**COMMISSION TO INVESTIGATE THE MAY 31, 2019, VIRGINIA BEACH MASS SHOOTING**

**MINORITY INVESTIGATION**

**FINDINGS**

June, 2023

David Cariens

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ACKNOWLEDGMENTS

The following pages draw on my work and the work of some others members of the *Governor’s Commission to Investigate the May 31, 2019 Virginia Beach Mass Shooting.* Rather than single out other Commissioners specifically, I thank all the Commissioners for the work they have done.

We have had sharp disagreements, but that is part of a healthy investigation into a major tragedy. Some have informally, and off the record, given me feedback on my thoughts and ideas in this *Investigative Findings.* I thank them very much for their ideas and support.

DEDICATION

 This document is dedicated to the families, survivors, and victims of the May 31, 2019 Virginia Beach massacre as well as to the citizens of Virginia Beach and all those who have suffered the loss or maiming of a friend or family member as result of gun violence.

The *Commission to Investigate the Virginia Beach May 31, 2019 Mass Shooting*, after more than two years of work,has failed to meet its obligations. Instead of conducting an investigation and publishing its investigative finding, the Commission appears intent on producing a report. An investigation and a report are two very different things. A report can be a coverup, concealing the truth and protecting organizations and individuals.

I take part of the blame for the Commission’s failure. I will always ask myself why I didn’t do more, why didn’t I fight harder? Have I let the current and future victims, their families, co-workers, and all Virginians down?

The victims’ families, those who survived, those who were in Building 2 on that fateful day want the truth, hoping to find justice through the facts and evidence. Unfortunately, when these mass shootings occur, the victims and their families almost always get lies; they get no truth, no justice. People in positions of trust and authority know no limits they will go to protect or advance their careers and shield government bodies from accountability.

To paraphrase John Steinbeck: The sharp pain of the truth—being told your loved one has been murdered—can soften, but the slow, eating agony of a lie never dies.

I hope I am proven wrong. I hope the *Commission* conducts a thorough investigation. But I will not be part of a lie.

*CONCLUSIONS*

*The Commission to Investigate the May 31, 2019 Virginia Beach Mass Shooting* appears to have been set up to fail from the outset.

It was not given adequate funding, $38,504 versus $460,000 for the Virginia Tech Commission. The Commission’s membership was 20 voting members and one non-voting. The Columbine and Virginia Tech Commissions had 10 and 8 members respectively.

The Virginia Beach Commission had to cancel, postpone, or hold more than half its scheduled meetings because of a lack of a quorum.

Membership on the Commission was a problem. Former mid- and high-level Virginia Beach city officials were members, including a former Deputy City Manager, former head of Emergency Planning, former Fire Chief, and a former Virginia Beach Police Officer. Their membership constitutes a conflict of interest.

The City of Virginia Beach apparently attempted to control the investigation and some Commission members may have been duplicitous in this effort.

Some Commissioners appeared to take their ques from the city, casting doubt and suspicion on the motives of other Commission members. For example, interviews with current and former city employees revealed that some city employees were discouraging other employees from talking to the Commission because some members want “to write a book.”

The apparent whisper campaign to discredit some Commissioners was echoed by Commissioners who were former city employees. They even put their suspicions in writing expressing doubt about the “motives of one member” and implying a Commissioner had a “bias.”

The Commission chairman, even read one of the accusations out loud in a Commission meeting in order to get it on the record.

The former city employees appeared to bend over backwards to prevent the Commission from finding the City culpable in any way. For example, one of them speculated in writing that perhaps the city could not do anything because it would violate the killer’s civil rights.

The questions that need to be looked are the violations of the civil rights of the 12 dead people’s, the four wounded, and all those impacted by the May 31, 2019 massacre.

The city turned down most FOIA requests—in one instance claiming they could not find the documents. And, despite requests for the city to facilitate interviews with Human Resources personnel, as well as the killer’s coworkers and supervisors, the interviews never took place.

The Virginia State legislature instructed the Commission, using the legal English imperative command “shall,” to investigate Craddock’s past, including his work history. Some cooperated, others did not. Two representatives of the killer’s past employees were interviewed, but the City of Newport News did not respond to interview requests. The killer was working on a project with Dominion Power. The energy company did not respond to requests for interviews with employees who interacted with the killer.

As recently as early 2023, some Commissioners repeatedly argued the Commission was to write a report, not an investigation.

These are two very different documents.

An investigation relies heavily on primary sources such as interviews. An investigation systematically collects the facts and evidence to determine the circumstances surrounding the case. Its goal is to find out the truth or furtherance of knowledge regarding the case. A report is a more academic look at available resources, often relies heavily on secondary sources, and may and may or may not include interviews. It often collates best practices and resources available.

Evidence that some Commissioners may have been in cooperating with the City is underscored by the fact the City had Commission meeting notes, without formally requesting them. The Commission’s documents are public records so the City had every right to see them. The question is, how did they get them. The Office of the State Inspector General reported that according to their records, the only Commission document the City ever requested was the *Interim Report*. The probability that one or more Commission members was feeding City officials a steady stream of information, and perhaps taking directions from city officials, cannot be rule out.

Even with the above obstacles, this investigation has been able to find evidence the City of Virginia Beach may be guilty of negligence on a number of fronts. No one could have predicted when or where a shooting would occur. But serious workplace violence of some sort was probably inevitable in Building #2 or some other city building. These findings cannot say whether this negligence broke the law, only a court can decide if any laws were broken.

During the years immediately preceding the mass shooting, the city suffered from pockets of poor management in critical positions. Top city management apparently had a draconian style and tone of “my way or the highway.” The result was a “toxic” work environment in many city facilities, particularly on the 2nd floor of Building #2. Nealy three-quarters of those interviewed referred to a “toxic work environment.”

Employees were discouraged from expressing grievances or concerns for fear of retaliation. This leadership tone appears to have given mid- and low-level supervisors a green light to engage in the worst forms of management—humiliating employees in front of co-workers, gossiping, and apparently, in at least one case, embellishing a personnel report in order to fire an employee.

There were work units with exemplary leaders, such as on the third floor of Building #2. There, a feeling of support and comradely apparently was, and still, is the rule. Unfortunately, good that management style apparently was not the case in other areas of Building 2.

In these cauldrons of incompetent leadership, there was a man suffering from mental illness. He was a man whose wife was leaving him. He felt his work was not appreciated. He saw his world falling apart. He became a killer. Whether the management style he encountered on the second floor of Building #2 played a role in turning him into a killer we will never know. He is dead.

Furthermore, we will not know, in part, because the FBI’s Behavioral Analysis Unit (BAU) asserts the killer was not sending signals he was violent. That assertion appears to be incorrect. This investigation uncovered detectable and visible signs by the killer, demonstrating he was mentally ill and possibly violent. These indicators are documented later in this *Investigative Finding.*

There were three areas in which the city appears to have been guilty of negligence. This investigative report will go into greater detail about these and other deficiencies in the body of the findings and recommendations. The following are the three areas:

1. Security: Despite the fact that Virginia was the site of two mass shootings since 2000, the city did not learn or heed the lessons of the Appalachian School of Law (January 2002, three killed, three wounded) or Virginia Tech (April 2007, 32 killed and at least 17 wounded). City officials apparently repeatedly diverted money from security to other expenses. They ignored concerns about security in Building 2. Active shooter training was not a regular part of employee training.

The city ignored earlier warnings about communications in Building #2 that surfaced during a fire drill in Building 2 a couple of years before the mass shooting. Nothing was done to remedy the problems. Those communications problem surfaced during and in the immediate aftermath of the mass shooting on May 31, 2019, contributing to the confusion during and after the shooting.

Security protocols in Building 2 were badly flawed—stopping police from gaining access to where the killer was carrying on his rampage. Police audio confirms that it took first responders nearly 20 minutes to gain access to where the killer was. Matching the timeline of events with the time of the audio, it appears at least one person was killed during this timeframe and one injured.

Better security might have prevented at least one death and one injury.

1. Human Resources: The City of Virginia Beach’s Human Resources (HR) was fragmented and inefficient. Many employees had no confidence in the HR Liaison Officers who had little or no training and experience for their duties. Specifically, they had no training in how to identify and help troubled or problem employees.

According to numerous interviewees there was a toxic work environment in which some mid-level managers publicly disparaging employees and gossiping about them behind their backs. There were also indications of racism. The killer filed a complaint about racism against a colleague. And, a co-worker said he was called “names” at work, but declined to say what names specifically.

1. Training: The City of Virginia Beach employee training was woefully deficient. Nowhere is that more evident than in a city employee threatening Red Cross officials (trained in Mass Casualty Incident Response) with arrest unless they left the scene of the crime.

Training for supervisors and employees did not include regular, mandatory active shooter training. The emergency or crisis training appears to have been substandard. For example, several employees said they had no idea of where to go or what to do when the shooting rampage started. Few HR liaison officers were trained for their duties and some gossiped about employees—they did not respect confidentiality. The HR liaison officers had access to confidential personnel files and handled sensitive problems.

Interview with high-level HR officers in the Federal Government, private business, academia, and another major Virginia city, revealed the City of Virginia Beach violated almost every norm in the use of HR Liaison officers. For example, sensitive personnel issues and problems are handled by fully trained HR officers, not HR Liaison officers—that is the HR industry standards.

Training is basic and essential to HR functioning and careers. The city’s failure to provide even the most rudimentary training to people expected to perform HR functions not only violate industry norms, but is tantamount to negligence. Whether or not it was gross negligence only the courts can determine.

A question the State Attorney General might want to investigate is: Do any of the obstacles outlined here and later in this report, amount to obstruction of a State Investigative Commission?

*INTRODUCTION*

The Commission’s failure to investigate the mass murder at Virginia Beach Government Building 2, means it failed the charter given it by the Governor, the state legislature, and the citizens of Virginia. The Commission has failed the victims and their families. More broadly, it has botched an opportunity to provide data to help our nation begin to find solutions to these senseless killings.

Some Commission members, from the top down, apparently want the end results of our work to be a glorified version of the *Hillard-Heintze* report. They appeared determined to make excuses for the city and objected to even remote suggestions the city had in any way culpable for what for the tragedy of May 31, 2019.

*Hillard-Heintze* is a Chicago-based security consulting firm hired by the City of Virginia Beach to write a report, not do an investigation. Representatives of *Hillard-Heintze* were candid to the point of being blunt about why they came to Virginia Beach. They told at least one victims’ family three times they came to Virginia Beach to do a report, not to do an investigation.

As noted earlier, from the outset, the City of Virginia Beach appeared to want to control the Commission and limit Commission member’s access to people and information. One former employee interviewed asserted, “I would be shocked if you can get any documents or records (from the city) giving you insights into what happened and what let up to it.” Sadly, he was right.

There will be no end to the mass killings until honest, unbiased investigations and analyses of these crimes are conducted. Only then and only then, can people in positions of authority and trust—e.g., doctors, politicians, mental health specialists, law enforcement, and members of the legal profession—begin to put together an all-encompassing plan help to bring an end mass killings.

Yes, I know, we will never end all of these killings, but that is not excuse for not trying to dramatically reduce their number. Other countries have adopted laws that have significantly reduced gun violence. So can this country.

The task is monumental, but it has to begin somewhere and that somewhere should have been the *Commission to Investigate the Virginia Beach May 31, 2019 Mass Shooting.* The Commission has not risen to this task.

Those doing these analyses should be able to tell the victims, their families, survivors, and the community, “We did the best we could and these are the results of our investigation.” If the crimes were truly unforeseeable, then Commission members should say so. But, if there was negligence or incompetence on the part of individuals or organization (public and private), that needs to be exposed.

It is not the job of any Commission investigating heinous crimes to determine if laws have been broken—that is the job of the courts. It is these Commission’s job and responsibility to do a thorough examination of the facts and evidence to determine how and why a mass shooting took place. In so doing, the Commission needs to be guided by the evidence.

I have seen and felt the pain of families ripped apart by gun violence—a mother who will need psychological counseling the rest of her life because her son was killed in a classroom; a father who was on suicide watch following the murder of this daughter; a man who is so traumatized from witnessing the murder of his co-workers that he has PTSD seizures and lives in an agonizing world of horrific memories.

In the case of the Virginia Beach mass shooting, the truth is still hidden. I hope one day all aspects of the May 31, 2019 will be investigated and exposed. The Governor’s Commission could have sought the truth—it did not.

The *Commission to Investigate the Virginia Beach May 31,2019 Mass Shooting* could have played a critical role in helping end these rampages and save lives by conducting a thorough investigation. It chose not to.

For the Virginia Beach Commission to produce a report and not an investigation is a form of a lie. It is a lie of omission—omitting or ignoring the instruction to investigate a major crime. It is omitting or ignoring the truth.

I cannot sign off on a “report” when the commission was mandated to do an “investigation.”

The following pages are based on my investigative work*.* It is the *Minority Investigative Findings.*

*SCOPE NOTE*

The author reviewed analyses of previous mass shootings, including Columbine in 1999, the Appalachian School of Law in 2002, and Virginia Tech in 2007. He read the City of Virginia Beach’s security protocol adopted in 2001 as well as a number of papers on mass shootings. The author also read Dr. Kathleen P. Decker’s *Fit, Unfit, and Misfits,* an analysis of stress factors and cognitive problems impacting police officers’ performance. The book’s contents apply to individuals in all walks of life. Ms. Decker is an M.D. and former Assistant Professor of Psychiatry at the University of Washington. In addition, the author read numerous media reports of the shooting and watched YouTube videos of the *Hillard Heintze* meetings with employees and citizens.

The excellent written submission done by the anonymous *Stronger Together Group* of city employees played a role in constructing this report and their words are folded into the narrative as well as into the *Timeline.* The author also read the FBI’s interview of the killer’s ex-wife. Human Resources officials in academia, private business, and local governments were interviewed.

The Virginia Beach Police Department’s (VBPD) April 24, 2020 Inter-Office Memorandum from Chief Cervera to City Manager Thomas Leahy, as well as the Summary of the final VBPD report played a key role in this document.

The author viewed the police photos of the killers condominium and read the inventory report the Virginia Beach Police made in their search of that condo. The author also viewed some of the contents of a laptop that was found in the condo more than two years after the rampage.

The author listened to a cell-phone recording of the mayor of Virginia Beach explaining why a husband could not get his dead wife’s insurance for himself and his three daughters—“technically” your wife did not retire.

Finally, the author participated in more than 35 interviews of current and past city employees, concerned citizens. The author filed numerous FOIA requests with the city. Over half of those requests were denied.

*OBSTACLES*

Some member of the Commission, from the outset, appeared to believe the job of the Commission was to report, not to investigate. The Commission’s duty was (and is), they apparently believed, to protect the city and its officials from culpability and possible litigation. How? By producing a *Hillard-Heintze*-style report about best security practices and resources and not delving into the facts and evidence of an investigative analysis.

The City of Virginia Beach may have found allies in its former employees and members of governments from surrounding communities who were on the Commission. These individuals repeatedly made excuses for why the city could not do this or that. For example, one Commissioner cited costs while another raised bogus issues such as the killer’s civil rights implying the city might not have been able to do anything even if the killer did send signals that he was a threat.

Another bogus issue raised was the cost of security measures. It was not the investigating Commission’s responsibility to do a cost analysis or even raise the subject of cost. It is the Commission’s responsibility to investigate, and make recommendations about should be done to make localities safer. Then those localities, not the Commission, decide what is appropriate and what they can afford. There should be a minimum of safety and security requirements for all localities no matter what their size. The Commission should not be handing localities “cost excuses” on a silver platter.

The raising of the killer’s civil rights is stunningly callous and inappropriate by any standards. Not once did these individuals mention the civil rights of those killed and wounded, The civil rights of the survivors, those suffering the mental anguish of seeing their coworkers murdered, and family members of victims never seemed to be of concern to them.

From its inception the *Commission to Investigate the May 31, 2019 Virginia Beach Mass Shooting* have been mortally wounded. Whether this was by design or by accident, I cannot say. But numerous factors proved to be serious obstacles to the Commission’s ability to investigate:

The following are nine of the most glaring obstacles:

First, the Commission did not meet until two years after the shooting.

By the time the Commission convened, two years after the shooting,

many people wanted to move on with their lives. Other peoples’

memories had faded. They were uncertain about facts and details.

Second, the Commission did not have subpoena power. A number of individuals would not talk to us because they did not have the protection against the possible city’s retaliation that subpoena power affords. There was nothing to compel people to talk with us. In one instance, a person refused declined to be interviewed because we lacked subpoena authority which would have given the individual protection from retaliation. Another person would not talk to us until after he resigned from the city and found a new job. A third person indicated a willingness to talk despite the risk of retaliation;

Third: The Virginia Beach Commission consisted of an unwieldy 20 voting members and one non-voting. The size of the Commission often prevented a quorum, caused cancellation of meetings. Some meetings were held without the requisite number of attendees—no votes could be taken.

Poor attendance of some Commission members may, in part, be

explained by covid-19 concerns and the fact some participants

thought the Commission would be able to meet via zoom. But, if

commission members realized they could not regularly attend

meetings in person (as required for a quorum), they should have

resigned. Whatever the reason, the Commission’s ability to conduct

business, including holding votes, interviewing people, requesting

documents, was seriously hobbled.

Despite the chairman’s request that all Commission members

perform some rudimentary tasks, such as examining the reports

already done on the shooting rampage—rarely did more than a

quarter of the members perform those tasks. Indeed, when the

chairman asked for a series of questions the Commission could use

as a basis for questions, only a few Commission members drafted

questions. One member’s questions were largely corrections of

another member’s questions, with few original questions. The failure

of some Commission member’s failure to perform even the most

elementary task being asked, is deeply concerning;

Fourth, the membership of the Commission was a problem. No one who had worked for the city of Virginia Beach—in any capacity—or any of the municipalities or government organizations in the Virginia Beach metropolitan area should have been on the Commission. The presence of these people on the Commission, if nothing else, undercut perceptions of credibility and objectivity. In the case of the Virginia Tech Commission, to my knowledge, no member of that Commission had any ties to the school. The same is true of the Columbine Commission;

Fifth, to take point four further, the Virginia Beach Commission suffered from the same flaw as the Virginia Tech Commission. As Dr. Bella Sood (a member of the Governor’s Commission to investigate the Virginia Tech rampage, wrote in her book, *The Virginia Tech Massacre*), “The subtext of the directive (Governor Kaine’s Directive setting the Commission up) in my view, was also that the state wanted to avoid findings that might have liability implications. The specter of possible litigation was ever-present.” Some Commission members not only said “there is confusion about whether we are doing a report or an investigation,” but they appeared to make excuses for the city;

Sixth: The Commission was not allocated the appropriate amount of funds to do its work. If money talks, the following dollar amounts scream. The amounts paid make it clear the State of Virginia and City of Virginia Beach were not serious about the Virginia Beach Commission doing a thorough investigation:

1. The Governor’s Commission to Investigate

the Virginia Beach mass shooting was budgeted……………………………………….$ 38,504

1. The City of Virginia Beach paid

*Hillard-Heintze* to write a report (not an

Investigation) of the rampage……………….. $483,000

1. The budget for the Virginia Tech mass

Shooting commission was…………………….$460,000

1. Virginia Tech paid *Firestorm*, public relations

firm, a princely sum for about a week of work

to spin the tragedy…………………………….. $150,000

1. When *Firestorm* did not appear to be up

to the job, Virginia Tech paid *Bursten-*

  *Marsteller*, one of this country’s most

 powerful PR companies, a king’s

 ransom to develop and spin the line,

 “Virginia Tech is a victim.” …………………….$663,000

1. Finally, the State of Virginia paid *Tri-Data*,

a company that does business with the

state, to write the Virginia Tech Report……… $600,000+

1. The *Tri-Data* Report had so many flaws

 that the outcry was deafening. Two revisions

 had to be made and the final Virginia Tech

 Report (which still contains errors) was

 published in December 2009. Because

 there was no “errors and omissions” clause

 in contract with *Tri-Data,* the company was

 paid and additional……………………………..$ 75,000

Seventh: The Virginia Tech Commission had eight *pro bono* lawyers at its disposal for legal advice. We had two lawyers on our commission. We could ask questions of the Attorney General’s office—the Virginia Tech commission had the latter option as well, but they still had *pro bono* legal resources and experts. The Virginia Tech Commission had 60 boxes of documents and evidence, the Virginia Beach Commission, dealing with Cho’s writings and other primary sources. The Virginia Beach Commission had few primary documents.

Eight: In examining the killer’s background, the Commission did interview representatives of two private companies where the killer worked, both of whom provided valuable information and insights. But others—including the City of Newport News where the killer worked immediately before being hired by Virginia Beach—did not respond positively for a request for interviews. Neither did Dominion Power. The killer was working on a project involving Dominion Power shortly before his murderous rampage.

Ninth: The City of Virginia Beach appears to have engaged in a campaign of obstructionism—keeping Commission members from interviewing City employees and withholding documents such as the findings of Mike Freeman. Mr. Freeman was hired by the City to review security and make improvements. When the author filed a FOIA for copies of Mr. Freeman’s reports and findings, the City responding saying they were “unable to locate the records.” What better way to prevent an investigation than deny the investigators valuable sources and information?

When the author of this Investigative Findings requested interview with city employees, Melissa C. Zibutis, Chief of Staff, assistant to the City Manager, responded with the following:

“According to the minutes of the Commission meeting on September 9, 2021, on a motion made by Butch Bracknell and seconded by David Cariens, Commission members adopted a resolution that “**members not conduct interviews individually** *(emphasis added)* and that information received by individuals be shared immediately with the entire Commission.…”

Ms. Zibutis and the City Manager’s office apparently did not check with the City Attorney’s office about a Commission change in procedure. The following was distributed to Commission members by Commissioner member David Lord (Deputy Commonwealth’s Attorney, Alexandria, Virginia) in September, 2022:

“I have spoken with Roderick Ingram, who is a Deputy City Attorney for the City of Virginia Beach (specifically tasked with policy and administration). He is familiar with our commission and I explained the process and how we wanted to proceed. … **He told me they have no problem with our reaching out directly to employees**.”

(Emphasis added)

It appears that a member(s) of the Commission has fed the city information and documents. A check with the Office of Inspector General, determined that the city had never requested any of our meeting minutes. The city had requested a copy of our *Interim* *Report*. All our proceedings are public, so the city is welcome to any and all our minutes and reports. The way the city chose to get the documents is eyebrow-raising.

Tenth: The City of Virginia Beach and some former employees of the City appear to have engaged in a campaign to undercut discredit the motives of some Commission members. Whether the City and the Commission members were coordinating is not clear. Specifically, City employee interviewees said they were told not to talk to the Commission because they want to write a book. One member who resigned from the Commission had, more than once, asserted another Commission member wanted to write a book. In his resignation letter he stated he was still concerned about the motives of one of the seven remaining Commission members. The sophomoric attacks on Commission members says a great deal about the unprofessional and unethical nature of some City employees and the accusers.

The question has to be asked, “What are these people hiding?” To paraphrase an old adage, “If you don’t like message and have no response, undercut and discredit the messenger.”

\* \* \*

The *Minority Investigation* that follows represent the results of the investigation done by the author and some of his colleagues, before his resignation from the Commission.

Before closing this section, I should add one Commissioner told me that not being able to break into small work groups was an impediment. “If we had been able to work in small groups collaboratively, just think how much more productive we could have been and how much quicker we would have been able to complete our work.” The rules establishing the Commission stated that any meeting of three or more Commissioners had to be a public meeting.

I quote extensively from interviews I participated in. It is important to hear the words of those impacted by the rampage. Their stories were moving and they spoke eloquently about their experience. Virginia Beach citizens need to hear their words. And, it is important for them and the citizens of the metropolitan Virginia Beach area to know the Commission listened.

**COMMISSION TO INVESTIGATE THE MAY 31, 2019, VIRGINIA BEACH MASS SHOOTING**

THE COMMISSION’S EIGHT CHARGES

C.1. The Commission shall:

1. investigate the underlying motive for the May 31, 2019, Virginia Beach mass shooting:

 DeWayne Craddock, the killer, died following a gun fight with law

enforcement. We will never know precisely what his motive was.

We can identify possible factors playing into the motives behind a

Mentally unstable man’s actions.

Craddock suffered from some sort of mental illness, that is clear—

probably undiagnosed paranoia and schizophrenia. The killer’s

motive lies somewhere in the dead man’s sick mind. We do know he

felt people were against him, he thought he was being picked on, and he was not being recognized for the work he was doing. He also appears to have had an inflated opinion of himself and his abilities. In other words, he believed he was not getting the recognition he deserved for the “quality of work” he was doing.

The words of one employee who knew DeWayne Craddock well are insightful:

*“I knew the killer … He was always nice, eager, and hardworking, but he had a lot of things happen. For example, people blamed him for things that were not true. He would take on a project and get it up and running and then it was given to someone else who would get the credit.”*

*“The shooter changed. More and more he stayed behind*

*closed doors. He stopped talking to people … He was upset*

*by his divorce—his wife could not handle his domineering style. … Although what he did was horrific, he was a human being, he had issues. I believe he was called words. (When asked what words, the interviewee declined to be specific.)*

Perhaps rather than speculate on what motivated the killer, it might

be more productive to try to determine what triggered his massacre.

Here too, we can only guess about what factors sparked his

murderous rage.

The killer worked in an unhealthy environment—a large number of

interviewees described it as “toxic.” There were individuals in

positions of authority who were not suited in skills and temperament

to hold their positions. A case in point appears to be the purchasing

agent, who although not authorized to do so, sent threatening

messages to employees for not following the rules.

Here are some of the quotes about the work environment from

interviewees:

*“The work environment in Public Works was toxic and abusive. For example, my supervisor was cruel, she made me feel like a frog.”*

*“It was common knowledge that the 2nd floor of Building 2 (Public Utilities) had an uncomfortable work environment, from*

*micro managing to hostile conversations and subordinates. Engineers looked forward to applying for openings …”*

*“The work environment was hostile toward employees. …*

*(You) cannot run a civilian organization the way you run*

*something in the way you run something in the military. Yet*

*that is what happened. Management is ‘command and control;’ it is their way or the highway.”*

*“The City of Virginia Beach administrative employees have a high level of education—there is no reason for this abusive management style, it’s partly because of the military influence.”*

*“HR always says there is nothing they can do. In that case they need to be fired.”*

*“We had eight people leave because of the way they were treated.”*

*“The type of management style was horrible. I saw the way (the killer) was treated …”*

*“My impression was Public Utilities (2nd floor of Building #2) was strictly by the rules. The third floor operated more like a family, the people were closer and worked together on the third floor of Building 2.”*

*“I knew (the killer) and I knew the atmosphere. We got a*

 *new purchasing agent ... she had started in 2018. She stared*

 *sending threatening messages to employees. She did not*

 *have the authority to do that and furthermore she did not*

 *have the knowledge to do the job. …”*

*“My impression was that Public Utilities, unlike the atmosphere*

 *where I worked (on the 3rd floor) looked for way to throw people*

 *under the bus.”*

*“I can only speak for myself and my immediate colleagues. We*

*did not perceive a toxic environment (interviewee worked on*

*the third floor of Building #2). We were a congenial group.”*

*“I didn’t talk to HR in Public Works. I didn’t trust her.”*

*“I did not personally witness any odd behavior out of the*

*shooter. However, a Public Works employee told me that he left*

*Public Works because he saw the way the shooter was being*

*treated and he started getting treated similarly by his supervisor. So, he took a job in Public Works. The shooter ultimately matters in his own hands and ‘snapped’ instead of leaving.”*

It is worth taking a look at what recourse city employees had prior to

May 31, 2019, if they had problems or wanted to file grievances.

The City of Virginia Beach’s Human Resources (HR) structure was

fragmented in the years prior to the mass shooting. The city relied

heavily on HR Liaison officers in the work units. Almost all of these

people were untrained and unqualified to do the work.

This investigation interviewed HR officials in academia, another

Virginia city, and in private business (with a background in heading

the HR Department for the U.S. Department of Justice. All cautioned

about the use of HR Liaison officers and stressed they need to be

trained and should not handle sensitive personnel matters.

Here is a professional, senior HR officer’s comment about the

importance of HR officers’ duties:

*“I am a strong advocate of meeting challenges head on before*

 *they occur. Human Resource capital—people—is the most*

 *important element in achieving and performing occupations.*

 *However, it is often deemphasized in discussing competing*

 *priorities …”*

Prior to May 31, 2019, the vast majority of the city’s HR Liaison officers had little or no training, but were allowed to handle very sensitive personnel matters such as reprimands. Numerous interviewees said they did not trust HR Liaison officers because some were heard talking about fellow employees in the hall or telling supervisors about sensitive personnel matters.

The City of Virginia Beach’s use of Human Resources Liaison Officers violated the standards adhered to by the profession. For example, the former head of Human Resources for the U.S. Department of Justice said that in the federal government, HR training on competencies is mandatory. All HR officers must have some training and knowledge about the basics of the profession. That was not the case in Virginia Beach.

The same former Human Resources professional said the following about HR Liaison officers:

 *“They are not subject matter experts in all things HR—and, do*

 *not understand to triage issues or incidents within the*

 *organization. They are less strategic and more focused on*

 *transactions. That creates problems. If someone in the role*

 *of HR Liaison is not familiar with the rules and regulations this*

 *is a problem and can lead to more problems.”*

When asked if HR liaison officers should handle sensitive personnel matters, professionals in private business, academia, local governments, and the federal government all said, “Absolutely not.”

That was not the case at Virginia Beach, were not only did some HR Liaison officers deal with sensitive matters, but few were trained about the profession’s ethic and the importance of privacy—some gossiped.

Among those city employees interviewed, there was near unanimous lack of confidence or trust in HR Liaison officers.

The point is, if a Virginia Beach employee felt he or she had a problem, in most cases there was nowhere to turn. That was the situation a mentally ill man found himself in—HR Liaison officers who were not trained to recognize warning signs and who, it was widely perceived, could not be trusted.

Here is a sampling of interviewee comments about HR Liaison officers:

 *“I didn’t talk to HR Liaison in Public Works. I did not trust*

 *her.”*

 *“It seems main HR was set up to benefit the employer,*

 *not the employees.”*

*“I had no confidence in the HR Liaison officer, she was*

*an idiot and a butt kisser.”*

*“HR Liaison officers did not have experience; they did*

 *what they were told. They were not for the employees.*

 *After the shooting, our HR Liaison officer (on the second*

 *floor of Building 2) apologized for some of the things she*

 *had done. I never trusted the HR Liaison officers to*

 *respect confidentiality. I know the killer was being*

 *gossiped about.”*

*“I never talked to HR Liaison officers because I didn’t trust*

 *them.”*

*“My sister was uncomfortable about approaching HR Liaison*

 *because she was scared.”*

*“The HR Liaison officer is a puppet. She does anything the*

*boss tells her to do.”*

*“Each division has its own HR Liaison officer—I had no*

 *confidence in HR policy. What HR said they would do and*

 *what they actually did were two very different things.”*

 Not all the comments about HR Liaison officers were bad.

 *“Yes, I dealt with HR Liaison officers. They were*

 *professional, but I disagreed with one of their actions.*

 *They embellished their findings in order to get rid of an*

 *employee.”*

 *“I never had a problem approaching her (the HR Liaison*

 *officer) and if I had encountered a problem, I would have*

 *been fine talking to her.”*

The killer had authorized a payment of over $3,000.00 without getting

all the necessary signatures. The purchasing agent argued with the

killer before the shooting and was known for sending threatening

emails to employees who deviated from the rules and protocols. One

of the interviewees said the following:

 *“I knew DeWayne Craddock and I knew the atmosphere. We*

 *got a new purchasing agent, … , she started in*

 *2018. She started sending threatening messages to*

 *employees. She did not have the authority to do that and*

 *furthermore, she did not have the knowledge to do the job.*

 *(The new Purchasing Agent) apparently told DeWayne he*

 *would have to pay the $3,000+ invoice out of his own pocket,*

 *and he said, okay. She said the city was not liable to pay. That*

*may have been the last straw. (The new Purchasing Agent) had*

*a lot of employees upset. The purchasing we have now is*

*great.”*

The victims appear to be a mixture of people the killer targeted and

poor souls who were in the wrong place at the wrong time, such as

the only non-city government employee, contractor Bert Snelling.

Laquita Brown may have been targeted. The killer apparently sexually harassed her and she rebuffed his advances. On the day of the shooting, he passed others to get to Ms. Brown, whom he killed. On the surface, it appears the killer’s motive, at least in the case of Ms. Brown, was she rebuffed his advances and filed a sexual harassment complaint against him. Sexual harassment is a violation of the city’s Violence Prevention Policy. It could result in disciplinary action including dismissal and criminal prosecution. (The Commission did not investigate the possibility the killer had sexually harassed other employees.)

As with many mental illnesses, if untreated the condition worsens. That is probably the case with Dwayne Craddock.

According to the FBI’s Behavioral Analysis Unit (BAU), the autopsy report did not find any illicit substances in his system. (Commission members were denied access to the autopsy report, so we cannot verify the FBI/BAU’s assertion.)

This investigation turned up problems with BAU’s analytic tradecraft and when added to the other problems cited earlier, are significant enough to cast doubt on the FBI’s assertion the killer was not sending any signals he was ill or violent.

This investigation found numerous warning signals.

When one of the authors of this investigative finding asked BAU analysts, on two different occasions, how they factored in the warning signs below, they responded, “We examined all the evidence the city gave us.” That does not answer the question.

To rely on the City of Virginia Beach to give BAU the evidence to be examined, is tantamount to allowing the suspect in a crime investigation to pick and choose what evidence is examined. The end result is to skew the findings in favor of the city; Findings there were no warning signs. To put it bluntly, if there were no warning signs, the city is not liable.

Our interviews also uncovered some disturbing aspects of the FBI’s investigative trade craft. A number of people interview said they ask the FBI to interview them and it never happened. One person said he had to go to the FBI office in Chesapeake, wait for nearly three hours and force someone to interview him.

 Below are the warning signs this investigation turned up. Whether or not they are enough to make the city liable, only a court of law can decide. These warning signs, however, cast serious doubt on the FBI Behavioral Analysis Unit’s methodology and findings. The warnings signs below should not be covered up:

--The night before the mass killing, Kate Nixon and her

husband had a conversation about the killer. Ms. Nixon was

so concerned about her safety that her husband wanted her to take a gun to work. Ms. Nixon did not take a gun to work—the next day she was killed. Mr. Nixon was interviewed by the FBI and told them of his conversation with his wife and her fears. The FBI did not explain how they factored this conversation into the assertion that the killer was not sending signals.

--At a luncheon with coworkers, the killer began hallucinating

 about other people talking about him. He pulled out his cell

 phone and began taking pictures of people eating lunch. This

 is a sign of mental illness seen by co-workers.

--Withdrawing within one’s self in a work environment is a

 signal something is wrong—FBI’s BAU never commented on

 this even though they are the ones who talked extensively

 about his “withdrawal.”

--How can the FBI’s BAU be sure the killer was not sending

 signals? The City of Virginia Beach did not use trained,

 professional Human Resources officers in its work units.

 Instead, they used HR Liaison officers—people with no

 training in handling trouble or problem employees. Mass

 murderers can and are often insidious—the signals they

 send of possible violence are subtle. The city’s HR liaison

 officers were not trained to pick up any “signals.” These

 liaison officers had other responsibilities that took precedence

 over their secondary HR duties. So, how can the FBI’s BAU

 be so certain there were no signals?

--The FBI said, in interviews with the *Washington Post* and *The*

 *New York Times,* that the killer was obsessed with workplace

 grievances and issues. He was “alienated from his coworkers

 over how they viewed him and his own perception of his work

 performance.” Yet BAU downplayed these factors to the

 Commission and would not release their Power Point

 presentation to the Commission so that we could examine

 their analysis in greater detail. As a result, Commission

 members cannot resolve what appears to be a discrepancy.

--The killer’s wife had divorced him several years before the

 massacre. She said he displayed signs of paranoia and

 schizophrenia. She also said that when they went out to

 dinner people were talking about him. The ex-wife’s

 comments are strong indications he was seriously ill and

 sending “signals.”

 --During one of the interview sessions, a city worker said that

 during the shooting, and before the killer’s name was

 released, a coworker said she knew who the killer was, it was

 Dwayne Craddock. That coworker certainly saw “signals.”

--The Commission did not follow up on any of the above with

 the FBI’s BAU. The two times BAU was asked about the

 warning signs, they responded by saying they “analyzed all

 the information the city gave them.” That answer is not

 satisfactory. Nor did the Commission interview the killer’s ex-

 wife, his former city employers, or his former city co-

 workers—all of whom may have seen signs of violence.

--A few days after the shooting, a source told *The* *New York*

 *Times* Craddock “recently” showed serious behavioral

problems and got into scuffles with other city workers. The

 same source told the paper the killer was involved in what he

 called “a violent altercation on city grounds.” (June 2, 2019,

 *New York Post.*)

--A relative of one of the victims reported being told by the

 victim that the killer threw things at work.

--Several people interviewed say they requested an interview

 with the FBI, but never got one.

The author of these investigative findings asked the FBI’s BAU (twice) how they factored in the above warning signs to their thesis the killer retreated within himself and therefore did not send signals. Both times they responded, “We analyzed everything the city gave us.” That answer is tantamount to a crime investigator asking a suspect, “What evidence should I look at?” FBI’s BAU investigation was flawed.

The killer is dead. The inability to have professional psychologists examine Dwayne Craddock means it is difficult for the Commission to say for certain what the killer’s motive was or what triggered his actions. The lack of subpoena power meant people were not compelled to talk to the Commission. Individuals who might have shed more light on the killer’s motive did not come forward voluntarily. And, the failure of the Commission to take a more aggressive posture toward interviews means that whatever chance there was to get a clearer reading on the killer’s state of mind has been lost.

RECOMMENDATIONS:

1. The legislature should draft and adopt a bill requiring all municipalities, schools, and counties to employee trained Human Resources (HR) people. HR Liaison Officers functions should be strictly limited, by law, to handling routine administrative work. HR Liaison Officers should be prohibited from dealing with complaints, fitness for duty reports or any personal and confidential matters, including reprimands. This latter point appears to be an HR industry standard based on interviews with HR professions in education, private business, the federal government, and city government.
2. There are numerous, inexpensive, or free, Human Resources certification programs available to government and private business. One excellent source is *The Society for Human Resources Management (SHRM).* They offer courses, seminars, and training for best management programs—and they are free. The City of Virginia Beach, all state municipalities and counties, and state government agencies should be required to develop and implement HR training programs as a requirement to become and HR officer or HR Liaison.
3. An HR director made the following point: “While there are many approaches to proactively (not reactively) addressing potential workplace violence, the most important factor is the ability to recognize the risk-factor that could lead to this happening. The legislature should require all managers in every state, municipal, or county government be trained in “conflict management,” as well as how to recognize warning signs of violence and what to do to get the individual help.
4. The legislature should adopt a law prohibiting former employees or people with family members working for the organization/institution being investigated from being members of an Investigative Commission. This should be done because of the appearance of, or real, conflict of interest. In the case of the Virginia Beach commission, no one who had ever worked for the city of Virginia Beach in any capacity or for any of the governments in the metropolitan Virginia Beach area should have been on the commission.
5. The legislature should adopt a law prohibiting state and local governments from redirecting or siphoning off money allocated for security and for training to other projects and expenses. In the case of Virginia Beach, some interviewed spoke of funds allocated to security or training being diverted from security and training.
6. The legislature should adopt laws prohibiting the use of racial, gender, or religious slurs in the workplace, holding responsible both the person uttering slurs and managers who do not hold those individuals accountable.
7. All state, municipal, and county governments should have available psychological counseling. These governments should be required to have a psychologist on the organization’s staff or having one on a retainer as a consultant.
8. All new managers should be required to go through a one-to-two-day course on best management practices. This training should include how to recognize the signals that an employee is troubled and where to go to get him or her help. This should be mandatory training with 60 to 90 days of a person becoming a supervisor.
9. The City of Virginia Beach, and all municipalities in the state, should consult with and learn from each other. The legislature should require such consultation and coordination. For example, the Director of Human Resources in Alexandria said in an interview, “In Alexandria we are in the process of beefing up our security. There is one reception area where everyone must check in. If a person is attending a meeting, he or she must be escorted. We are analyzing and reviewing our security all the time. … During our orientation for new employees, we talk about their need to be aware of their surroundings, aware of coworkers, and people who come and go. We tell employees when they ask someone, ‘How are you?’ listen carefully to the answer and if they need help refer them to someone, such as HR or EAP.” Sharing of HR information between HR professionals should, and most likely would, help reduce the possibility of a mass shooting.

1. investigate the gunman’s personal background and entire prior employment history with the City of Virginia Beach and his interactions with coworkers and supervisors, including but not limited to formal documentation and informal incidents;

The failure of the Commission to have subpoena power, as mentioned before, hampered its ability to interview people and carry out this part of the investigation. Employees and managers had no incentive to talk with the Commission.

Fear of retaliation was omnipresent. One employee would not talk to the Commission for fear of retaliation by the city and indicated a willingness to talk only if the protection of a subpoena existed. Another city employee would not talk to us until he resigned and was settled in a new job. Again, the reason was fear of retaliation.

The Commission was not able to “investigate the gunman’s personal background and entire prior employment history with the City of Virginia Beach and his interactions with coworkers …” because we could not arrange interviews with his former coworkers and managers.” Also, the City of Newport News did not respond to our requests to interview coworkers and supervisors during his employment there.

The author of these findings did interview two of the killer’s former employers. The City of Newport News did not respond to requests to meet with people who worked with and supervised the killer in the immediate period before he started working for the City of Virginia Beach.

One of the former employers of the killer said he reached out three times to the FBI to be interviewed, but never heard anything back. I heard the FBI did come to our firm, but they asked routine questions such as, “Did the killer work here?” And, “How long did he work here?”

“The killer was not our worst performer, and he was not our best. He was middle of the road. He was put on our list to be let go (in an economic downturn), but left before he was terminated.”

“During a team-building exercise, he said something that bothered me … and he was aggressive during the exercise. A few days later I asked him to lunch and during lunch I told him his comments bothered me. He responded saying, ‘When I was growing up, I elementary school I was bullied. When I got to junior high and high school, I began working out and became strong. When people tried to bully me, I hurt them bad. But I am no longer like that, I’ve changed.”

The same former employer said, “A couple of people in our office, when they heard about the shooting and before the shooter’s name was released, said, ‘That’s DeWayne Craddock.’” It is clear this person saw some warning signs.

The second former employer said the killer worked for his company for about six months, shortly before the U.S. invaded Iraq. “The reason I remember the timeframe is that he was a member of the National Guard Reserve and I asked him if he was going to be called up. I remember because he was not working out. My personal problem with him was he was slow. We had budgets and deadlines to meet. Craddock had trouble with deadlines. I remember giving him a project and asking for it by noon. He didn’t meet the deadline. … It was clear he would have to go. I thought if he is called up, this is an opportunity to get rid of him.”

This second former employer also said, “I know the company I was doing some business with at the time of the shooting had a contract with the city and DeWayne Craddock was the contract manager. There were problems.” The interviewee did not know what the problems were.

On the day of the shooting, the same former employer, told a Commission interviewer that when the news came over the radio about a shooter in a Virginia Beach government building, a former co-worker of the killer said, “I bet it’s DeWayne Craddock.”

A co-worker of killer said, “I knew DeWayne Craddock. I was on a panel with him—the Engineering Selection Committee. He was always up on the 3rd floor. He kept to himself, was quiet, and not very talkative. I saw no aberrant behavior out of him, nor did I see anything that would make me think he was violent.”

The comments of this co-worker generally it descriptions of the killer by others. Many interviewed described the killer as withdrawn and not overly communicative.

A former city employee described the killer as “having a swagger.” He went on to say the ladies in Public Works did not like him. He ‘hit on them’ and was always turned down. One of the women said, “He gives me the creeps,” but I always found him soft spoken and respectful.”

Another employee said, “Craddock was bullied over the $3,027 invoice (he authorized without following procedure). It (the bullying) was intentional. Why? It was a power grab. These women (managers) were over the top with confidence and power hungry. Someone should be fired.”

Others saw him as polite. “The day before the shooting, Craddock came to our building to handoff plans. He was friendly when he handed me the plans. During the invoice review, I would give him the review in person, he would smile. He would frequently say, ‘You know.’ He used that phrase a lot and would wink at me.”

There are conflicting reports about his interaction with coworkers. One employee said, “The media gets things mixed up. We had luncheons four times a year—called birthday celebrations. The luncheons would rotate among offices who were being treated by other offices. We also had luncheons, so there were a total of seven a year. We also had ‘water weeks’ where we would go to parks. Craddock participated in these events. The media said he did not socialize, but he did socialize.”

The above paragraph also contradicts the FBI BAU’s assertion that the killer withdrew within himself. The killer apparently did some socializing with coworkers.

Still another former city manager said, “In the six years I worked with him, I saw nothing out of the ordinary and nothing was reported to me. … I did not see any Red Flags. … Everyone described him the same virtually the same way: very private, quiet, introverted, a loner, not particularly friendly. But no one said they thought he was violent or in any way capable of committing this horrific act.”

A retired city employee may have summed him up best, “I would call the shooter, stoic, private, defensive, and combative. … I stayed away from him. … His office was immaculate. He worked out regularly and was muscular. You would think he was a linebacker. He was aggressive and never scared. I was afraid to approach him. … Management said he was not doing his job, but I am not sure they knew he was violent. I think Craddock came into the city that way. We all knew as soon as the city hired him something was wrong with him. The city had 10 years to do something about him, but didn’t.”

RECOMMENDATIONS

1. Fear of retaliation by the City of Virginia Beach hampered and limited interviews. The legislature should draft and adopt a bill giving all future state investigative commissions subpoena power. Subpoena power does two things: 1) It provides protection from retaliation against employees who talk to a commission, and 2) it gives people an incentive/compelling reason to talk to a commission.
2. The legislature should adopt laws guaranteeing anonymity to individuals who want to speak to investigative commissions.

One employee with pertinent information and evidence pertaining to the work of the Virginia Beach would not talk to the commission for fear of retaliation. Another employee would not talk to the Commission until he found a new job (again, for fear of retaliation.)

1. If a local or state government, either encourages people not to talk to investigating bodies, or threatens people to keep them silent, the legislature should have in place laws and penalties to hold organizations and people accountable for obstruction of a State Investigative Commission.
2. determine how the gunman was able to carry out his actions;

This was not a random shooting. All most all mass shootings are well planned. Some of the killers even leave manifestos explaining their actions. This was not the case in the Virginia Beach rampage.

Some said the killer had a list of victims. I have not found a list, but it does appear that he targeted managers or people he felt had done him wrong—e.g. Kate Nixon who had written him up for poor job performance. He

There is circumstantial evidence that he was on out for revenge against those whom he felt had injured him and his career. For example, one woman would speak to him every day when he came in the building. He would nod back. On the day of the shooting, the woman dropped her purse and when she looked up Craddock was pointing a gun at her. He saw he face, nodded, turned and walked away.”

He targeted supervisors on a day he knew they were meeting. He timed the killings to coincide with when meeting would end. The sister of one of the victims reported her sibling had told her the killer was hanging around on the third floor and appeared to be scouting offices out. He was “just walking and looking.”

A city employee said:

“*I believe the killer planned the shooting. Two days prior, he came through a different door as if he were scouting out entrances. Before that, he always came and went through the same door. The way he came in that day let right to where the managers’ officers were. I think he was trying to see if his badge would work*.”

There may have been more signals. In the months leading up to the massacre, however, no one with training in how to recognize signs a person is troubled was in place to pick up on the signals and conduct intervention.

The ability to make judgments and come to conclusions about security for this *Investigative Findings* was hampered because the author did not have

access to critical sources and information. For example, Mike Freeman, the former FBI agent the city hired to review security, never addressed the Commission. A FOIA request for the reports and findings Mr. Freeman wrote was turned down because the city “could not find them.”

One interviewee said after May 31 2019, he worked with Mr. Freeman on an Emergency Action Plan, but it went nowhere. An Active Shooter Plan was also developed, but it too went nowhere. The interviewee said he knows Mr. Freeman made recommendations to the city regarding security. Unfortunately, the city’s FOIA response indicated they had “lost” them.

One interviewee said that on the day of the shooting Craddock was upset and that a fellow employee tried to calm him down. The *Hillard-Heintze* report makes reference to the killer being agitated when someone said to the killer that he had heard the killer was resigning. But other than that, the author of these *Finsdings* cannot confirm this incident.

There are conflicting reports concerning the killer’s movements during the rampage. Those conflicts are noted in the *Timeline* at the end of this document. For example, one survivor said, “… there is an error in the Virginia Beach Police Report. When the Craddock came up to the third floor, he did not go directly to LaQuita Brown’s desk. I know, I was an eyewitness; I saw it. So, I am not sure why the report is incorrect. I gave a written statement to that fact.”

The same survivor said, “I saw the killer; I am lucky to be alive. The killer used a silencer. It sounded like a nail gun. There had been work in the building and we were used to the sound of nail guns. I thought someone was hanging a picture. Then I heard a loud thud—I assumed someone had dropped something. A coworker came out of her office. She was shot, but lived. My coworker and I hid under the desk. As I was crouching down, I could see him head down the hall toward LaQuita’s office.”

The survivor then added, “He came to the third floor a second time. By then I had barricaded myself in my office and locked the door. I called 911 when I heard him come up the stairs and I heard more shots.”

If you ask how did Craddock carry out his rampage, many survivors said it was because he had a silencer. They could not hear shots on other floors.

Clearly, the gunman was able to carry out his actions because the City of Virginia Beach because of a number of flaws in Building 2 security. Even rudimentary security measures were not in place in Building 2, where the rampage took place.

 --The City of Virginia Beach had a security plan adopted in

 2001. That plan was never updated despite the fact that

 Virginia was the site of two mass shootings, the Appalachian

 School of Law (2002) and Virginia Tech (2007). The city

 apparently did not examine and learn lessons from those

 two shootings.

--The city’s security plan was not updated. It did not mandate

 such things as regular crisis/emergency drills; did not have

 active shooter training as part of the regular, mandatory

 training, nor did it ensure that each employee had something

 as simple as an *Emergency Response and* *Procedures*

reference at his or her desk.

--One interviewee said who the Commission, *“ The city*

 *regularly took money out* *of the budget marked for security*

 *and spent it elsewhere. The city always put funding security*

 *on the back burner.”*

--Security in Building 2 was fragmented, e.g., different floors

 had different lock and entry procedures. As a result, first

 responders were not able to get to the killer while the

 rampage was in progress. This flaw in the city’s security

 security protocol endangered and lost lives.

--Two years prior to the May 31, 2019 tragedy, a fire drill was

 conducted in Building 2. Participants in the exercise identified

 major shortcomings in communications. Those shortcomings

 were passed to the fire chief and the city manager, but no

 actions were taken by the city to correct them.

 Communications proved to be a major flaw during, and after

 the killer’s rampage on May 31, 2019.

--The City of Virginia Beach had a law preventing employees

 from bringing a firearm into work. Ordinary citizens, however,

 can bring firearms into municipal buildings. The law needs to

 be changed. Either everyone can bring a firearm in or no

 one can. The current situation disarms and makes honest,

 hard-working municipal workers sitting ducks for angry

 and demented individuals.

One of the interviewees, who was involved in emergency and crisis planning was extremely critical of the city, saying:

 *The city had ‘sh..ty management.’ I begged the head of HR for more*

*staff but never got any. We had an evacuation drill in Building #2 less*

*than a year before the shooting. … I never have worked anywhere*

*where the government is so disengaged; I have never worked*

*anywhere like this—a vacuum. It is the leadership; the leadership*

*isn’t trained. There was inaction on valid requests before the*

*shooting.”*

*“All three chiefs of risk management are now gone. Mr. Redick (he*

*was on the Commission) was the head of Emergency Management*

*Planning for the City. … You need to file FOIA requests. Don’t trust*

*the city attorney.”*

*“The Virginia Beach Fire Department does not manage building*

*evacuations. My office did. One person in my office managed that,*

*as well as a variety of different types of training. I told HR we don’t*

*have the people to manage evacuation drills. I asked for more money*

*for personnel and equipment such as laptops and defibrillators.*

*After the shooting, the city got millions of dollars. We didn’t get*

*any of this. All I could get were stair chairs.”*

RECOMMENDATIONS

1. The legislature should lay out standards for safety in all public buildings, at all levels of state, county, and municipal buildings. These standards should include, but not be limited to, banning all guns from government buildings; metal detectors at all entrances; 24-hour security at all entrances; standard locks, key cards, or combinations for entering all parts of a building; and a Knox box, in a central location, guaranteeing first responders can access all parts of a building. This lack of security standardization was a problem at Virginia Beach for first responders.
2. The legislature should adopt laws requiring regular “active shooter” training for all state, city, and county employees. This training should be followed by annual “active shooter” drills.
3. The legislature should ensure that emergency and fire drills exercises (including active shooter drills) should be conducted once every six months in all state, city, and county buildings. These drills should test communications, so that if a crisis occurs, lines of communications will have been practiced and known to first responders. This training should be mandatory for all employees and first responders.
4. The legislature should require all incorporated municipalities as well as counties have an up-to-date security plan specifying the requirements laid out in the first three recommendations above.
5. The state should require that all state entities have an Emergency Action Plans (EAP) and that all EAPs be reviewed annually. The reviews should be conducted by certified by state authorities. Components of an EAP should include updated blue prints and grided reference graphics—all of which should be readily accessible to first responders.
6. identify any obstacles confronted by first responders;

First responders on May 31, 2019, encountered numerous obstacles. The police arrived on the scene at 4:12:15 p.m. Some first responders apparently were confused about which building was Building 2. One officer is heard on police audio asking if the “incident” is in Building #1 or Building #2.

Once inside Building 2, the shooter retreated into locked areas not readily accessible to the first responders who did not have a master key or swipe cards to enter all sections of the building.

The killer had resigned, so his badge should have been immediately deactivated. The process is simple and takes a few seconds—a few strokes on a computer to deactivate. But this apparently was not done. He was able to retreat to a part of the building the police could not access.

If the killer’s badge apparently was not deactivated, why are there still contradictions about his movements? Building badges activated proximity sensors that tracked people throughout Building #2. Something does not make sense here.”

There was no Knox Box—A box that would have contained all the swipe cards, combinations, and whatever was need to access all parts of Building 2. As a result, the killer continued his rampage while police scrambled to gain access to parts of the building.

Police audio recordings confirm law enforcement could not access parts of the building.

*At 4:29:45 p.m. an officer says they need access keys. Approximately 17 minutes after arriving on the scene, the police still cannot get access to where the killer was carrying on his rampage because there is no Knox Box for emergencies.*

Lives were undoubtedly lost because of this obstacle first responders faced. The author of this report matched up the timeline with the police audio recording. The police audio recordings confirm, when matched with the timeline of the shooting, that at least one person was killed and one wounded while law enforcement repeatedly called for keys or swipe cards--some way to gain access to where the shooter was.

There was confusion about a unified command as the rampage unfolded with conflicting officials (fire or police departments) claiming they were in charge.

In an active shooter situation, there is always a certain amount of confusion. But incompetence should not be brushed aside by calling it “fog of war.” That was true at the City of Virginia Beach on May 31 2019. The confusion in and around Building #2 on May 31, 2019 was beyond acceptable bounds.

Threatening Red Cross officials, who arrived on the scene to offer help, with arrest unless they left is not a “misunderstanding” as one Commission member wrote. It is incompetence, reflecting a lack of training and knowledge, and common sense.

One of the criticisms frequently heard by family members and survivors was the confusion in the immediate aftermath of the shooting. Turning away the Red Cross, with its well-trained Mass Casualty and Incident Response Teams, is not only unconscionable, but it is inexcusable.

The invaluable professionalism and humanitarianism of the Red Cross was lost. The chance to bring Red Cross professionalism to help establish some sort of order in the shooting aftermath was wasted. The loss of Red Cross professionals, skilled in grief counseling and trauma care, meant the survivors and family’s anguish and pain continued unabated.

Clear-cut lines of communication during and after a mass shooting are of paramount importance. There were serious communications problems at Virginia Beach.

RECOMMENDATIONS

1. The state legislature should consider adopting a bill mandating uniform security measures on all state and local government buildings, as well as a Knox box that contains all the necessary combinations, swipe cards, and or keys to ensure first responders can get access to all parts of any building. The failure to have a Knox Box in Virginia Beach municipal building #2 appears to have cost lives. When the timeline is matched with the police audio or first responders, it is clear that law enforcement did not have access to the area where the killer was carrying out his rampage for around 20 minutes.
2. A unified command and control center is essential to successfully handling an active shooter situation (and other crises). This was a problem on May 31, 2019 at Virginia Beach. Therefore, the legislature should consider a bill that would make the establishment of a unified command part of active shooter (all crises) training.
3. The legislature should ensure that active shooter drills should be held every 3-5 years so that first responders are familiar with public buildings. There should not be a repeat of what happened at Virginia Beach where apparently some first responders did not know which building was Building 2.
4. There is a computer vision that will automatically lock down a building. It is widely used in state and local governments, as well as in private business. The legislature should mandate this—or a similar system—be mandatory in all state buildings, including universities.
5. identify and examine the security procedures and protocols in place immediately prior to the mass shooting;

Building #2 had poor security protocols. There were two, open public entrances to the facility. One on the northside the other on the southside. People were free to come and go at well. There were two locked entrances, one on the eastside and one on the westside. There was no way to open those doors from the outside. They were mainly used by city employees to exit the building. Floors two and four had badge-swipe access security.

There was also an open entrance at the basement loading dock. And, there was a locked tunnel leading to Building #1 (City Hall).

Average citizens could carry a gun into the building—and many did—because of the state’s open carry law. But the city had a policy prohibiting employees from carrying a weapon while at work. That meant city employees, might have to deal with irate, armed citizens with no means to defend themselves. In the current political climate some politicians fan hatred by using government workers as scapegoats to promote their careers—violence was bound to happen. If it had not been Craddock, it might have been some one furious over receiving a late charge on a tax or city service bills.

There was no reception or security at any of the building’s entrances. Nor was there any security on the first floor. Building #2 was wide open. A check with Alexandria HR Department revealed their city building security includes one open entrance to the public with security and a receptionist. If a person is there for a meeting, he or she has to be escorted.

While there was a protocol prohibiting city employees from being armed, there was no way of enforcing the protocol. The killer brought weapons into the building in the evening several days prior to the rampage and, according to one source. He then hid them in a locker.

There was no way to detect or prevent a city employee from bringing a weapon into Building #2

There clearly were flaws in the City’s security protocols. For example, each floor of Building #2 had different locks, swipe cards, or combinations to enter that prohibited first responders from pursuing the killer.

RECOMMENDATIONS

1. The legislature should adopt a bill specifying what should be

 included in all security plans—ranging from establishing a single

 emergency command, to standardized locks and access

 procedures, having Knox boxes guaranteeing quick access to all

 parts of buildings, ensuring uniform communication systems that are

 familiar to all first responders, and having immediate and long-term

 post-crisis counseling for victims’ families as well as those

 traumatized by the incident.

1. The State legislature should consider adopting a bill making it illegal

 or state for local government entities to syphon off funds allocated

 for security purposes. Some of the Commission’s interviewee

 indicated

 this was a fairly common practice by Virginia Beach.

1. In an interview with the City of Alexandria, Va., Director of HR, she

 said the following. “In Alexandria we are in the process of beefing up

 our security. We are reviving badges that identify staff, contractors,

 and visitors. There is a reception area where everyone must clock

 in. If a person is attending a meeting, he or she must be escorted.

 We analyzing and reviewing security all the time.” She also said,

 “During our orientation for new employees, we talk about their need

 to be aware of their surroundings, aware of co-workers, and people

 who come in and out. We tell employees when they ask someone,

 ‘How are you?’ to listen carefully to what they answer and if they

 need help, refer them to someone, such as HR or EAP.” The

 legislature should look at what Alexandria is doing and draft state

 safety guidelines and security protocols on that city’s model.

1. examine the post-shooting communications between law enforcement and the families of the victims;

There were numerous complaints about the post-shooting communications between law enforcement and the city on the one hand, and the families of the victims on the other. From the outset of the shooting, communications were flawed. As noted above, some confusion can be expected in the heat of the moment, during a fast-moving crisis. Apparently what crisis training the city had, gave short shrift to post-shooting communications.

While there is always some confusion during and in the immediate aftermath of a mass shooting, you cannot blame what happened in Virginia Beach on “fog of war.”

Two years prior to May 31, 2019, there had been a major fire drill in Building #2. Serious communications problems surfaced at that time and were reported to officials—but nothing was done to correct the problems.

There was confusion in the immediate aftermath of the rampage over who was in charge—the Fire Department or the Virginia Beach Police Department.

Families of victims repeatedly complained about post-shooting communications. One family member said this:

 “*During the shooting the channels of communication were not good.*

 *Our family did not learn that my sister was killed until around 11:00*

 *p.m. From the time of the killer’s rampage until we got word of (my*

 *sister’s) death was the worst in my life. It was horrible. No one told*

 *us anything—communication was awful. We could have been*

 *informed earlier. (She) was killed in her office. She had an I.D. on*

 *her. She had I.D. on her. There was no reason for the delay. No*

 *one told us anything.”*

One of the interviewees said the city does not inform employees about anything that is not a city function:

 *“We heard about the Commission meetings through the grapevine.*

 *Since most of the victims suffer from PTSD, they choose not to face*

 *the Commission. The Commission should have had a way to contact*

 *each of the victims to inform them about meetings. I found out about*

 *the local meeting dates too late to attend. To attend meetings in*

 *Richmond, I have to take a personal day.”*

There were many complaints about the city’s lack of support for victims. Here are some of the comments:

 *“The Commission should look at the number of people who worked in*

*Building #2 who have left city employment since the shooting,*

*compared to previous years. I know five people (including me) who*

*retired or left the city precisely because of the way city leadership*

*treated survivors. … It is difficult to get any assistance from*

*Workmen’s Compensation claims, certainly not something someone*

*who is struggling with PTSD needs to worry about.”*

*“I received therapy and other support through my own efforts, not*

*city leadership.”*

*“I had to struggle to figure out how to get paid for counseling.”*

 Jason Nixon’s response to the interviewers question, “Are your

 medical bills and those of your three daughters being paid for by

your late wife’s insurance?” Mr. Nixon said, *“No, Mayor Bobby*

*Dyer said ‘Kate did not technically retire, so I cannot have her*

*insurance.”* Then Mr. Nixon pulled out his cell phone and played

a recording of his conversation with Mayor Dyer and I heard him

say, “*Kate did not technically retire that is why you cannot*

*have her insurance.”*

*“The City of Virginia Beach has money and I did get some help from*

*them. But after time, not even the co-pays were being reimbursed.*

*Someone is making money off this—where is the money going? For*

*example, supposedly Towne Bank gave $500,000 after the shooting.*

*What happened to that? Did the city use it for something else?*

*VBStrong dragged things out waiting for the two-year time limit and*

*then said they had no more money. …”*

*“I went through a lot of stuff on the day o the shooting. I heard people*

*screaming. When I went back to work my supervisor told me to be*

*productive.”*

*“The Department of Public Works, instead of bringing in temporary*

*help, cut the healing, claiming they needed coverage. Several*

*employees claimed that they were not allowed to go to more than one*

*hour of counseling a week. The supervisors are not trauma informed.*

*They should not be defining how many hours it takes to properly heal*

*from a mass shooting.”*

*“Now, almost three years later, people have retired or left the city and*

*upper management has less empathy for the survivors.”*

*“The take-away from all this is that we have supervisors who were in*

*the building taking care of people who were in the building. We have*

*supervisors who were not in the building also psychologically affected*

*by the loss of their subordinates and co-workers. Those people are*

*not considered victims; but they too are having issues. And they feel*

*supervisors guilt because they can’t imagine what we went through.*

*In addition, they are not trained to know how to handle these*

*situations. There is an error in the plan put into action. An outside*

*trauma-informed leader should have been placed in charge of*

*handling all these trauma victims.”* (Note: The interviewee’s

comments underscore the severity of the mistake of turning the Red

Cross away and threatening to have them arrested if they did not

leave. The Red Cross has the specialists to deal with mass casualty

trauma victims.)

*“We were encouraged to use our own resources to seek help. But*

*in a week before we were expected to be back at work and*

*that week we spent attending the funerals of those who taken or*

*being with those trying to make some sort of peace.”*

*“The VB Strong Center helped a lot of people. For me, however,*

*counseling came late. VB Strong counseling was not set up until*

*the end of October. I needed something immediately. … I did not*

*trust the person I was sent to. He knew everything, which means*

*he knew nothing. Fortunately, I have a friend who had a degree in*

*psychology. She gave me things to look for in a therapist. I started*

*seeing a psychologist in July (2019). So many people went for*

*months without help. VB Strong should have been set up much*

*faster.”*

*“My line management was spectacular and incredibility supportive.*

*The city gives a lot of leeway to managers—there is an inconsistency*

*in giving managers training for dealing with trauma. My wife was in*

*Public Works Operations. She was going through a lot on her own*

*and having to help me. She was not getting support.”*

*The city does not inform employees of anything outside of city*

*Functions. We heard about the Commission through the grapevine.*

*Since most of the victims suffer from PTSD, they choose not to*

*face the Commission. The Commission should have a way to*

*contact each victim to inform them of the meetings. I found out*

*about the local meeting dates too late to plan to attend. To attend*

*meetings in Richmond, I must take a personal day.”*

*“Through the support of my supervisor and his supervisors, I have*

*received psychological support needed to continue to heal from this*

*event. However, please note that I sought out my therapist and asked*

*Corvel to pay for it. Then I received permission to have a separate*

*therapist. At one time, I had three therapists and the VBStrong*

*Center. … Without the resources I sought on my own, I would not be*

*able to function today.”*

*“Many people have only seen a therapist once or twice. I do not be*

*around when they finally deal with their pent-up trauma. DPU*

*(Department of Public Works) has a lot of temp agency employees*

*who missed out on a lot of benefits we received as full-time*

*employees. This does not seem fair … We now have mass trauma*

*victims, Virginia citizens, whose wellness was not addressed.”*

*“VBStrong did a great job. The city of Virginia Beach has given us*

*nothing.”*

*“I was told I would be given lifetime benefits, but I am not getting*

*my therapy paid for.”*

*“….(praised) the services offered by the city to employees in the first*

*month after the shooting—they couldn’t do enough. After that,*

*however, the city washed its hands of the survivors. I became*

*disgusted by the way the city treated survivors.”*

*“There needs to be a recovery plan, a policy in place specifically*

*dealing with the mental health care rights—workmen’s compensation.*

*We had to fight for claims.”*

*“After the shooting, they gave us forms—I was still in shock. Two*

*weeks later I was back at work. When the second anniversary of*

*the shooting came, if you had not signed up for life-time benefits,*

*you could not get them. No one from the city told us that. I found*

*out by accident and just in time and called as many people as*

*possible. I have my benefits.”*

*“As for Virginia Beach Strong, it was more a referral service than*

*anything else. The city could have had counselors, someone who*

*would help with our feelings and emotions. After the shooting, the*

*city expected us to work at the same level as before the killings.*

*We need more education on how to handle trauma.”*

*“The city referred us to the Virginia Beach Strong Center. Then*

*the city saw no role to help us. There was no consistency in the*

*city’s approach to us after the shooting. The city refused to*

*acknowledge us as survivors.”*

*“After the shooting there was no organization. We were put in a*

*trailer—it felt very unsafe. It was hard to work with Corvel (Workers*

 *Comp Insurance).”*

*“We had to sign an affidavit that we will not be emotionally disturbed*

*by going back to work in Building #2. We went to work in the*

*basement. I have never seen a Continuity of Operations Plan*

*(COOP). I am involved in Hurricane Damage Plans.”*

*“I did go to Virginia Beach Strong, but it was not for me. Virginia*

 *Beach Strong keeps you anchored in the moment and I needed to*

*move on. I did not need them. I had support. I had my family and*

*friends for support. I could only do Virginia Beach Strong for so*

*long. We need to adapt and more on.”*

*“I can honestly say the city did absolutely nothing to help me. I got*

 *nothing from the city because I was a ‘temp employee.’ The city*

 *could not help me because I was not an employee. They gave me 10*

*phone numbers of counselors to call to help me. I called all 10 and*

*they all only counseled children. My boss help me find a counselor*

*who would work with me pro bono.”*

*“What bothers me is the city takes care of the deceased people’s families, but they do nothing for us who are survivors. They only gave us a week or two off. They don’t realize we were stepping over bodies, walking in blood, I saw the injured man in the truck outside. We had to leave the building with our hands in the air.”*

*“Almost all temps left, I am the only one who stayed. I am now a city employee and a full-time worker.”*

RECOMMENDATIONS

1. The legislature should adopt measures related to ensuring a standardized communication system for dealing with active shooter and other crises. That legislation should stipulate that police and fire employees are required to be familiar with that communication system.
2. The legislature should adopt a bill ensuring that first responders are trained in how to handle the emotional complexity of survivors of mass shootings (and all crises), as well as notification and counseling of next of kin. Families and survivors of the Virginia Beach shooting reported unconscionable conduct in dealing with families and survivors in the immediate aftermath of the May 31, 2019 rampage, as well as in the days and months that followed. Some people interviewed by the Commission reported horrific actions and words by city employees in dealing with families, survivors, and the Red Cross. In the case of the latter, Red Cross employees, specialists in handling post shooting incidents, were apparently threatened with arrest if they did not leave the site of the rampage. Given the number of complaints and concerns expressed in interviews by families and survivors about the confusion in the post-shooting period, the city’s actions/attitude toward the Red Cross is unconscionable.
3. The state should adopt a mandatory training program for all first responders on how to use understanding and compassion in dealing with victims, survivors, families, and all individuals traumatized by a tragedy. There were glaring examples of inexcusable behavior by city officials and police in dealing with survivors and families of the Virginia Beach rampage. For example, the words and actions of a female Virginia Beach Detective in dealing with the widow of a victim, go far beyond insensitive. The detective’s words conduct and words redefine the words “rude” and “obnoxious.”
4. assess such other matters as it deems necessary to gain a comprehensive understanding of the tragic events of May 31, 2019, and

The Commission did not “gain a comprehensive understanding of the tragic events of May 31, 2019,” because it did not have the tools to do so. The Commission did not have subpoena power, it had a limited budget preventing it from bringing in experts, the Commission’s size (20 voting members and one non-voting member) was unwieldly and on numerous occasions cancelled meetings for lack of a quorum.

The Commission did not assess many documents concerning “other matters deemed necessary to gain a comprehensive understanding of the tragic events of May 31, 2019.” The Commission ignored the expertise of some of its members; its requests for documents from the city were almost all rejected; the Commission did not pursue what happened to the computers the city removed and replaced right after the rampage (the law may have been broken), it did not interview the mayor and members of the city council, and it did not bring in and talk to experts on mass shootings to help with its analysis, conclusions, and recommendations.

The failure of the Commission to aggressively tackle the tasks given it, coupled with the legislature’s failure to give the Commission the tools necessary to do the work, means the conclusions of this *Investigative Findings*—or any of this Commission’s reports—are not as thorough as they needed to be.

Time and time again, the majority of people interviewed, both past and present city employees, complained about a lack of training. The training complaint spanned all aspects of work life in the city: While active shooter training was available, it was not required or encouraged. When the shooting started some complained they had no idea where to go or what to do. Nearly 100% of those interviewed said they had no confidence in Human Resources Liaison Officers—some HR liaison officers talked about people behind their backs and revealed confidential information. The vast majority of those interviewed complained about a toxic work environment.

Based on the interviews conducted by the authors of this Investigation, top city management set the example of a toxic work environment. While this toxicity was not a policy, it did set a permissive tone allowing the worst management practices to survive. There were pockets of good management practices such as the third floor of Building 2. People who worked on that floor talked about a congenial, supportive work atmosphere as well as a great deal of support and understanding or those traumatized by May 31, 2019 tragedy.

One person interviewed said she had the impression employees on the second floor could not wait to find other employment.

RECOMMENDATIONS

1. The legislature should consider adopting legislation that requires all commissions such as the *Commission to Investigate the Virginia Beach Mass Shooting on May 31, 2019*, to regularly report back to the legislature on the progress made in each area the commission has been asked to investigate. The report should also identify obstacles the commission is facing to fulfill their assigned tasks.
2. The legislature should adopt a law specifying that any commission established to investigate a mass shooting (or any tragedy), should convene no later than three months after the mass shooting (or any tragedy). This legislation should spell out the difference between a “report” and an “investigation.” There was public confusion about the city’s hiring *Hillard-Heintze*, a Chicago-based security consulting firm,to write a report and the state establishing a commission to investigative the tragedy. Many did not understand that a report and an investigation are two very different product with different goals. This confusion was an obstacle to the commission’s investigation.
3. develop recommendations regarding improvements that can be made in the Commonwealth’s laws, policies, procedures, systems, and institutions, as well as those of other government agencies and private providers, to minimize the risk of a tragedy of this nature from ever occurring again in the Commonwealth.

In addition to the recommendation list in each of the preceding sections, below are recommendations of a more general nature.

RECOMMENDATIONS

1. The words “negligence,” and “gross negligence” should be defined by the legislature in order to prevent a miscarriage of justice as was done by the Virginia State Supreme Court’s decision overturning a jury verdict in Pryde and Petersen vs. Virginia Tech lawsuit.
2. The legislature should consider tapping into state universities and colleges’ *Criminal Justice Departments* and *Homeland Security Departments*. For example, give graduate students the assignment of “Red Teaming” security protocols in state and municipal organizations and their buildings. By “Red Teaming,” I mean have the students examine security in a given building and then plan how, if they were planning a shooting spree, they would circumvent existing security. Then have the students write an analysis of the weaknesses of the respective security protocols. This is a no-cost initiative that marshals state resources (its colleges and universities) to help curtail gun violence.
3. The legislature should consider adopting a *Virginia Mass Violence Care* *Fund* (for Virginia Beach and all potential Virginia citizens who might become the victims of gun violence). Such a bill should guarantee medical care for victims in perpetuity. The victims should include a wide spectrum of people, immediate family members, relatives, friends, and co-workers.
4. The legislature should consider adopting a bill requiring immediate action if a person expresses fear for his or her safety. Usually this involves the chief of police responding to the complaint by picking up the person in question and escorting him or her to a mental health facility for evaluation. The individual is not allowed on a campus or in a public building until he or she has been deemed not a threat. (Yes, this is tricky. But such a law exists in Ohio.)
5. Virginia’s Sovereign Immunity Law should be abolished. If not abolished, the law should be amended to define gross negligence as a way of helping to prevent the biases of judges and politicians from influencing their definition of “gross negligence.” The law makes it economically more viable to pay the sovereign immunity liability of $100,000 than pay the cost of tightening security. If the Sovereign Immunity law continues in any form, the amount of money any government is liable for, should be raised from $100,000 to at least $100,000,000. The threat of a $100,000 fine or legal judgment is not enough for state and local government entities to take security seriously and to make security a high priority.
6. Future Mass Shooting Commissions involving an investigation of rampages at schools, universities, or any state or local government facility should consist of no more than 10 Commissioners. The membership model for the Virginia Tech Mass Shooting Commission is an excellent example: Eight members. A lesson learned from the Virginia Beach Mass Shooting Commission is 20 voting members and one non-voting member is far too large and cumbersome, hobbling the Commission’s work. The Virginia Beach Commission was forced to cancel numerous meetings. Some meetings were held without a quorum; nothing could be voted on.
7. Adequate funding and *pro bono* lawyers are essential for any commission to do its work. The Virginia Tech Commission had a budget of $460,000 and access to eight *pro bono* lawyers. The Virginia Beach Commission had a budget of $38,504 and did not have access to designated, *pro bono* lawyers. The Virginia Beach Commission, therefore, did not have the resources to bring in specialists for consultations in the fields of psychology, security, Human Resources, or lawyers who specialize in handling mass shootings.
8. Commissions, such as the Virginia Beach Commission, should have subpoena power. Subpoena power affords those talking to the Commission protection against retaliation. The Virginia Beach Commission was hampered in its investigation because a number of individuals feared retaliation by the city. For example, one man refused to talk to the Commission because he did not have subpoena protection. He indicated if he did talk to the Commission he might be fired. Another would only talk to the Commission after he had left city employment and found a new job. And still another, said she overcame her concern about retaliation and decided to talk with the Commission.
9. .Subpoena power is powerful tool that helps a Commission break

down obstacles as well as managers’ and employees’ lack of willingness to cooperate in an investigation. (This recommendation reinforces the recommendation in Section Two, based on the eight charges laid out to the Commission by the State legislature, charge ii, Recommendation #1.)

1. Not only should the number of Commission members be capped at 10, but the makeup of the Commission should ensure gender balance. The Virginia Beach Commission started with 20 members, two of whom were women. Gender balance is important not only because this 2023 not 1923, but because men and women bring different innate skills and approaches to analysis and problem solving. One female member found it difficult to attend meetings in person, as require, and after the initial zoom meeting (permitted because of COVID restrictions), she attended no meetings and resigned. The second female member resigned in November, 2022. In her resignation letter she wrote, “In my opinion, manipulative attempts have been made to stifle information-seeking, and as I reflect on my time on the Commission, I have concerns that the Commission’s work is being obstructed from within, either deliberately or due to negligence.”
2. No individual with any work history or business contacts with the government entity where the mass shooting took place should be permitted to be a Commission member. In the case of the Columbine and Virginia Tech Commissions, no member on either body had any current or past ties to the schools where the violence took place. The presence of former Virginia Beach City fire and police department employees gave the impression, rightly or wrongly—of bias and lack of objectivity. This impression was underscored by such comments as a member who wondered if the city could not have prevented the shooter from carrying out his rampage because the action might have violated the killer’s civil rights. Furthermore, individuals with private security or investigative businesses should be only used as consultants. They should not be voting members on the Commission; they can be used as a resource. (This recommendation reinforces the recommendation made in Section Two, based on the eight charges given the Commission by the State legislature, charge i, Recommendation #2.)
3. There were small, but significant details, exposing the fact that the state apparently did not take the Commission seriously. The Commission had troubles finding a room in which to meet. The Commission’s venue changed frequently and several meetings had to be held in the Office of Inspector General’s (OIG) conference room. The meetings were supposed to be open, but to get to the OIG room required escorts—it was something of an obstacle. There was little to no publicity about Commission meetings—time, date, and place. Commission’s meetings did appear on a state calendar, but 99% of Virginians are not familiar with the calendar. Some of those interviewed said they learned about meetings via the grapevine and often too late to attend.

EPILOGUE

FORESEEABILITY AND ACCOUNTABILITY

From the outset, the dark cloud hanging over the Commission was the specter of litigation. No one uttered the words “foreseeability” or “accountability.” Nevertheless, they were uninvited attendees at each meeting. Some members of the Commission went so far as to frequently appeared to make excuses for the city—why the city could not have seen or prevented the tragedy.

Would the Commission, in anyway, find the City of Virginia Beach culpable—or even remotely imply City policies or personnel were part of the problem leading to the rampage? The chances of that happening were slim to none. The presence of former city officials and Virginia Beach police on the Commission ensured there would be no accountability.

Let’s take a moment and look at the words that frightened the City of Virginia Beach: 1) Foreseeability—could the mass shooting have been foreseen and therefore prevented, and 2) Accountability—if the shooting could have been foreseen, who is accountable for not taking steps to prevent it?

The city’s fears were unwarranted. The legal system in Virginia, all the way up to the Virginia Supreme Court, has generally followed the political theory that no one person, institution, or organization can be held accountable for someone else’s actions. Virginia Supreme Court decisions attest to that philosophy and fact.

The Virginia Supreme Court’s overturning the jury verdict against Virginia Tech in the Pryde and Petersen lawsuit is all the proof you need. That decision allowed a lie to be part of its decision and in so doing re-wrote history. The lie was who was in charge of the investigation on the morning of April 16, 2007.

The Supreme Court wrote it was the town of Blacksburg police who were in charge of the investigation. Blacksburg did not have the authority to warn the campus—the trial transcript as well as the legal agreement between the town and the university attest to that fact. The Virginia Beach Police were in charge of the investigation and they had the authority to warn.

The Virginia Supreme Court allowed the rewriting of history and got the university off the hook.

Even if the Commission had pointed to, or found, gross negligence, there was no way the City of Virginia Beach would have been held accountable. The Virginia Supreme Court would, undoubtedly, ensure that.

The Virginia Supreme Court has said, “In Virginia, we adhere to the rule that the owner or occupier of land ordinarily is under no duty to protect an invitee from a third person’s criminal act committed while the invitee is upon the premises.” *Gupton v. Quicke, 247 VA. 362, 363, 442 S.E 2d 65, 658 (1994.* The court also said, “We also have stressed that ‘before any duty can arise with regard to the conduct of third persons, there must be a special relationship between the defendant and either the plaintiff or the third person.”

But even when a “special relationship” does exist, the business owner has no obligation to protect anyone.

In the case of *Wright v Webb, 234 Va. At 533, 362, S.E. 2d* the court addressed the “special relationship” between the business owner and the invitee. The court held “that despite the existence of that special relationship, the business owner does not owe a duty of care to protect its invitee unless it ‘knows that criminal assaults against persons are coming, or are about to occur, on the premises, which indicate an imminent probability of harm to (its) invitee.’” The court also said, “we further held that for the duty to be imposed there must be ‘notice of a specific danger just prior to the assault.’”

The Virginia Supreme Court time and time again, refuses to recognize the responsibility of a business proprietor to protect “its invitees from unreasonable risk of physical harm.” The Supreme Court specifically rejected 314A of the Restatement (Second) Torts. “Acts of assaultive criminal behavior cannot reasonably be foreseen.” The Virginia Supreme Court reasons:

*In ordinary circumstances, it would be difficult to anticipate when, where, and how a criminal might attack a business invitee. Experience demonstrates that the most effective deterrent to criminal acts of violence is the posting of a security force in the area of potential assault….”*

The court however, in refusing to recognize businesses responsibilities responsibility to protect “invitees” appears to indict the City of Virginia Beach for its lack of security. If “the most effective deterrent to criminal acts of violence is the posting of a security force…” then the city’s gross negligence in terms of security would seem to make it culpable.

The City of Virginia Beach’s failure in three responsibilities—security, Human Resources, and training—appears to make it culpable for contributing to the inevitability of workplace violence. And if a lower court should find that to be the case, it is almost a certainty the Virginia Supreme Court would overturn the verdict.

3/29/23

UPDATED 4/22/23

BLENDED TIMELINE

For the

MAY 31, 2019 TRAGEDY\*

 To understand the events of May 31, 2019 and the killer’s movements we have constructed a timeline built on several timelines and police evidence. We have combined Virginia Beach Police Department information with the *Hillard Heintze* timeline. Those entries are in Calibri font (Black). One entry is in Apple Chancery font because it is from the text of the *Hillard Heintze Report, but* does not appear in their timeline. (Red)

The Stronger Together Peer Group Timeline is in Brady Hand font. (Green)

**The Virginia Beach Police body cam audio recording/timeline is in bold print. (Purple)**

April 1996-April 2002: Craddock serves in the Virginia National Guard. He is

 assigned to Army National Guard units in Norfolk and

 Hampton, Virginia.

April 2002: Craddock receives honorable discharge from the National

 Guard.

\*One of the Commissioners maintains that he heard communications. The author was not able to verify or find missing communications. This timeline may be flawed because those communications are missing.

May 2002: Craddock graduates from Old Dominion University. He accepts a position as an Engineer at Lewis and White.

May 2003: Craddock resigns from Lewis and White.

 Craddock accepts position as Project Engineer at MSA Engineering.

February 2008: Craddock is laid-off from MSA Engineering. An involved individual close to the subject said her complained about the lack of promotion and perceived racism.

 Craddock marries.

 Craddock accepts offer of position as Project Engineer III at Draper Aden Associates.

July 2008: Craddock resigns from Draper Aden Associates.

November 2008: Craddock accepts a position as Engineer II for the City of Newport News, Virginia.

January 2010 Craddock resigns from city of Newport News.

February 2010 Craddock accepts offer of position as Engineer II at City of

 Virginia Beach, Virginia.

2011-2017 Craddock receives annual evaluation and is rated “Meets Standards.”

January 2012 Craddock purchases a home in Virginia Beach.

September 2012 Craddock receives “Thumbs Up” Award.

April 2014 Craddock receives “Excellence in Service Award.”

May 2015 Craddock receives “Team Participation Award.”

December 2015 Craddock receives “Excellence in Service Award.”

April 2016 Craddock applies for and obtains Concealed Handgun

 Permit. (First gun purchase.)

July 2016 Craddock purchases H&K USP45C ACP pistol.

 Craddock purchases JRC JRCV067138 45 ACP carbine rifle.

August 2016 Craddock begins visiting gun websites via his phone.

September 2016 Craddock separates from his wife.

 The first images of weapons appear on Craddock’s phone.

 Craddock purchases a Glock 21 45 ACP pistol.

October 2016 Craddock submits a request for Suppressor Transference Certification. (Silencer)

December 2016 There are Issue occurs regarding missing contractor checks

 on Craddock’s project.

As 2016 came to a close, Craddock began to encounter challenges at work regarding appropriate financial and contracting records—and in engaging with citizens and contractors. (*Hillard-Heintze*, page 43)

January 2017 Management letter documents Craddock’s mishandling of contractor checks. Additional investigation determined that

 Craddock allowed a total of 13 checks to surpass the “stale date” of 180 days from date of issue. (*Hillard-Heintze*, page

 43)

June 20, 2017 Craddock is placed on a Performance Improvement Plan (PIP) dealing with three areas specifically: 1) Working Relationships, and 2) Project Management, and 3) Responsiveness to Customers. The PIP ended successfully on August 15, 2017. (*Hillard-Heintze*, Page 43)

 Craddock emails supervisor attesting that his work was

 above average, but that his salary did not reflect that.

June 2017 Craddock’s wife moves out of their home.

 Craddock emails his supervisor complaining he is assigned a project above his expertise and paygrade.

 Management places Craddock on Performance Improvement Plan (PIP) for deficiencies in project

 management skills.

July 12, 2017 Craddock’s supervisor issues a Letter of Expectations. The

 subjects addressed were: better oral/written communications

 skills, exercising good judgment, meeting project deadlines,

 and dealing effectively with the public.(*Hillard-Heintze*, Page

44)

July 18, 2017 Craddock’s supervisor issued him a Written Reprimand for Poor Performance. (*Hillard-Heintze*, Page 44)

Aug, 22, 2017 Craddock’s Annual Performance Evaluation includes a “Improvement Required ” (PIP?) in the following

 fields:

1. Working Relationships with Coworkers, Supervisors, the Public and Outside Contracts
2. Knowledge of the Field
3. Compliance with City and Departmental Policies and Procedures
4. Conflict Resolutions
5. Commitment to Exceptional Customer Service
6. Oral and Written Communications (His supervisor indicated he struggled to respond clearly to a citizen’s email complaint about a project. (*Hillard- Heintze*, Page 44)

August, 2017 Craddock directs attorney to proceed with filing

 divorce. Craddock completes his Performance

 Improvement Plan successfully. Suppressor

 registration completed.

September, 2017 Craddock’s divorce is finalized. Craddock texts

 “somebody close to him” that he “finally got

 my suppressor today.”

December, 2017 Craddock purchases Bond Arms Backup Derringer 45

 ACP pistol. The frequency of the subject’s communication

 with his mother begin to decrease.

February, 2018 Subject’s communications with ex-wife increase.

April, 2018 Craddock receives “Thumbs Up” Award.

May 21, 2018 Craddock goes on CNN news website that included

 coverage of Texas shooting.

June 2018 Craddock purchases second Glock 21 45 ACP pistol.

July 2018 Craddock receives a written reprimand for poor

 performance as well as a Letter of Performance

 Expectations.

 Craddock submits written grievance to supervisor.

 Craddock submits written grievance to Department

 Head to remove reprimand. Craddock, in response to

 annual evaluation, complains that he is

 discriminated against by being assigned critical projects

 above his paygrade.

 Craddock drafts work email expressing concerns he

 is being “sandbagged.”

September 22, 2018 Craddock accessed a *Washington Post* website

that discussed two separate shootings in the

Washington, DC area.

September, 2018 Craddock emails Department Head after the meeting

stating that he is clearly being discriminated against through project assignments. Request, again, that the reprimand be removed. Craddock is informed that the reprimand will remain.

Craddock elects to end his grievance and not to appeal it to the Personnel Board.

November, 2018 Craddock stops communicating with his mother.

 Craddock stops communicating with his wife.

January, 2019 Craddock uses Smart TV Guide to visit a news report about

 Orlando Square Mall shooting.

March 2019 Craddock visits gun conversion kit website.

March 8, 2019 Craddock viewed content on CNN website and one

 story on that website was a triple shooting in

 Willowbrook, California.

April 3, 2019 Craddock drafts a work email on his perceptions of

 his professional relationship and stressors.

` Craddock drafts, but never sends, emails that reflect

his irrational and suspicious beliefs. (NOTE: What are

those irrational and suspicious beliefs? Is this a

reference to the emails on pages 44 and 45 of

*Hillard-Heintze*? If so, why are they irrational and

suspicious? They appear to be worth investigation.

Were his accusations every investigated? (See *Hillard-*

*Heintze* pages 54—57 show emails and clearly show

mental illness.)

April 7, 2019 Craddock browses Premier Body Armor website and

 views body armor and ballistic plates.

April 8, 2019 Craddock views Level 3A ballistic body armor panels via his

 mobile telephone.

April 10, 2019 Craddock receives an email confirming delivery of

 purchased body armor.

April 12, 2019 Craddock purchases a Ruger Rifle.

May 4, 2019 Craddock viewed CNN site that included a story

 about a shooting at the University of North Carolina.

May 20, 2019 Craddock searches on his computer for maps of

 Building 2 and the Municipal Center.

May 23, 2019 He sets message on his computer that he will be out

 of the office from May 24 to 28.

May 28, 2019 Craddock emails Contracts Unit asking them to

 expedite the payment of $3,027.48 contractor

 invoice for which funds have not been properly

 obligated.

May 29, 2019 Finance Officer in the Business Division received an

 invoice for $3,027.48 that Craddock submitted for

 work performed for a contractor or vendor (which

 one was it?).The Finance Office perceived this as a

 serious violation of fiscal guidelines because the

 work was clearly unauthorized and performed before

 funding was approved for the work. (*Hillard-* *Heintze*, Page 46)

The Finance Officer reported that Craddock had a pattern of not following fiscal policies and procedures, noting he was the engineer with the most fiscal violations and that he often submitted his documentation late. (*Hillard-Heintze*Page 46

May 29, 2019 Contracts Specialist emails back requiring justification

for, and additional information about the purchase

order and directs subject to email City Procurement

Office with request.

 Craddock emails Procurement Office seeking

assistance to resolve purchase order issue.

Procurement Officer leaves voicemail for Craddock about the purchase order issue, telling him that he has made an unauthorized purchase and violated a City ordinance. Procurement Officer inform subject that she will send him an email as well and asks him to call her back.

 Procurement Officer cites three problems:

1. Craddock signed a contract with a vendor but was

not an authorized representative of the City,

1. contracts need to be reviewed by the legal

department, and

1. his conduct violated a City ordinance. (*Hillard-*

*Heintze*, Page 46)

 Procurement Officer emails subject that fiscal policies

 have not been adhered to and procurement

 procedures have not been properly followed on the

 matter, and that full documentation will be required.

 Craddock replays the voicemail for supervisors.

 Craddock emails supervisor on now he will respond

 to Procurement Officer’s email.

Another employee receives pre-dismissal letter from

supervisors. A Virginia Beach Police Department (VBPD) office

is posted to Bu9ilding 2 as a precaution.

May 30, 2019 The other employee receives a termination letter

and a supervisor escorts him out of the building.

 Craddock states he is to upset to meet with the

 Procurement Office and will pay $3,027.48 from his

 personal checking account to correct the error. (NOTE:

 Did Craddock receive a threaten email from the

 Procurements officer—is that why is so upset?)

In the evening, Craddock places a 54-second call

from his mobile phone to his desk phone.

 In the evening, Craddock makes two personal calls-

one to his ex-wife, in which he is apologetic in

nature; the other to his mother, in which he refers to

his insomnia and problems with supervisors at work

but is otherwise upbeat in tone.

**MAY 31, 2019**

The purchase order ($3,027.48) was not resolved before the rampage on May 31st.

A supervisor reported that this incident (the $3,027.48

purchase order) would not have led to Craddock’s

termination. The same supervisor said Craddock was on track

to get a “Meets Expectations” on his August 2019 Annual

Performance Evaluation.

 6:58 a.m. Craddock leave residence.

7:16 a.m. Craddock arrives at city’s municipal complex.

7:21:30 a.m. Craddock swipes card for entry into Building 2 Ops/PU,

 2nd floor Engineering North Hall.

7:23 a.m. Craddock starts up his work computer and checks

 his Outlook mail.

10:00-10:30 a.m. Craddock conducts internet searches for Building 2, the

 ECCS and the Municipal Center Building Map.

10:31 a.m. Craddock emails supervisor his resignation and refers to personal reasons.

10:46 a.m. Supervisor responds saying he hopes that Craddock resolves his personal reasons and asks for confirmation that his last day will be June 14.

10:49 a.m. Supervisor forwards Craddock’s resignation emails to other managers and copies the subject.

10:52 a.m. Craddock swipes card for entry into Building 2 PU 2nd floor East Engineering South.

11:25 a.m. Craddock responds to supervisor’s email with email, “Thank you. Yes, that is correct.”

11:23-11:33 a.m. Craddock sends routine work-related emails.

11:58 a.m. Craddock swipes card for entry into Building 2 Ops/PU

2nd floor Engineering South.

1:00 p.m. Craddock swipes card for entry into Building 2

1:04 p.m. Craddock and two co-workers leave Building 2 to travel

By car for routine inspection of three project sites

1:06-3:06 p.m. Craddock is at project site with co-workers and in transit.

3:11:49 p.m. Craddock swipes card for entry into Building 2 Pps/PU

2nd floor Engineering South.

3:55 p.m. Craddock sends routine work-related emails.

3:57 p.m. Craddock is observed bruising teeth in 2nd floor bathroom.

*3:55-4:07 p.m. 3rd floor: On break Kelly Mills (361-A) was texting a friend about volleyball. She heard a tapping through the wall rom downstairs like someone was hanging pictures, but, did*

*not what it was.*

*4:00 p.m. 3rd floor: Rommel Tamayo and Dan Adams met with a citizen in 3rd floor lobby. Rommel and the citizen went to the citizen’s vehicle to retrieve a document. Dan*

 *Adams remained in the lobby the whole time.*

4:00 p.m. A co-worker of suspect sees him (Antonio Dewayne Craddock)

 in the parking lot of Building 2 at approximately at 4:00 p.m.

4:00-4:03 p.m. Suspect shoots and kills first victim, Robert “Bobby”

 Williams, parked two spaces from the suspect’s car.

 Suspect walks toward entrance to Building 2 and

 shoots second victim, Herbert “Bert” Snelling, Jr. on

 the sidewalk leading to the front door of Building 2.

 (The police report does not give more specific times

 for these two killings.)

4:03 p.m. Suspect reaches the entrance of Building 2 and enters,

 killing victim three, Michelle “Missy” Langer in the

 stairwell near the first floor.

*4:03:41 1st floor: Two deceased outside (Bobby Williams and Burt Snelling), one deceased in stairwell (Missy Langer)*

*4:03:41 2nd floor Shooter walks to the second floor—Found leaning against a wall by co-worker. He shoots at her multiple times and misses—she goes down the north stairs.*

*4:04 p.m. 3rd floor: Tamayo scanned a document that the citizens had brought in. Adams was in the lobby. Tamayo returns to the lobby.*

4:04-4:05 p.m. It took the suspect approximately 37 seconds to reach

 the third floor, southeast door which he accessed.

 Suspect follows LaQuita C. Brown, fourth victim, to her

 office and kills her. (The police report does not put a

 specific time on the killing). The suspect then kills victims five and six, Mary Louise “Mary Lou” Crutsinger Gayle,

in the hallway outside her office, and Alexander Mihail Gusev, in his office. (The exact time is not in the police report.)The suspect then shot and injured victim seven and shot and killed Christopher Kelly Rapp, victim number eight; he shoots and injures victim number nine (in the same room as victim number eight.) Shooter then kills victim number ten, Tara Welch Gallager.

*4:05:56 p.m. 2nd floor: Shooter walks into office area on 2nd floor/east side*

*(two deceased). Shooter shoots Kate Nixon. Nixon calls her husband. Husband calls 911. Shooter returns to shoot her again. Shooter shoots Josh Hardy after a scuffle. Returns to shoot him again (10 times).*

4:05-4:06 p.m. 2nd floor: Suspect arrives on second floor, southeast door, enters the area and shoots and wounds Katherine “Kate” A. Lusich Nixon (victim number eleven).

4:06 p.m. Suspect encounters Joshua O. Hardy, victim number twelve.

Suspect then returns to Mrs. Nixon’s office and shoots her again—this time killing her. (This conclusion is based

on a cell phone conversation Mrs. Nixon had with her

husband following her being wounded.)

4:06 p.m.? Suspect encounters a coworker with whom he had an

 emotional conversation earlier in the day, points a gun

 at him, but does not shoot.

4:06 p.m. Virginia Beach Emergency Communications and Citizens

Services (9-1-1) received first 9-1-1 call about a male bleeding behind Building 2. Detective Bureau staff responded on foot to Building 2, entered upon arrival and began searching for suspect.

*4:06:32 p.m. First 911 call received.*

4:07 p.m. Suspect leaves the southeast area of Building 2.

4:08 p.m. (Twenty seconds are unaccounted for.) At approximately

 this time, the suspect encounters Ryan Keith Cox, victim

number thirteen, who was shot and killed at approximately

that time.

*4:08 p.m. 3rd floor. Sue Kriebel send an Instant Message (IM) to Tarig.*

*4:08 p.m. While in lobby with citizen and Tamnayo, Dan checked time on this phone.*

*4:08:13 p.m. 2nd floor (west side): Suspect enters west side of 2nd floor*

*floor (one deceased). Thomas Colson comes face-to- face with the shooter three times; not knowing he is the*

*shooter, and sweeps area to warn and help people. He ducks*

 *in corner office. Shooter peers in, but keeps moving.*

*4:09 p.m. 3rd floor: Tarig answers Sue’s IM.*

*4:09 p.m. 3rd floor: Craddock walks to 3rd floor, five deceased, three*

 *injured.*

*4:09 p.m. 3rd floor: Jack Jones notices LaQuita Brown walk by.*

*4:09 p.m. 3rd floor: Jack Jones steps out of his office and finds shooter in Brown’s doorway. Shooter kills Brown. As shooter turns around, Jones runs out of the office to warn others.*

*4:09 p.m. 3rd floor: Steve Poe saves file. Shortly thereafter, he hears*

 *shots and Jack’s warning. He turns out office lights.*

4:08-4:09 p.m. Suspect goes up the north stairwell to the third floor where he

shoots and injures victim number fourteen. He then returns to the second floor.

*4:09 p.m. 3rd floor, shooter kills Mary Lou Gayle and Alex Gusev.*

 *Shooter kills Christopher Rapp and Tara Gallagher,*

 *injures two others.*

4:10 p.m. Page 73 of *Hillard Heintze Review*: “ECCS (Emergency

 Communications and Citizens Services) call records identify that at 4:10 p.m., two detectives and two K9 officers, were

among the first on the scene, entered Building 2 in pursuit of

the attacker.” If these officers entered the building at 4:10

p.m., then they encountered the shooter on the second floor, exchanged shots with him, and he retreated behind locked doors—doors these officers could not access. Uniformity in physical security might have saved lives. Even when the

SWAT Team arrived at 4:26 p.m., the killer was behind secure doors, officers could not access. That is a 15

minute plus delay in pinning the killer down. This is not in

the timeline.

4:10 p.m. 9-1-1 caller indicated suspect was a black male.

4:10 p.m. Active shooter reported by 9-1-1 caller.

*4:10:19 p.mm 1st floor: VBPD officers and detectives enter building.*

4:11 p.m. 9-1-1 Dispatch received a call incorrectly identifying the shooter as a different employee who was fired the day before.

4:11 p.m. The fire alarm was activated.

*4:11 p.m. 3rd floor: The shooting stops. Steve Poe goes to the reception area to try to escape the building with other employees and one sees shooter head their way. Everyone scatters. Poe runs to Kelly Mills’ office.*

*4:11 p.m. 3rd floor: In 361A, Mills hears a scream (Sara at 345-B). Within seconds, she heard people running. From the lobby (345A/B), Poe ran to Mills’ office. When he arrived at Mills’ office he frantically said, “He’s got a gun. Call 911.”*

*Mills pulled Poe into the office and they barricade the door with a desk.*

*4:11 p.m. 3rd floor: Tarig Omer was in the hall speaking to Jim White who was in his own office (361-B). He saw someone running, pointed toward Jim’s desk and said, “Get under the*

*desk. Shooter.” Tarig joined Jim in his office.*

*4:11 p.m. 3rd floor: Laurie Murphy (372, 3rdd floor) head “pop, pop” and closed her door.*

*4:11:26 p.m. 3rd floor: City employee (Jerold of Traffic Engineering) pulls fire alarm. Rebecca Lear (3375-D) heard Fire Alarm, left office, and found Carl Britt on the floor at kitchen entrance.*

4:12 p.m. Suspect uses access card at the southwest door of the second floor. (The next movements of the suspect are not known.)

4:12 p.m. 9-1-1 callers indicated the shooter had a silencer on his

 Weapon.

*4:12 p.m. 3rd floor: After Poe and Mills move desk in front of door, Mills calls 911 (4-minute conversation)*

**4:12:15 p.m. Officer puts on vest from trunk of police car and from**

 **this point there is no video displayed but just audio.**

*4:12:40 p.m. 2nd floor: Killer enters the second floor?*

**4:12:45 p.m. An officer says they (police) are on the 2nd floor and**

 **notes the suspect has a blue polo shirt and is 6’ tall.**

4:13 p.m. 9-1-1 caller provided the suspect’s correct name as the

 shooter.

**4:13 p.m. An officer tells someone to get in his/her car.**

**4:13:51 p.m. An officer asks dispatch to confirm if the incident was**

 **in Building 1 or Building 2.**

*4:14:03 p.m. 3rd floor: Lear called 911 and is put on hold.*

4:15 p.m. Suspect enters the southeast door of second floor. He

 kills victim number fifteen, Richard H. Nettleton and

 injures victim number sixteen.

*4:15:07 p.m. 2nd floor: (Craddock?) walks into east side of 2nd floor. One deceased, on injured.*

4:15 p.m. An additional 9-1-1 caller incorrectly identified the shooter.

*4:15:07 p.m. 2nd floor: Shooter kills Rich Nettleton and shoots another person. Injured person escapes out window (on top of tunnel).*

**4:15:26 p.m. Yelling with alarm in background, apparently**

 **evacuating people.**

**4:15:45 p.m. An officer notes that another office has a long gun**

 **and should be in front.**

*4:16 p.m. Officer shoots suspect.*

**4:16:20 p.m. An officer yells for someone to leave the building.**

**4:16:40 p.m. An office describes the suspect as a black man with**

 **a bald head.**

4:18 p.m. All available Virginia Beach Police Department (V
 BPD) Special Weapons and Tactics (SWAT) officers called to respond.

4:18 p.m. Two carbine rifle shots heard over officer’s body camera.

**4:18:25 p.m. An officer notes that all available SWAT are**

**responding.**

**4:18:40 p.m. An officer asks people to put their hands up.**

**4:18:50 p.m. An office notes the suspect is surrounded on the 2nd**

 **floor in the middle.**

4:19 p.m. Reports of shooter on second floor.

4:19 p.m. VBPD sergeant called over the radio in reference to a person jumping from the second-floor window. Officers

 searching for suspect, find him on second floor. The suspect is wounded. Officers are unable to pursue the suspect through a door because they did not have the rights to the key entry door (Lenel) within Building 2.

4:19 p.m. One of the officers engaging the suspect is shot in toro and becomes victim number seventeen.

*4:19 p.m. “Officer down” radio broadcast.*

4:19 p.m. VBPD sergeant transmits over the air an officer had been shot.

**4:19:12 p.m. An officer notes that an officer has been hit.**

**4:19:30 p.m. An officer says the name Dewayne Craddock.**

4:20 p.m. Radio transmission officer down.

**4:20:40 p.m. An officer says there is a gunshot victim outside the**

 **building.**

**4:21:05 p.m. An officer notes the shooter is surrounded in the**

 **stairwell between the 2nd and 3rd floors.**

**4:22:20 p.m. An officer asks about the last location of the shooter.**

**4:22:44 p.m. An officer says the shooter is shooting through a door**

 **or doorway.**

4:23 p.m. Suspect was still actively shooting.

**4:23:04 p.m. An officer says they believe the shooter is isolated**

 **but can’t confirm it.**

**4:23:50 p.m. An officer discusses a rescue unit for the officer who**

 **has been hit.**

4:24 p.m. Officer who was shot was evacuated out of Building 2.

4:25 p.m. Federal Bureau of Investigation (FBI) Task Force provided information on the suspect.

4:26 p.m. VBPD SWAT officers entered Building 2.

*4:26 p.m. SWAT on the scene.*

**4:27:45 p.m. An officer notes they’ll be sending out multiple**

 **citizens shortly.**

4:28 p.m. Regional air ambulance “Nightingale” placed on standby.

**4:28:44 p.m. An officer notes channel 11 is open or rescue efforts**

 **and a k-9 unit is coming.**

*4:28:00:14- Lear spoke to 911.Reported Karl is carried downstairs*

*4:29:50 p.m. by a co-worker.*

4:29 p.m. VBPD sniper on the scene.

**4:29:11 p.m. An officer instructs someone to carry an injured party**

 **outside.**

**4:29:45 p.m. An officer says they need access keys. (Note:**

 **Approximately 17 minutes after arriving on the scene**

 **the police cannot get access to the killer because**

 **there is no Knox box for emergencies.)**

4:30 p.m. FBI agents assigned to the Joint Terrorism Task Force Squad 6 initiated a controlled response to the scene. Upon arrival they assisted with relocating witnesses to the basement of the courthouse to provide witness statements.

*4:30-4:43p.m. Mills, White, and Poe heard “Police.” Via cell phone, Mills called 911 back to ask how we know it really is the police. She said they would say, “Police, Police.” Mills and Poe talked to the operator for 13 minutes. The operator said they were removing the threat.*

**4:31:16 p.m. An officer says that the doors are locked, key codes**

 **don’t work and they need a manual key. (Note: The**

 **police have now been on the scene for nearly 20**

 **minutes and still do not have access to the rampage**

 **site.)**

**4:31:29 p.m. An officer notes there have been no shots in a while**

 **and asks if the shooter is still isolated.**

**4:32:05 p.m. An officer notes that citizens are carrying an inured**

 **party outside.**

**4:33:10 p.m. An officer notes that his wife just called him, and an**

 **acquaintance of hers called to tell her she is hiding**

 **in the 3rd floor bathroom.**

4:34 p.m. Officers isolated shooter in hallway.

**4:34:01 p.m. An officer says a victim who has been shot in the face**

 **is still alive.**

**4:34:07 p.m. An officer asks other officers to stay off the radio**

 **channel as they have the suspect barricaded behind**

 **a door.**

**4:34:17 p.m. An officer says they need key card access right now to**

 **the 2nd story north end.** **(Note: It is now 20 minutes**

 **that the police have been on the scene and they**

 **still do not have access to all the building.)**

**4:34:57 p.m. An officer repeats multiple times that they have an**

 **access key.**

**4:36:00 p.m. An officer asks other officers to stay off of the radio**

 **as they’re working the scene.**

**4:36:18 p.m. An officer asks for any unit with a sledge hammer to**

 **come to them as their key won’t work and they need**

 **to open the door. (Note: It is now 22 minutes since the police arrived and the key won’t work.)**

**4:38:33 p.m. An officer tells others on radio to switch to channel**

 **11 for rescue efforts.**

4:40 p.m. VBPD personnel began forming teams upon arrival to make entry to clear the building.

4:40 p.m. A stand-off existed until police SWAT executed a tactical maneuver to breach the locked door and take the suspect into custody; he is given immediate medical care and transported to the hospital.

4:41 p.m. Officers reported having the suspect on the ground.

**4:41:45 p.m. An officer notes that SWAT has cleared every room.**

**4:42:35 p.m. An officer asks if they are confident the shooter is**

 **still on the 2nd floor.**

**4:43:45 p.m. An officer says the suspect is in custody.**

4:44 p.m. Officers placed the suspect in custody.

*4:44 p.m. 2nd floor: Suspect in custody, first aid rendered.*

*4:44 p.m. Building 2 employees gathered. A 3rd floor ROW employee (who had barricaded herself under her file room desk) told Mills that the suspect had been to*

 *Right-of-Ways that morning. She said that he got into an argument about a Dominion Easement with Mary Lou. After Mary Lou went back to her office, suspect asked an employee for her business card.*

4:44 p.m. Additional VBPD personnel began forming teams upon arrival to make entry to clear the building.

**4:47:14 p.m. An officer notes the 5th floor is cleared.**

4:48 p.m. Officers advise a tourniquet was placed on suspect’s leg and he had a chest wound.

**4:49:00 p.m. An officer notes room 240 has a victim and that the**

 **2nd floor is clear.**

4:50 p.m. Virginia State Police (VSP) rescue team entered Building 2.

**4:51:50 p.m. An officer threatens to arrest someone (Red Cross?),**

**apparently, and then there are screams about an officer being down.**

**4:52:29 p.m. An officer is screaming and identifying themselves as**

 **Virginia Beach Police.**

**4:55:00 p.m. Officers discuss which floors have been cleared.**

4:57 p.m. Third floor, Building 2 cleared.

**4:57:30 p.m. An officer notes they gave their access card to**

 **Someone, who they think was on the SWAT team.**

4:58 p.m. Second floor of Building 2 secured.

**4:58:48 p.m. An officer notes there are deceased on the 3rd floor.**

4:59 p.m. VBPD deputy chief requested assistance from the FBI for evidence response. (What does “response” mean? Gathering, analyzing? I assume it means both.)

5:00 p.m. FBI supervisor confirmed FBI intelligence group would work directly with VBPD Intelligence.

**5:00:30 p.m. An officer notes a room was locked and couldn’t be**

 **Opened after an injured party was taken from it.**

**(Note: There are still issues with locks.)**

5:01 p.m. Regional air ambulance “Nightingale” landed near the scene.

**5:01:50 p.m. Sounds can be heard of breaching a door.**

5:03 p.m. Alcohol, Tobacco, Firearms (ATF) supervisor contacted VBPD advising ATF staff will be responding to assist.

5:03 p.m. Suspect placed in an ambulance.

**5:04:00 p.m. An officer speculates that the shooter had to have had**

 **an issue with people in a particular room as there were**

 **five victims found in there.**

**5:04:14 p.m. An officer says, vaguely, that they feel like someone**

 **said this was an issue before.**

**5:04:20 p.m. An officer says that everything but locked rooms have**

 **been cleared. (Note: Does this mean that more than**

 **an hour after the shooting began, there was an issue**

 **with locked doors?)**

5:05 p.m. Virginia State Police (VSP) assisted in clearing building.

5:08 p.m. First floor of Building 2 cleared.

**5:09:00 p.m. An officer says that this was the only building without**

 **a sheriff’s deputy in front of it.**

5:11 p.m. Command Post set up behind 1st Precinct; Special Operations Captain in command.

5:12 p.m. FBI Norfolk Evidence Response Team (ERT) placed on standby.

5:13 p.m. FBI advised VBPD they had initiated a mass shooting investigation. No additional FBI assets requested at that time other than ERT to remain on standby.

5:20 p.m. Investigative command post established by VBPD.

5:25 p.m. Basement of Building 2 cleared.

5:31 p.m. VBPD drone placed in flight.

5:26 p.m. Suspect Is pronounced dead.

5:32 p.m. VBPD officer called suspect deceased at Virginia Beach General Hospital. Actual time of death 5:26 p.m.

*5:32 p.m. Suspect pronounced decreased at VBGH.*

NOTE: The timeline items in this section are based largely on *Hillard-Heintze reporting,* interviews, 9-1-1 calls, and crime-scene details.

5:34 p.m. Building 2 is secured. No additional wounded are in

the building.

5:36 p.m. Killer’s backpack and additional firearms are found on

the 2nd floor.

5:42 p.m. Explosive detection K9s begin sweeping the parking

lot.

5:43 p.m. Killer’s vehicle is located in the parking lot in front

 of the south entrance.

5:55 p.m. HR Communications Coordinator sends email to all city employees marked, “Importance High” with subject,

“All Mun. Ctr. Employees can leave except for Bldg. 2

 employees.”

 The message reads, “Today’s situation is ongoing but

the suspect is in custody. It is now safe for Municipal

Center employees to leave the area. However, those

who work in Bldg. 2 must remain here until further

notice. Police/fire officials will inform Bldg. 2

employees when it’s safe to leave. Please drive safely

when leaving. Thank you.”

 6:00 p.m. The first public message was released from the City Manager’s Office, informing the public of the attack

and that the press briefing would be held at ECCS at

7:00 p.m.

6:00 p.m. FRC is opened at Princess Ann Middle School.

6:09 p.m. Explosive sweep of Building 2 begins.

7:18 p.m. Explosive sweeps of Building 2 are completed.

7:19 p.m. Transmission that Building 2 is ready for forensics teams and detectives.

9:00 p.m. Death notifications begin.

12:00 p.m. Last local death notification is completed.

**JUNE 1, 2019**

June 1, 2019 1:00 a.m. Final death notification completed out of

state by assisting law enforcement agency.

June 1, 2019 The Facilities Engineer learned of the attack when his

director contacted him and advised the municipal complex was on lock-down and told him to report to the EOC on June 1, 2019. (WHEN was the Facilities Engineer told this—I assume on May 31st. What time?)

June 1, 2019 The Facility Engineer, at the direction of the city

manager, assembled and led the work group that

began constructing the ECO. Employees from Building

2 were assigned across the city to nearly 30 different

work locations. The relocations started on June 1.

**JUNE 2, 2019**

June 2, 2019 FRC closes

June 2, 2019 The city manager had approved a comprehensive

Emergency Continuity of Operations Plan (ECO) to

address business continuity. Family Assistance Center opens at

Princess Ann Recreation Center.

**JUNE 9, 2019**

June 9, 2019 Family Assistance Center closes at Princess Ann

Recreation Center.