and collect a gunshot-residue sample. The sample did not produce a field result. It required laboratory work and was never analyzed because later events resolved the question another way. Older accounts said he passed a residue test; the corrected report withdrew that claim.[VT1]

Police did not establish the link between the two attack sites until ballistic examination and other evidence became available. The morning's changing suspicions cannot be rewritten as if investigators already possessed the later result. Nor does the early theory erase the information the university did have: two students had been shot, no one was in custody and the weapon had not been recovered.

Norris Hall

At 9:01, the shooter mailed a package at the Blacksburg post office. It contained photographs, recorded statements and written material prepared earlier. The review panel examined it but found no complete explanation for the first victims or a coherent motive for the attack. Reproducing its performance would give the killer's chosen presentation more space than it deserves. Its evidentiary importance is narrower: he had prepared a public message, mailed it before the second attack and anticipated the violence that followed.[VT1]

He reached Norris Hall carrying two semiautomatic handguns, ammunition, chains and other equipment. He chained the three public entrances from the inside. A note threatening a bomb was placed on an interior door leading to one of the vestibules. A faculty member gave it to a custodian to carry to the dean's office. A call to police had not been completed when the shooting began.[VT1]

People had seen the chains and had seen the shooter looking into classrooms. The signs did not then join into a recognized warning. Construction was underway, and a chained door could be mistaken for part of that work. Earlier bomb threats elsewhere on campus had proved false. The report recorded failures to report the chains and bomb note. Its recommendations called for immediate reporting of bomb threats and changes to door hardware.[VT1]

The shooting began at about 9:40 on the second floor. The panel cautioned that its account conveyed the principal actions rather than an exact route through every doorway. The first attack was in room 206, an advanced hydrology class taught by Professor G. V. Loganathan. The shooter then moved among nearby rooms, sometimes returning after he had left.[VT1]

In room 207, Christopher Bishop was teaching German. A student tried to free a podium fixed to the floor to use as a barricade. After the shooter left, wounded and uninjured students held the door against his return. They kept their bodies low and away from the center. He fired near the handle but did not regain entry.[VT1]

Room 211 held Jocelyne Couture-Nowak's French class. At her direction, Colin Goddard called 911. After he was wounded, Emily Haas kept the open phone hidden near her head while she lay still. That call gave dispatchers continuing information. The class tried to block the door with the instructor's table, but the shooter forced his way inside and later returned.[VT1]

Students in room 205, a scientific-computing class, heard the shots and held their door closed. The shooter pushed against it and fired through it but did not enter. No one in that room was wounded by gunfire.[VT1]

In room 204, Professor Liviu Librescu braced himself against the door and directed students toward the windows. Ten students escaped through them. Librescu was shot through the door and killed. Other students were wounded while trying to leave. The windows were nineteen feet above the ground, and people who escaped suffered

injuries from the fall as well as from gunfire.[VT1]

Kevin Granata was on the third floor. He first directed students into a small room and helped secure them. Then he went toward the sound from the second floor and was killed. Others hid in locked offices, laboratories and restrooms until police cleared the building.[VT1]

There was no single response available to everyone. Some people barricaded a door. Some escaped through windows. Some lay still among the dead and survived. Some went toward danger to protect or help others. The records support these actions without requiring a writer to supply courage as dialogue or fear as an imagined interior monologue.

Three minutes and a chained door

The first 911 call reporting shots reached Virginia Tech police at 9:42. The first officers arrived at Norris Hall at 9:45. Many police were already nearby because of the West Ambler Johnston investigation. Virginia Tech and Blacksburg officers had trained together and moved as mixed teams rather than pausing to sort themselves by agency.[VT1]

The officers determined that the shots came from inside. They tried one public entrance and then another, finding both chained. A shot at the lock on the second door did not open it. They moved to a maintenance-shop entrance whose ordinary lock had not been chained, shot that lock open and entered at about 9:50.[VT1]

Five officers formed the first team. A second mixed team entered moments later. The first moved toward the gunfire on the second floor while the second reached the opposite end and then cleared the third floor to avoid creating a crossfire. As the first officers reached the second-floor corridor, the shooting stopped. The shooter had killed himself in room 211.[VT1]

The panel estimated that the attack in Norris Hall lasted about ten to twelve minutes, with roughly nine minutes passing after the first call

reached campus police. Investigators recovered evidence that at least 174 rounds had been fired. More than 200 live cartridges remained. Thirty students and faculty members had been killed there, seventeen had been wounded by gunfire and others were hurt while escaping.[VT1]

Photographs broadcast that day showed officers outside behind trees and vehicles. Those images did not show the officers already advancing inside. The police outside were establishing a perimeter in case another shooter emerged. The difference between a photograph's frame and the whole response matters. The panel found the entry extraordinarily fast and credited joint training and immediate active-shooter tactics with saving lives.[VT1]

Once the firing stopped, officers had to move between two duties. They searched rooms for another attacker and began carrying survivors out. The use of two different-caliber weapons had created a reasonable initial fear that more than one shooter might be present. Officers could not assume every hidden person was safe or that the dead man was the only threat. Some survivors experienced the armed room clearing as another frightening encounter. The report treated that fear as real while finding that police had correctly put the search first.[VT1]

At about 9:50, a second campus message announced that a gunman was loose and instructed people to remain in buildings and stay away from windows. The message arrived as police were entering Norris Hall. A later notice said a shooter was in custody while police searched for another. The shooter was dead, not arrested. The wording recorded uncertainty during the response; it was not a legal description of an apprehension.[VT1]

The living and the dead

Virginia Tech's student-run rescue squad had responded to the first attack. When its members heard the Norris Hall call on the police radio, they activated their mass-casualty plan and staged until police permitted entry. Tactical medics entered with police and began triage at about 9:52.[VT1]

The first triage inside the building had to identify who could benefit from immediate treatment. Medics divided the classrooms between them and used a rapid classification system. They applied chest seals, controlled bleeding and taught police officers to use medical supplies while the building was still being secured. The panel identified application of a tourniquet to a severe leg wound as probably lifesaving.[VT1]

Responders moved patients from the building to treatment areas and then to hospitals according to the urgency of their injuries. The last transport did not imply that someone with the most critical survivable injury had simply waited. Less severely injured patients could remain in a treatment area while the people in immediate danger went first. Every Norris Hall patient who was alive after the shooting survived through hospital discharge, according to the panel.[VT1]

The review praised that result and the relationships among rescue agencies. It also found problems. Virginia Tech police and Montgomery County communications sent separate dispatches. Agencies used different radio systems. Responders were initially uncertain about staging and command. A unified command post and emergency operations center were not established early enough to coordinate the wider event. These weaknesses did not negate the lifesaving work. They explained why successful medical care could coexist with confusion around it.[VT1]

The Office of the Chief Medical Examiner faced a different responsibility. Because the deaths resulted from crime, it had to identify each person scientifically, determine cause and manner of death and preserve evidence. The Roanoke regional office received help from staff

elsewhere in Virginia. Fingerprints became the primary means of identification, with dental records and other individual characteristics available where needed.[VT1]

The office completed the examinations and thirty-three legal identifications, including the shooter, within three working days. The panel found that the technical work was accurate and appropriately performed under intense pressure. It reached a sharply different judgment about public information and family care.[VT1]

Families gathered at The Inn at Virginia Tech without a single reliable source for answers. The university assigned liaisons, many of whom families later described as caring and helpful. The volunteers had not been trained for a mass-fatality response and did not all have the information or ability to continue for the time families needed. Professional victim-service personnel did not arrive in force until two days after the attack. Media, volunteers and organizations crowded the same setting.[VT1]

Some families misunderstood why a visual identification could not simply replace the medical examiner's process. Officials, in turn, did not explain the process consistently or sensitively. A request that families raise their hands if they wanted to view a loved one's remains deepened the distress. The panel found no single agency clearly responsible for operating the family-assistance center. Scientific care in preventing misidentification did not excuse poor communication with people waiting to learn when the process would end.[VT1]

Records before the attack

The panel also examined the shooter's contacts with schools, police, courts and mental-health services. That record is often reduced to a list of warnings that someone supposedly should have assembled into a prediction. The final revised report shows why such a summary is incomplete.

During his junior year, professors reported disturbing writing and behavior. The English department chair removed him from a professor's class and arranged individual instruction. Students reported unwanted contacts. Police spoke with him and directed him to stop contacting one student. On December 13, 2005, after he sent a message suggesting suicide, police took him for evaluation. A community-services prescreener found an imminent danger to himself or others, and a magistrate issued a temporary detention order.[VT1]

The next morning, an independent evaluator and a hospital psychiatrist did not find an imminent danger. A special justice nevertheless found danger to self and ordered outpatient treatment. These were different decisions by different people under different roles. The order was not an involuntary inpatient commitment, and it was not a finding that he posed a danger to others.[VT1]

At 2:25 that afternoon, the counseling center received a hospital fax containing discharge and screening records. At 3:00, he appeared for an appointment and was evaluated for the third time in fifteen days. A later psychiatric summary also reached the center. No effective process joined the order, hospital contacts, police encounters, faculty concerns and counseling records into sustained follow-up.[VT1]

The original review had been told that the counseling file could not be found. In 2009, during discovery in civil litigation, a former counseling-center director located it among files he had taken home when leaving his position. The revised report corrected the earlier chronology. It also found that the newly recovered material reinforced the problem of weak record handling and follow-up rather than establishing a simple missed diagnosis that would have foretold mass murder.[VT1]

The discovery also shows why version control matters in writing about the case. The final revised report still reproduces some original language before adding correction pages. A reader who stops at the old passage can repeat a claim the same document later withdraws. The

controlling chronology places the December 14 hospital fax at the counseling center before the afternoon appointment. It also corrects titles, actions and times that had shaped public criticism. Correction does not erase the underlying failure to coordinate care. It changes which act can fairly be called a failure.[VT1]

Privacy law was part of the institutional confusion. The panel found that federal education and health privacy rules allowed more sharing for health and safety than many university employees believed. That did not mean every record could be circulated without limits. It meant that a broad culture of caution and misunderstanding could prevent permitted communication among people responsible for a student's care and the safety of others.[VT1]

The firearms record contained another institutional gap. The December 2005 court order was not reported in the state database used for a purchase check. The panel discussed a federal prohibition and the state's narrower reporting practice for outpatient orders. It did not inspect the actual purchase forms and could not establish from them whether the buyer knowingly made a false statement. The weapons were purchased after background checks found no disqualifying record in the system consulted.[VT1]

None of this supplies a definitive motive. Mental illness does not itself predict violence, and disturbing writing does not establish a future crime. The panel's work identified specific failures of records, reporting and coordination. It did not prove that a single corrected appointment, disclosure or database entry would have prevented every later act.

Three public judgments

The review panel issued findings and recommendations. It concluded that the university had failed to send a timely, sufficiently explicit warning after the first shooting. It also praised the immediate police response at Norris Hall and the medical work that followed. It recommended clearer warning authority, multiple communication systems, plans for class cancellation, joint training, interoperable radios, unified command, improved threat assessment and professional family assistance.[VT1]

The panel's authority had limits. It worked under a short deadline, could request cooperation but could not compel testimony and received police briefings rather than the complete investigative files. The 2009 revision was prepared by the panel's support contractor at the governor's request after new material and family comments entered the public record. The original panel was not reconvened to vote again. The revised report remains the most complete official synthesis used here, but its provenance makes findings and corrections more accurate labels than a later judicial verdict.[VT1]

Virginia Tech's October 2008 progress report said it had created a threat-assessment team, revised reporting procedures, updated its emergency plan and expanded alert capability. It reported interior locks for general-assignment classrooms, changed exterior door hardware so entrances could not be chained shut and continued joint active-shooter training. It also described victim-assistance and counseling measures. Some entries were complete, some were in progress and some proposals had been rejected. The report documented what the university said it had done by that date; it was not an independent guarantee of safety.[VT2]

The state wrongful-death litigation asked whether the Commonwealth owed a legal duty to warn two of the people murdered at Norris Hall, Erin Peterson and Julia Pryde. A jury returned awards for each estate. The trial judge reduced each award to the limit then applicable under the Virginia Tort Claims Act.[VT3]

In 2013, the Supreme Court of Virginia reversed and entered final judgment for the Commonwealth. It assumed without deciding that a special relationship existed between the university and its students. Even under the lower foreseeability standard it considered, the court held that the information available before Norris Hall did not establish a duty to warn of the third party's criminal acts. Because it resolved the case on duty, it did not decide causation as a separate basis for judgment.[VT3]

That decision did not declare the morning's warning process sound. It answered a state tort question under Virginia law. Peterson was an eighteen-year-old first-year student in international studies, a former high-school basketball captain and co-president of a group supporting the confidence of younger girls. Pryde was a graduate student in biological-systems engineering whose work included water quality, sustainable agriculture and conservation. Their lives existed before their estates became names in a duty case.[VT5]

The federal Clery proceeding asked another question. In August 2012, the Secretary of Education held that a warning was required after the first shootings and that the 9:26 email had not been timely. The Secretary imposed a \$27,500 fine for that violation. Once he decided the timing issue, he did not separately decide whether the message's content was sufficient.[VT4]

The Secretary also found that Virginia Tech had inconsistent warning policies and had not disclosed one of them. He sent that issue back for a separate fine calculation. An administrative judge imposed \$5,000 in December 2012. In January 2014, the Secretary affirmed that amount. The orders therefore contained a \$27,500 fine for the untimely warning and a separate \$5,000 fine for the inconsistent and undisclosed policy.[VT4]

The Clery decisions did not establish state tort liability. The Virginia Supreme Court decision did not erase the federal administrative finding. One body applied federal campus-safety disclosure and warning law.

The other applied Virginia's rules governing a duty to protect against criminal acts by a third person. The review panel conducted an administrative inquiry and made recommendations. The records can disagree in emphasis without one being a substitute for the others.

The sequence also prevents a misleading claim about vindication. The civil jury found for the estates, but the state Supreme Court's final judgment displaced that result. The federal Secretary's untimeliness finding remained a separate final administrative decision. The later \$5,000 ruling concerned the undisclosed and inconsistent policy, not a reduction of the earlier \$27,500 warning fine. No source reviewed for this chapter proves when the money was paid, so the chapter reports the orders rather than an unverified payment.[VT3][VT4]

The stones

In the hours after the attack, students placed thirty-two pieces of Hokie Stone in a semicircle on the Drillfield. The spontaneous memorial became the model for the permanent one. Thirty-two engraved stones now stand along two paths, with another stone at the center honoring everyone killed or injured that day. Benches recognize the survivors.[VT6]

The arrangement preserves the count without reducing it to a statistic. Thirty-two stones are thirty-two names. They do not include the person who killed them, and they do not rank a professor above a student or one classroom above another. The memorial holds the two first victims beside the thirty killed later because all were lost on the same morning.

The official files explain much that happened after 7:02 and much that failed before 9:51. They show fast medical decisions, delayed warnings, accurate identifications, painful communication failures, brave actions and uncertain causes. They show institutions correcting a chronology after missing records appeared and public bodies reaching different legal results from different questions.

What the files cannot do is supply the conversation no one heard, the motive the evidence did not establish or the future each person would have lived. For that, the record returns to names, fields of study, music, horses, classrooms, service, research and families. The stones carry what no administrative finding can complete.

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Thirty-Two Stones

[VT1]: TriData Division, System Planning Corporation, *Mass Shootings at Virginia Tech, April 16, 2007: Report of the Review Panel*, November 2009, revised December 2009:

<https://scholar.lib.vt.edu/prevail/docs/April16ReportRev20100106.pdf> .

Complete 210-page consolidated report read, including correction pages and notes. Corrections control over repeated original passages. The original panel was not reconvened for the revision. Claim anchors by physical PDF page: victims and biographies, 15-19; corrected chronology, 51-62; earlier contacts and recovered counseling records, 63-101; privacy and firearms, 103-119; West Ambler Johnston and corrections, 121-136; Norris Hall and corrections, 137-150; medical response, 151-174; identification and family aftermath, 175-200. Source limits and conflicts are recorded in the Unit 01 source-screen memo.

[VT2]: Virginia Tech, *Progress Report: Recommendations by Initiative*, October 31, 2008: https://www.weremember.vt.edu/content/dam/weremember_vt_edu/2008-10-31-implemented-recommendations.pdf .

Complete 17-page report read. Used as dated institutional reporting; proposed, completed and rejected measures remain distinct.

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[VT4]: United States Department of Education, *In re Virginia Polytechnic Institute and State University*, Docket 11-30-SF: Secretary decision and order of remand, August 30, 2012,

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[VT6]: Virginia Tech, "The April 16 Memorial": <https://www.weremember.vt.edu/april-16-memorial.html> . Complete substantive page read. Used for the student-created stones and permanent memorial design.

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