Oneida County Sheriff's Office:

AFTER ACTION REVIEW & REPORT

Knoxboro Road Incident **June 6th and 7th, 2011**

An independent review of the actions of the Oneida County Sheriff's Office during the Knoxboro Road incident, June 6 - 7, 2011

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In Memory of Deputy Kurt Wyman

EOW: June 7, 2011

Biography:

Kurt Brian Wyman was born on February 19th, 1987 to his parents, Brian and Lynnette Wyman. Kurt also had an older sister, Angela Wyman Denton. As Kurt grew up, faith was an integral component of his and his family's lives, and they were very active in their church. Kurt attended the Maranatha Christian Academy, where he excelled at soccer, enjoyed singing in the choir, and acting in the many different productions that the school and church put on. At the end of his senior year of high school, Kurt was introduced to his future wife, Lauren Territt.

After the tragic events on 9/11, Kurt repeatedly visited the local Marine recruiting station. As soon as he turned 18 he signed up to be a Marine Reservist, and two days after graduating high school, in June of 2005, left for boot camp. Upon completion, Kurt returned home. That fall he began his college education in Criminal Justice at Mohawk Valley Community College. In 2007 he was hired by the Oneida County Sherriff's Department and he began his training and career with them. His training was interrupted when he was called up to be deployed with his Marine Reserve unit, the 2nd Battalion 25th Marines Fox Company. He served with distinction and was quickly promoted to Sergeant. While in Iraq, Kurt was awarded the Iraqi Campaign Medal (with one bronze service star), the Sea Service Deployment Ribbon, the Armed Forces Reserve Medal, and the Navy and Marine Corps Achievement Medal. When his tour of duty was finished, Kurt returned home and completed his training with the Sherriff's Department. He was honored as 2010 Rookie of the Year, and was a two time recipient of the Grand Cordon Medal.

Kurt and Lauren corresponded by mail during the time he was away for Boot Camp. During a trip to New York City with their parents, Kurt proposed to Lauren while on a carriage ride in Central Park. They were married in August of 2008, just before Kurt deployed to Iraq. In June of 2009, following his return from Iraq, they celebrated their marriage with family and friends with a church ceremony followed by a reception. In January of 2010 Kurt and Lauren welcomed their son, Alexander Paul (Zander) into their lives. Later that year, Kurt and Lauren were excited to find out that they were expecting a little girl.

In the early morning hours of June 7th, 2011 Kurt's family was awakened by a pounding on the door. They would soon learn about the incident that ended with Kurt being shot and killed while the suspect was being apprehended. Kurt was never able to hold his newborn daughter, Adyson Jynnette (Ady), who was born that very day.

EXECUTIVE SUMMARY

The Oneida County Sheriff's Office initiated this effort to develop a comprehensive After Action Report following the tragic events surrounding the death of Deputy Sheriff Kurt Wyman, which occurred on June 7, 2011 on Knoxboro Road in the Town of Augusta, Oneida County, New York. The intent of this document is to conduct an independent, objective review of policy, planning, training, and response activities. The findings and recommendations identified in this document will assist the Oneida County Sheriff's Office (OCSO) in their ability to plan, train and respond to critical incidents which require the implementation of their Emergency Response Team.

The resulting after action report will serve as a roadmap to enhance the outcomes of emergency management and critical response, and be a resource for not only the Oneida County Sheriff's Office, but also for all law enforcement agencies responding to similar incidents.

While this process is focused on the events surrounding the shooting of Deputy Kurt Wyman, it is designed to strengthen the Oneida County Sheriff's Office capacity to respond to critical incidents involving the following type incidents; barricaded gunman, hostage situation, and/or a suicidal person with a weapon.

The review committee was comprised of the following members:

1. Chief Michael D. Ranalli, Town of Glenville Police Department
2. Chief H. Lloyd Perkins, Village of Skaneateles Police Department
3. Chief Joseph F. Snell, Jr., Town of Cicero Police Department
4. Captain James Watson, City of Utica Police Department

The willingness of the Sheriff, Undersheriff, and all members of the Oneida County Sheriff's Office to both undertake this independent review and fully cooperate with the committee, as all members did, is to be commended. It is not easy for anyone to subject themselves to a critical review of anything. But the willingness to do so is the sign of true professionalism, and an indication that the Oneida County Sheriff's Office and its individual members are dedicated to providing the best service possible to the community.

The report is structured to fulfill two primary tasks. After the Introduction and Incident summary, the report is divided into two distinct components. Part 1 is designed as a comprehensive review of all aspects of the response to the incident at Knoxboro Road on June 6-7, 2011. Initially, the existing policies of the agency will be reviewed as they pertain to the response. Next is an assessment of the training received by the members prior to the incident. The report will then shift to an assessment of the response itself, with specific findings and

recommendations provided. This portion is broken down into the various aspects of the response: the initial patrol response, command and control, the Emergency Response Team, and equipment considerations.

Part 2 is entitled Lessons to be Learned. The intent of this section is to give an overview of contemporary issues in law enforcement involving the human dynamics of high stress situations. While the implications of this material will be applied to the Knoxboro Road incident, it is designed for all law enforcement personnel who may be faced with similar situations. The concepts discussed are far reaching and can actually be applied in many different situational contexts. Next is a description of the post incident, self-initiated corrective actions taken by the Oneida County Sheriff's Office prior to the undertaking of this review. This is followed by a general discussion of post traumatic incident procedures for all law enforcement agencies to consider.

Research from other disciplines that may be directly unrelated to law enforcement is periodically referenced, with the relevance explained. Further, a comprehensive bibliography is provided in Appendix A for those in law enforcement who would like to conduct their own further reading and research.

Further Appendices provide: (B) an incident personnel chart, (C) a narrative of the Utica Police Department Crime Scene Unit forensic reconstruction and scene diagram, (D) an incident timeline, and (E) the biographies of the committee members.

OVERVIEW OF THE ONEIDA COUNTY SHERIFF'S OFFICE

The Oneida County Sheriff's Office was established in 1798 and is the longest standing law enforcement agency in the County of Oneida. The Sheriff's Office currently employs approximately 435 members, of which about 350 are sworn. These members provide Correctional, Law Enforcement (Patrol), Civil, and Court public safety services to the nearly 232,000 county residents within the 1,235 square miles of the land and waterways of Oneida County.

The Sheriff's Office is operated from the Public Safety Complex in Oriskany, New York, and has civil offices in Utica & Rome, and patrol field offices in Camden, Barneveld, and Waterville. The Correctional Facility in Oriskany has a capacity of 630 beds. The Sheriff's Office operates 24 hours 7 days a week 365 days per year.

The Sheriff's Office provides numerous community resources such as; Project Life Saver, VINE, SAVIN-NY, Yellow Dot, Education for the incarcerated, Domestic Violence follow ups, Vehicle & Traffic Safety grants, Tobacco Enforcement, Operation Safe Child, Leads Online, Offender Watch, and more.

Specialty units that support OCSO operations are, Sheriff's Emergency Response Team (Corrections), Special Weapons and Tactics (Patrol), Underwater Response Team, K-9 units, DWI patrol, Marine Unit, Bike, ATV, & Snowmobile Patrol, Criminal, Forensic, and Narcotics Investigations, Warrants, Training, Information Systems, Records, Court Security, School Resource Officers, and the management of the county Child Advocacy Center.

The Sheriff's Office operates on a budget of approximately $33,000,000 and handles nearly 18,000 calls for service a year. The agency's law enforcement and civil division are both accredited. (Source: OCSO Administration)

INTRODUCTION

Purpose of the Independent After Action Report:

The primary purpose of this independent After Action Report (AAR) is to use the tragic circumstances surrounding the death of Deputy Kurt Wyman as the impetus for a thorough and comprehensive review of the law enforcement response during the incident. The fact that the Oneida County Sheriff's Office even commissioned this review indicates their willingness to be a learning organization, demonstrating a willingness to acknowledge and accept the possibility that their organization may need improvement in some areas. This attitude is commendable and should be duplicated by law enforcement agencies everywhere. Lessons that can be learned from this incident may not only help to improve the policies and procedures of the Oneida County Sheriff's Office, but also aid all law enforcement agencies. It is the hope of the members of the review committee that the results of this review and the report may help to guide officers facing other potentially life threatening situations, possibly saving other officers from injury or death.

It is the experience of the committee members that law enforcement, in general, tends to be result oriented. The result tends to be the primary determining factor as to whether the situation was handled properly or not. So, if there is a good result, the process leading to the result tends to be ignored. If Christian Patterson had not been able to fire his shotgun and Deputy Wyman was not killed, then these words would have never been put to paper. Since we do know the result of the incident, the committee members feel it necessary to caution the reader of this AAR that they are subject to the impact of hindsight bias. The result of this incident is in fact known, so, it is therefore, very easy to now read the accompanying description of the incident and the discussion with the bias of interpreting everything that happened as supportive of what resulted. Things that are ambiguous become magically less so after the incident is over. Hindsight bias can then lead to unfair criticism of the deputies, who did not have the benefit of a crystal ball during a stressful and dangerous situation. (Further discussion of this concept can be found in Part 2 of this AAR.)

Assumptions of the After Action Report:

The first assumption involves a critical point that must be immediately addressed, and that is that Deputy Kurt Wyman is dead for principally two reasons. The first and primary reason is that Christian Patterson refused countless lawful orders of numerous deputies and negotiators, including Deputy Wyman, to drop his weapon and surrender. He refused, forcing the incident to extend for hours, leading to his eventual action of shooting Deputy Wyman. All culpability is with Patterson, since he had the ability to safely end the incident at any time he desired, and

instead he ultimately pulled the trigger. The secondary reason is that Deputy Wyman heroically and tragically placed the safety and well-being of Christian Patterson ahead of his own. Deputy Wyman left a position of relative cover and exposed himself in an attempt to use a less lethal device on Patterson, hoping to end the incident with minimal or no injury to Patterson. This unfortunate act of selflessness placed Deputy Wyman in a vulnerable position and made it easier for Patterson to use deadly physical force on him, ending his life.

The second assumption involves the legality of the presence of the members of the Oneida County Sheriff's Office on the premises of Christian Patterson's home. A 911 call indicated a violent domestic had occurred, which gave every indication that criminal charges were already possible. In addition, the perpetrator, Patterson, was described as hostile and had threatened to obtain and use the weapons he had on premises. This provided responding deputies and New York State Police troopers with the logical presumption that Patterson was an ongoing and potentially dangerous threat to himself, the victim, neighbors, and responding officers. When faced with all of this information, a legal "special relationship" was created, which provided the deputies with a legal duty, in addition to a moral duty, to take action to ensure Patterson could not further harm the victim or other innocent citizens.

The final assumption is that, in the opinion of the committee members, the force used against Patterson was in fact objectively reasonable. The legal standard for the use of force and deadly physical force is that of objective reasonableness. In analyzing incidents in which deadly physical force was used, the legal standard is whether at the moment in time that the force was used, was there a reasonable belief that an officer or a third person was at risk of serious physical injury or death? The answer in this case was clearly yes, as Deputy Wyman was already shot by Patterson when other deputies returned fire. This is a strict, objective legal standard that is applied without 20/20 hindsight and has been the law for decades.

This review and report, therefore, is not to determine the direct cause of Deputy Wyman's death, as that has been clearly stated above. Nor is the purpose of this report to review the legality of the deputies' presence or the force used by the deputies against Christian Patterson. The purpose is to consider all of the law enforcement actions undertaken during the incident and identify the strengths and weaknesses of the law enforcement response. This will be done by means of an objective incident critique, comparing these actions to both established and contemporary issues affecting law enforcement response to critical incidents. As will be discussed in more detail in Part 2, any response shortcomings identified in this report do not create any type of duty of care as to Christian Patterson. It is also hoped by the members of the committee that members of the public who read this report will also learn about, and better understand, the realities and difficulties faced by law enforcement.

After Action Report Development:

Members of the AAR review committee, Chief's Ranalli, Perkins, Snell and Captain Watson, were provided with written incident reports, dispatch reports, civilian statements, deputy statements and court transcripts from the trial of Christian Patterson. In addition, committee members conducted interviews with most of the deputies who played a significant role in the incident. Crime scene photographs and diagrams were also reviewed, along with recordings of related phone calls and radio transmissions. The committee convened several meetings and once the interviews were completed, discussed and developed their findings. Chief Ranalli then served as the principal author of the report, preparing a draft for review by the other committee members. After a committee comment and modification period, this final version was agreed upon and presented to the Sheriff by the committee members.

Names of all participants, with the exception of Deputy Wyman and Christian Patterson, have been replaced in the body of the report with codes relevant to their rank or assignment. This was done in an attempt to protect the privacy of the individual members to the fullest extent possible. The Sheriff and Undersheriff positions are unique, and therefore are unavoidably easily identified. In addition, the position of Captain of Patrol is also easily identified due to the circumstances. A table with all of the report codes can be found in Appendix B. Nothing will change the outcome of this incident now. What anyone did or did not do is therefore now irrelevant, except for the role this awareness will lead to their future actions. There is, therefore, no purpose to be served by releasing the names of those involved.

The committee members would like to commend the willingness of the deputies of all ranks involved in this incident to candidly and openly discuss their role and observations. It became clear during the interviews that this was a traumatic event for all of those involved, and the incident has had lasting effects on them.

The committee members would also like to acknowledge the role of the New York State Police troopers who responded to this incident alongside the members of the Oneida County Sheriff's Office. As the troopers who responded were used primarily in perimeter and support positions, and since the incident itself was managed by members of the Oneida County Sheriff's Office, no State Police members were interviewed for this report. Their presence was critical for the support role they fulfilled during the incident. No disrespect is intended by their exclusion in the review process.

This incident was viewed and treated as a barricade situation for purposes of the review. Oneida County Sheriff's Office Policy BMP 45.01 "ERT Operations" provides the following definition:

> **Barricade Situations** – The standoff created by an armed or potentially armed suspect in any location, whether fortified or not, who is refusing to comply with police demands for surrender.

This is consistent with other model policies and is a generally accepted definition. The key is that readers understand that a literal physical "barricade" is not necessary or required to meet this criteria for tactical response and planning purposes.

Goals and Objectives of the Report:

The primary goals and objectives of this AAR are to:

1. Provide the Oneida County Sheriff's Office (OCSO) with a critical assessment of the actions taken by its members during the incident on Knoxboro Road.
   - Review the policies, procedures, and training of the OCSO and compare their content to the actual actions taken.
   - Review of the initial patrol response and the impact, if any, on the remainder of the incident.
   - Review of the decision making structure and process of the command function of the OCSO during the incident and their implementation of actions decided upon.
   - Identification of any weaknesses of the OCSO response, with specific findings and recommendations provided.
2. Provide all law enforcement with lessons learned that can potentially be applied to future incidents, improving the efficiency and effectiveness of the law enforcement response while also enhancing the safety of officers and civilians.
   - Identify law enforcement related issues arising within the Knoxboro Road incident that could arise in other types of incidents.
   - Identify and discuss contemporary issues in law enforcement dealing with the human dynamics of high stress incidents which could directly impact the outcome of such incidents.
   - Identify the factors impacting decision making in critical incidents and discuss relevant decision making processes to be followed.

INCIDENT SUMMARY OF EVENTS

The following is merely a summary of the events of the night of June 6-7, 2011. Many actions were taken over the course of the approximate six hours of the incident, but only the most relevant to the purpose of the report will be set forth. In addition, only those facts that appear to be uncontroverted will be discussed. As with any large scale incident of a long duration, individual recollections can differ from person to person. Only facts that are substantiated by recordings, physical evidence or are corroborated by two or more of those involved will be relied upon. All of the law enforcement officers involved in the incident played an important role, and the minimization or omission of a certain action(s) they may have individually contributed is not intended to diminish their contribution. A satellite overview of the property and a scene diagram are included at the end of Appendix C. A graphical timeline is included in Appendix D.

The Domestic Dispute:

Figure 1: View from road of driveway and house. Unit 462 is visible in front of van.

Christian Patterson resided with his girlfriend and their son on Knoxboro Road in the Town of Augusta. During the evening of June 6, 2011, Patterson and his girlfriend got into an argument which turned physical, with Patterson being the physical aggressor. She attempted to leave, but he followed her out to her truck and then back into the house. He pushed her into the bathroom and at one point he locked her into their bedroom, and made, what she perceived, as veiled threats to kill her and himself. He then broke the glass on the gun cabinet which was located in the bedroom. They continued to fight as she tried to escape the bedroom. After he ran back towards the gun cabinet she was finally able to escape and fled with her son to a neighbor's house, where the neighbor called 911 at 8:08 p.m.

The first units dispatched were Deputy Wyman in Unit 462, DEP1 in Unit 453, and a N.Y.S. Trooper in Unit 1D11. While these units were still en route, information was transmitted indicating Patterson had been physical with the victim, that he had made threats to kill his girlfriend, and that he had threatened to get his guns, which were located within the residence. Further transmissions relayed information that it was believed he was breaking into his gun cabinet and that Patterson had nine or ten shotguns and rifles in the house. The house had a

gravel driveway and was set back from the road approximately 100 feet. There were two garage doors which were perpendicular to the driveway. Deputy Wyman was the first to arrive and he pulled directly up the driveway and stopped at the first garage door, which was open with Patterson apparently standing inside. DEP1 in 453 arrived approximately one minute after Deputy Wyman, at approximately 8:22 p.m., and he parked his car at the end of the driveway near Knoxboro Road. DEP1 immediately saw that Deputy Wyman had his handgun pointed at someone and appeared to be talking to whomever it was, although he could not hear anything. He then removed and charged his shotgun and moved to a position of cover behind a tree at the northeast corner of the house. Since Patterson was inside the garage, it was difficult for DEP1 to get into a position to clearly see him. DEP1 asked Deputy Wyman over the radio to nod if Patterson had a gun, but he apparently either did not physically hear this, or his attention was so completely focused on Patterson that auditory exclusion resulted. In either event, Deputy Wyman made no head movements or any radio transmissions at all. DEP1 directed the positioning of 1D11 via his radio and posted him in his current position at the house northeast corner. DEP1 then began to move around the residence to attempt to find a position of cover where he would be able to see Patterson. Through a garage window, DEP1 was finally able to see that Patterson did in fact have what appeared to be a Remington shotgun in his hands and his right index finger appeared to be on the trigger. DEP1 then called this information in to dispatch and moved behind vehicles parked in the driveway past the garage.

Figure 2: Overview of house & Unit 462 in driveway. Personal vehicles of residence also present. Garage is light gray.

Realizing Deputy Wyman was at a disadvantage having only a handgun as compared to the 12 gauge shotgun possessed by Patterson, DEP1 decided to move to join him at Unit 462. Deputy Wyman was talking with Patterson and asking him to put the gun down, but he kept refusing and finally stopped talking altogether. DEP1 then tried to talk to Patterson, and he continued to refuse to put the gun down. The deputies had to use the vehicle spotlight to illuminate Patterson as it was dark in the garage. Unit 462 was located less than 40 feet from Patterson's position within the garage.

DEP2 arrived at approximately 8:40 pm and took up a position on the northwest corner of the house. DEP3 arrived and was equipped with an AR-15 patrol rifle. He took a position on

Knoxboro Road and had a view of Patterson in the garage. SGT1 arrived at 8:50 p.m., and was the first supervisor on scene. He positioned his patrol unit, 451, to block the road on the northeast east side of Patterson's residence. He was then joined by the Sheriff at Unit 451. SGT1 continued to set up perimeter assignments and had Knoxboro Road blocked from both directions. ERT1 had been on patrol and was field training DEP4 at the time of the incident. DEP4 dropped ERT1, equipped with an AR-15, off at Unit 451 and then responded to a traffic control post.

At approximately 9:00 p.m., NEG1 arrived and was the first trained negotiator on the scene. He was then escorted to Unit 462 by ERT1 and shortly took over negotiations from the deputies positioned at the patrol unit. He was the primary negotiator until he was joined by NEG2 approximately one half hour later. They ended up sharing the bulk of the negotiating duties for the rest of the incident.

Role of Emergency Response Team and Command and Control:

Approximately one half of the OCSO Emergency Response Team (ERT) was either working at the time or had been called in. During the course of the incident, a total of eight ERT members were at the scene. Of those, one ERT member did not have his equipment as it was stored within Unit 462. The remaining team members were not called in and were apparently being kept in reserve. As team members arrived, they were used in various capacities. ERTC was both the tactical commander and the team leader, and upon his arrival assumed command of the tactical personnel. ADM1, ADM2, and the Undersheriff arrived shortly after the Sheriff and all remained positioned predominantly at Unit 451. ADM3 was the only ranking supervisor with extensive tactical experience. Since the Sheriff and Undersheriff had only been with the OCSO since January, and because of ADM3's prior experience, it was decided to leave him in charge of the scene. ADM3 viewed his role as that of Incident Commander, and the consensus of all OCSO members directly involved with the incident believed him to be in overall charge.

Unit 462 remained the primary assignment area for both patrol deputies and ERT members. As explained during the interviews, this position was maintained because of the fear that Patterson would enter the house and gain access to the high powered rifles within. In addition, it was felt that if he went inside they would also lose all communication with Patterson. Prior attempts to get him to answer his cell phone had failed. In an attempt to ensure that Patterson would not be able to reenter the house and access more weapons, three ERT members were deployed to the front porch area. ERT4 was equipped with his service handgun and a 40mm less lethal projectile launcher; ERT5 had his service handgun and a ballistic shield; and ERT6 had his service handgun and an MP 5 submachine gun. The hope was that they would be able to enter the main house and cut off Patterson's access from within. Once they entered the porch, however, they found the interior residence door to be locked. They were not equipped with a

ram (a door breaching device) so were not able to move any further. At this point they remained posted within the porch as there was a window that looked inside the kitchen. Visible from this window through the kitchen was an open door leading from the kitchen to the garage giving them a limited view of Patterson where he was sitting.

Positioned at Unit 462 for some or the entire incident was NEG1, NEG2; Deputy Wyman, DEP1, ERT1 (with an AR-15), ERT3 (with a 40 mm less lethal launcher), ERTC and ERT7 (with a shotgun and a ballistic shield). ERT4 eventually was told by ERTC to leave the front porch with the other 40 mm less lethal launcher and join the others at 462. ADM3 had to move between the staging area (the neighbors driveway), Unit 451 and Unit 462. When ERT4 arrived at 462 he was told by ADM3 that he believed Patterson was going to kill himself and that, if the opportunity arose, he and ERT3 were to use the less lethal rounds to attempt to dislodge Patterson's weapon. At times there were as many as ten deputies taking cover behind Unit 462. The driveway was gravel which made it very difficult for the deputies to kneel behind 462 for long periods of time. Some deputies used their coats to kneel on.

Figure 3: View of garage, where Patterson was located, from 462 in its final resting place

All negotiations were done from a position behind Unit 462, where the negotiators could see Patterson. The deputies positioned at the vehicle had to use the vehicle spotlight and personal flashlights to keep Patterson illuminated. As he moved around within the garage, they would have to reposition the lighting. The deputies would also have to periodically start 462 so the battery would not drain down because of the spotlight. At all times Patterson's finger remained within the trigger guard of the shotgun. On several occasions, Patterson moved his position on the stool he was sitting on so that the weapon was pointed towards 462. Each time this occurred Patterson would eventually respond to the deputies' commands to not point the weapon at them. In addition, on a couple of occasions Patterson would place the stock of the shotgun towards the floor and appeared to be trying to position the weapon so he could shoot himself. It was the belief of several of the deputies involved that it was possible Patterson was either going to kill himself or act in a manner to threaten the deputies so that they would shoot him instead, otherwise known as "suicide by cop". A plan was formulated and agreed to by ERTC, NEG2 and ADM3 that if Patterson appeared to be trying to kill himself again, or if he were to remove his finger/hand from around the trigger guard, then they would deploy less lethal munitions in an attempt to separate him from the shotgun. At one point

during the night ERTC told Deputy Wyman, who was equipped with a Taser, that if the opportunity arose for the ERT members to move in on Patterson that he was to stay behind the team members as they moved forward and be prepared to deploy the Taser, if called for by ERTC. After ERTC told him this, Deputy Wyman drew his Taser and "laser pointed" it at Patterson. ERTC immediately told him to put the Taser away and not deploy it unless ERTC called for him to do so.

At approximately 2:00 a.m., Patterson began moving around inside the garage, making it difficult to see him. It was decided they should move 462 forward so the spotlight could be repositioned. NEG2 told NEG1 to move the car forward, and he entered the vehicle and started to move it. Meanwhile, Patterson had removed a jacket from the rear of the garage and began to put it on. When his right hand left the shotgun, ERTC and NEG2 simultaneously decided it was the opportune time to use the less lethal projectiles to attempt to separate Patterson from the shotgun. ERT3 and ERT4 fired and both less lethal rounds struck Patterson in the torso, knocking him backwards into the wall. The shotgun, however, was not separated from him and remained in his lap. As this occurred, Deputy Wyman left the rear of the 462, crossed in front of ERT4 and ERT7, and ran towards the garage with his Taser extended out in front of him. ERTC saw Deputy Wyman start to move, but could not reach him to stop him. NEG2 yelled "no" to Deputy Wyman, but he continued on towards the garage opening. Patterson turned the shotgun towards Deputy Wyman and pulled the trigger. The round hit him directly in the neck, causing a fatal wound. NEG1 saw the shotgun rounds being fired and attempted to leave the patrol unit, but could not get the door open. He drew his weapon and fired three rounds through the windshield towards Patterson, with none of the rounds hitting him. ERT6, armed with the MP 5 in the porch area, fired three rounds through the window. Two of the rounds impacted in the refrigerator and the other passed on into the garage without striking Patterson. DEP3, positioned behind 462, aimed his AR15 at Patterson and pulled the trigger, but the gun did not fire. He then ejected the round and tried again, but the gun still did not fire. ERT7 was armed with a shotgun behind 462 and fired twice at Patterson, hitting him with both rounds of buckshot. Patterson then went down. ERTC ran towards Deputy Wyman and pulled him away from the garage opening. ERT2, a trained team medic, and other members immediately began care of Deputy Wyman who was then transported by ambulance to a hospital, but he succumbed to his wound. Patterson was transported to the hospital by ambulance.

At the request of the administration of the Oneida County Sheriff's Office, members of the Utica Police Department Crime Scene Unit responded to the scene at Knoxboro Road. Once there they performed an extensive forensic examination of the scene and produced a comprehensive Forensic Reconstruction Report. This is included in this report as Appendix C along with the diagram.

Additional Scene Pictures:

Figure 4: View of the garage where Patterson remained for the entire incident. It was still daylight when Deputy Wyman arrived on scene

Figure 5: View from the garage of Unit 462 in its final resting place in the driveway, showing Patterson's viewpoint. (The gas grill had been removed for this picture)

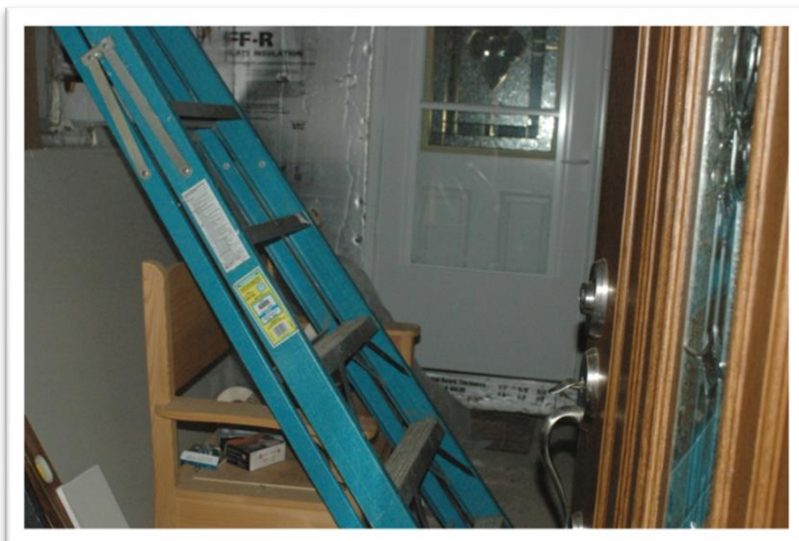

Figure 6: View of the interior of the front porch where 3 ERT members were deployed to attempt entry into the residence. The interior door was locked.

Figure 7: View of window between front porch and kitchen. The penetration of three MP 5 rounds fired by ERT6 is visible in the window.

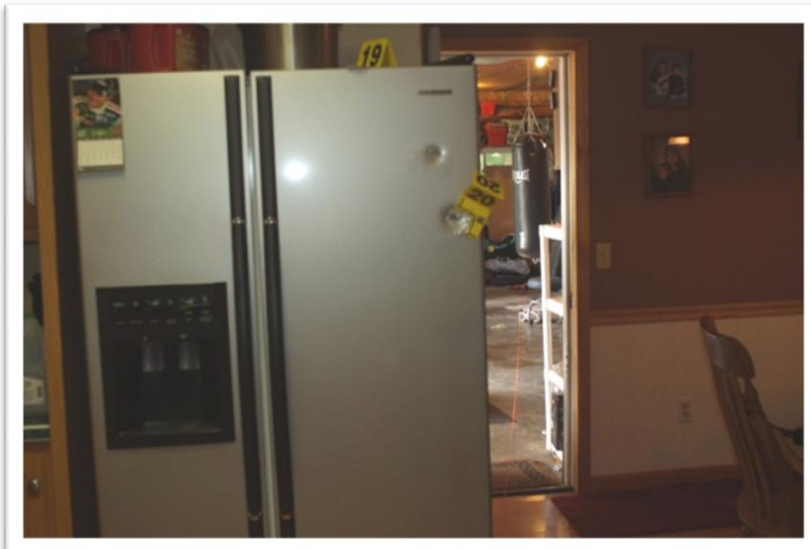

Figure 8: View of limited visual field ERT members on porch had of the garage. Two of the MP 5 rounds can be seen in the refrigerator.

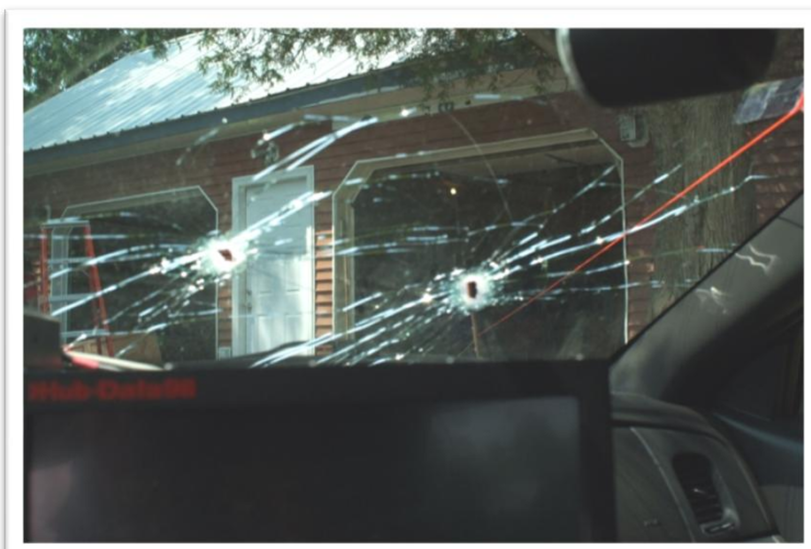

Figure 9: View from inside of Unit 462. Bullet holes in windshield are from two of the three rounds fired by NEG1 from inside the vehicle.

PART 1: INCIDENT FINDINGS AND RECOMMENDATIONS

A. POLICY AND TRAINING

Agency policy should be clear, concise and relevant. In addition, policies should be updated and revised to reflect current structure, chain of command, and duties and responsibilities of the entire organization, as well as the specific divisions and units. Training should be consistent with, and in furtherance of, policy requirements. Training should provide personnel with the knowledge and skills to competently perform the tasks that could reasonably be foreseen to arise under the agency's stated duties and responsibilities. Special units and functions, such as the Emergency Response Team (E.R.T.) and the Hostage Negotiation Team (HNT), should be trained to be mission capable. In other words, training should be sufficient to develop and maintain the critical tasks and skills the team will be reasonably expected to perform.

Policy Review: The Oneida County Sheriff's Office Policy manual was reviewed and analyzed in light of the Knoxboro Road incident. The purpose of this review was to determine if, prior to the incident, the agency policies provided sufficient guidance and clarity of personnel roles for an incident of this nature. This review led to the following findings and recommendations:

1. There is no specific policy governing the Hostage Negotiation Team (HNT). Policy BMP-45.00 – ERT Overview – indicates the "Emergency Response Units" of the OCSO consist of the Emergency Response Team (ERT), the Underwater Search and Rescue Team (U.S.R.T.), and the Hostage Negotiation Team (H.N.T). This policy also designates that all three units have a lieutenant or a sergeant as unit supervisors, and that all three are overseen by the Captain of Patrol. The policy further provides that the Captain is responsible to see that each unit conducts training on a regular basis. The ERT has a policy specific to it (BMP-45.01) as does the USRT. (BMP-45.02), but there is nothing specifically governing the HNT. BMP-45.01 references hostage negotiators as "support personnel". That same policy also states in the Command and Control Structure section that the "Team Commander will work closely with the Hostage Negotiation Team to ensure a coordinated response;…" It is not clear in that sentence, or in any other policy, who the HNT members would report to during a critical incident. The HNT also does not appear on the organizational chart for the OCSO. These policies, or lack thereof, are confusing in that the role, function and placement of the HNT within the critical incident chain of command are not clearly defined.
    - The existing relevant policies need to be revised and an additional policy drafted to clear up the existing ambiguity. Revised or new policy should clearly establish the command relationship between the HNT, the ERT/Tactical Commander, and the Incident Commander, if any. The HNT and ERT commanders should have equal standing in the ICS command structure.

2. Policy BMP 45.01 specifies that the ERT Commander shall be appointed by the Captain of Patrol. During the incident on June 7, 2011, the Captain of Patrol was identified by team members as the ERT Commander. This is inconsistent with the policy, which also states the Team Commander reports directly to the Captain of Patrol. The policy also calls for two positions of Team Leader, whom can be of any rank. On June 7, 2011 there was only one team leader. Based on interviews of OCSO personnel, it appears as if the Team Leader was also serving as the de facto ERT Commander prior to this incident.
    - The existing relevant policies need to either be revised or personnel appointed and clearly designated into the respective positions that are vacant. The actual ERT Commander needs to be a lieutenant or sergeant, as per BMP 45.00.
3. There is no policy directing the use of the National Incident Management System (N.I.M.S) or the Incident Command System (I.C.S.), which is a critical component of N.I.M.S. There is also no clear requirement of the use of a command post to facilitate I.C.S. and N.I.M.S. protocols. BMP-45.01 - Emergency Response Team – indicates that the ERT Commander is to supervise the "overall operation from the tactical command post." This reference leaves unclear whether the "tactical command post" is separate from or the same as the overall incident command post. During the incident, the Captain of Patrol appeared to be serving as Incident Commander in addition to ERT Commander. It is very difficult to oversee a situation that you are fully immersed in.
    - The existing relevant policies need to be revised and/or an additional policy drafted to clearly direct and define the use of the I.C.S./N.I.M.S. protocols, including the use of an incident command post. Clear lines of responsibility need to be defined and established for all support elements involved in a critical incident. The ICS management components and the structure of incident management desired by the OCSO should be clearly named and defined.
4. The OCSO does not have a policy governing calls involving barricaded subjects. Nor is there a policy governing a designation of life priority for tactical planning purposes.
    - It is recommended that the OCSO adopt a policy pertaining to barricaded subjects that includes a designation of life priority during such an incident. For example, the International Association of Chiefs of Police (IACP) has a comprehensive model policy on barricaded subjects. The safety priorities in this model policy are, in order of priority, as follows: hostages, innocent involved civilians, police officers, and suspects and subjects. (IACP, 2007). It is recommended that priority of life also be included in written deliberate action plans.

Training Review: Agency training records and interviews of personnel were used to review the training provided in the year preceding the incident. The primary focus was on the personnel of the Emergency Response Team and the Hostage Negotiation Team.

1. OCSO policy BMP-45.01 states "The Emergency Response Team will train as a group or separately a minimum of eight (8) hours a month (this may be overruled by staffing issues within the Agency, but we must attempt to maintain this level)." Training records provided indicate the ERT trained only three times in 2010. There is also no record of joint training conducted with the hostage negotiators. There was also no indication that the ERT sniper/observers conducted and additional, specialized training, as required by the policy. In addition, although "regular training" is required by BMP-45.00, HNT members received virtually no in-service training at all. There was also no indication that the ERT cross trained with any members of the patrol unit.

   Recommendations:

   - There are at least two relevant existing standards the OCSO should consider in creating a mandatory training standard. The National Tactical Officer's Association (NTOA) in the publication *SWAT Standard for Law Enforcement Agencies* (NTOA, 2011), recommends a minimum of 16 hours of training per month in order to meet many mission capabilities. The State of New York Municipal Police Training Counsel (MPTC) has adopted the *SWAT Team Certification Standards Guide*, produced by the State of New York Division of Criminal Justice Services, Office of Public Safety (2010). Along with this guide, the MPTC also adopted the *SWAT In Service Course Administrators Guide* (2013 version, initially adopted in 2010). While these documents guide agencies who wish to have their tactical teams attain New York State certification, their content can also be used as guidance for all teams. These standards require 96 hours of annual training, with flexibility in how these hours of training can be spread out and/or combined together in blocks of training. This requirement is closest to the current OCSO training requirement of 8 hours per month. That standard, however, was not followed in the year preceding the Knoxboro Road incident.
   - The referenced documents from the Division of Criminal Justice Services are designed for tactical teams seeking state certification, and meeting all of these standards admittedly may be difficult for some agencies. It does appear, however, that the OCSO would have the resources to meet these requirements. In any event, the guidelines could still be used internally as much as possible to drive training and policy. Use of the standards would cover most of the recommendations in this section, as well as some in other sections of this report.
   - The leadership of the OCSO needs to define the tasks and situations the ERT will be utilized for. The specific amount of training should then be dictated by what it will

take to make the ERT mission capable in those tasks and situations. If necessary, a mutual aid agreement with another tactical team should be considered to assist in meeting the demands of those tasks. If a written mutual aid agreement is not possible (i.e. N.Y. State Police cannot enter into written agreements with municipalities) then such a practice in reality should be developed.

- Sniper/observer members of the ERT should conduct additional, task specific training, in addition to the regular ERT training. Complete and thorough documentation of all training must be maintained.
- HNT members should receive regular training. This should include scenario based, joint training with the ERT. This training should also involve the activation of the ICS system, necessarily requiring the participation of the entire administrative Incident Command structure of the OCSO.
- Tabletop scenario based training should also be utilized for OCSO personnel of all ranks and assignments.
- Periodic training should also involve other agencies that the OCSO would reasonably expect to call upon for assistance. For example, the New York State Police work side by side with the OCSO answering calls for service on a daily basis. They also have additional resources that the OCSO can and should rely on. Specific examples of this will be discussed in subsequent sections of this report.
- CRITICAL: These recommendations are made with the understanding that, in general, training is typically one of the first budgetary cuts made to discretionary spending. This, unfortunately, is incredibly risky as such decisions are typically based on the flawed premise that since all has been fine in the past with no major problems, why do we need the training? Since basic personnel costs (pay and all benefits) comprise the vast majority of all law enforcement budgets, the actual savings from cutting training is minimal and can cost far more to the municipality in the long run. Law enforcement operations that are high risk and low frequency, such as tactical deployments, are dangerous to officers, to persons involved, and to the surrounding public. In addition, they are high liability areas which must be prepared for appropriately.

2. The ERT had available equipment that the members had never, or at most infrequently, trained with. Specifically, at least one member tasked with operating a 40 mm less lethal projectile launcher could not remember the last time he had trained with the device. There were also sets of night vision goggles available that had never been trained with and were not deployed. There were two ballistic shields available at the scene, but by all accounts they were not deployed to their full capability. Finally, while training with the AR15 is required annually, some of the deputies stated it had been some time since they had fired the weapon.

Recommendation:

- All equipment and weapons available to the ERT should be utilized in training on a regular basis. This training should also involve training at night to simulate the reality of when many situations may occur. This would include both range and scenario based training. This concept will be further discussed in Part 2 of this report.
- Training records indicate that while range training and qualifications are held twice per year, deputies only qualify with the shotgun and AR15 patrol rifle in the fall. Training with these weapons should occur at both range sessions.

B. *THE RESPONSE: INITIAL PATROL RESPONSE*

The initial patrol response to any incident can frequently set the tone for all or some of the incident to follow. Responding patrol officers, deputies and supervisors must quickly assess and utilize available information to plan the initial response. When there is no known imminent victim or citizen safety threat, it can be beneficial to slow the response to some degree in order to coordinate the response.

Findings:

1. The interoperability of the OCSO, patrol members of the New York State Police, and the Oneida County 911 Center was seamless and effective. The deputies of the OCSO and the troopers of the NYS Police work very well together and several troopers participated in both the initial and subsequent long term perimeter control. This is a relationship to be valued and also emulated by other jurisdictions.
2. Deputy Wyman, in Unit 462, was the first deputy to arrive at the home and, in spite of the information given out by dispatch; he pulled directly up the driveway and apparently immediately encountered Patterson within the garage. It is unknown what Deputy Wyman was thinking, or what he saw, when he decided to drive directly up the driveway. It is possible, as information disclosed at trial indicates, that Deputy Wyman saw Patterson outside without his weapon, thereby thinking it was safe to approach him, and that Patterson only picked up the shotgun after Deputy Wyman approached him. His exact thought process, however, will never be known.
3. DEP1 arrived shortly after Deputy Wyman, and noticed that 462 was parked in the driveway near the garage. Deputy Wyman had his handgun out and pointed at someone while standing on the other side of the vehicle from the garage. Due to the nature of the call, DEP1 took a more cautionary approach, which was warranted. He parked his vehicle at the end of the driveway, armed himself with his shotgun, and attempted to gain a visual perspective of what was happening from a position of cover. Once he observed that Patterson was in fact armed with a shotgun, he chose to move to Deputy Wyman's position in order to provide him with direct support. This information was immediately radioed in.
4. SGT1 was the on-duty road supervisor who was monitoring the initial response from the OCSO Law Enforcement Building. During his interview with the committee, SGT1 indicated that he believed he had called communications to have them tell the responding officers not to enter the driveway of the residence. The recordings of the radio transmissions do not indicate that any such order was ever transmitted over the air. SGT1 then responded to the scene and also notified ADM2 via his cell phone.
5. Once on scene, SGT1 began to organize the inner and outer perimeter, assigning NYS Police and OCSO personnel as they arrived on scene. SGT1 quickly established the initial

command post at his unit (451) down the road from Patterson's residence. This command post, however, was never replaced, as will be discussed in the next section.

6. The initial 911 call came at 2008 hours from a neighbor when Patterson's girlfriend arrived there after fleeing the residence. By 2058 hours no deputy had come to their residence, prompting the neighbor to call a second time. It was at this point that a deputy was detailed to meet with the complainant. Under the circumstances and timing of the unfolding incident, SGT1 realistically could not have detailed a deputy any faster than this.

Recommendations:

- CRITICAL: Deputy Wyman was the junior officer in both rank and agency experience of all of the initial responding officers. During routine calls for service, micromanaging a deputy's response is typically not warranted. During an incident like this one, however, involving violence and the threat of weapons, supervisors and/or more experienced deputies should not hesitate to take charge and coordinate the response while en route over the radio. Bruised egos are secondary to ensuring the most effective, efficient and safe response possible. Such communications must be direct and concise. Further discussion on the importance of direct interpersonal communications can be found in Part 2 of this report.
- All communications with dispatch pertaining to the response should occur over the radio and not via telephone or cellular phone. In incidents such as this, once the frequency is isolated from other radio traffic, it is important for all information to be heard by all of the deputies who are responding. Use of portable or mobile radios should be used rather than attempting to relay information through dispatch via phone. Once the ERT is deployed, it would be beneficial if they had a dedicated frequency to use which would be monitored at the command post.
- Future training should incorporate the patrol decision making process. While the ideal way to accomplish this would be through table top and scenario based exercises, this is manpower intensive training and can be difficult to schedule on a regular basis. Incident debriefings, however, can be conducted right at the patrol division, or even shift level. Supervisors need to take advantage of incidents that agency members have responded to and debrief them. These debriefings should include deputies that were not involved in the incident so they may learn from it as well. The use of such debriefings can expand the experience of all deputies, while enabling all members to learn the thought processes of their supervisors and peers. An additional benefit will be in the creation of a learning environment with an open exchange of ideas and information.
- It is not uncommon in incidents such as the one at Knoxboro Road, for personnel resources to be quickly used up in establishing a perimeter. In spite of this, priority should to be given early on in having a deputy detailed to the victim in order to

develop as much information as possible about all aspects of the incident, the scene and the suspect. Again, under the initial circumstances of this incident, it did not appear that this could have been done sooner, but it is an important task that should be considered in all future responses.

C. THE RESPONSE: COMMAND AND CONTROL

The command response to any major incident needs to be coordinated and effective. Clear lines of authority should be established with responsibility for certain aspects or tasks related to the response effectively delegated. Rank may not be the primary driver of delegation of responsibility as superior experience can be relevant in deciding delegation of responsibility. The use of the NIMS Incident Command System (ICS) is the best system to accomplish this. The Incident Command Post needs to be established quickly and its capabilities expanded as the incident expands.

Findings:

1. As stated in the previous section, SGT1 initially established a working command post at his patrol unit 451 on Knoxboro Road. This initial command post, however, was never replaced and was in line of sight, and therefore line of fire, of the garage where Patterson was located. While many command personnel stayed at this position throughout the night, it did not function as a true command post.
2. The Sheriff and Undersheriff had only been members of the OCSO for less than six months at the time of this incident. In addition, neither had any tactical experience in their previous law enforcement careers. As they were also still learning the capabilities of their organization, they understandably deferred to the prior tactical experience possessed by ADM3, making him the tactical commander for the duration of the incident. What may not have been known at the time by the sheriff and undersheriff, was that ADM3 had not worked with the ERT in some time.
3. ADM3, however, effectively served as tactical commander, ERT team leader, and, to some extent, overall incident commander. While other administrative personnel did assist with perimeter control, virtually all personnel viewed ADM3 as being in overall command. This in and of itself is not an unreasonable decision, considering his prior experience in such matters. But this function should have been fulfilled while in a functioning and staffed command post. Instead, ADM3 attempted to manage the incident while moving back and forth between unit 462 on the inner perimeter, and unit 451.
4. No overall operational plans were developed and clearly transmitted to the scene personnel. The primary goal of the response appeared to be to keep Patterson in the garage. This goal served two purposes, keeping Patterson engaged in dialog with the negotiators and preventing him from entering the residence where he could obtain other weapons. This latter goal, however, ignored the fact Patterson was already armed with a potent weapon that has significant range (see bullet 6 below).

5. An attempt by ERT to enter the residence for the purpose of securing the weapons ended when the interior front door was found to be locked. The windows were also found to be locked. All further discussion on entering seemed to be abandoned at this point. This is not to imply the goal of keeping Patterson in the garage was without basis. The point is that without a functioning command post, no alternative goals and objectives were developed, discussed and attempted.
6. As the incident progressed, a rough plan was formed to use less lethal projectile weapons in an attempt to incapacitate Patterson should he remove his hand from the trigger area of the shotgun. This plan was not directly communicated to all inner perimeter personnel, just to those directly involved. Other deputies indicated in interviews that they either were not aware of it or just overheard the discussion of the plan. Even members that were aware of it were not sure what the specific plan was on what should happen once the less lethal rounds were fired.
7. Neighbors of surrounding homes were not evacuated at any time during the incident.
8. ERTC had initially decided, per standard operating procedure at that time, to not call in approximately half of the ERT in order to keep them for relief. This severely limited the ability to relieve the ERT members stationed at 462. In addition to the normal fatigue that would develop during the time they were positioned there, they were also suffering from the discomfort of having to kneel on the gravel driveway.
9. There was no discussion regarding requesting the Bearcat armored vehicle possessed by the NYS Police until ADM3 became concerned about the coming dawn.
10. The tactical management (other than logistical matters) of the incident effectively became sitting and waiting to see what Patterson would do.
11. An overall life priority was established by action, if not by conscious and deliberate decision. ADM3 stated in his interview that the deputies at 462 “were at risk, but not unacceptable risk”. Based on the interviews and the actual events, the overall priority seemed to have been established by ADM3, and was to prevent Patterson from killing himself. Many of the members interviewed indicated they were not comfortable with their proximity to an armed subject, but they admittedly failed to pass their concerns on. (See Part 2(A)(6) of this report for more discussion on this issue).
12. No post incident debriefing was conducted.

Recommendations:

- CRITICAL: The initial command post should have been replaced both in location and in function, as described in the following bullets. A location should have been selected that was not potentially in harm’s way and would have power, phones and other logistics needed to run a functioning command post. If there is a county incident command vehicle available, then it is suggested that it be used in that capacity.

- The command post should have been staffed, at the minimum, the following personnel:
    1. Overall incident commander (this would not necessarily have to be the sheriff or undersheriff, but designation and authority must be clearly conveyed)
    2. Tactical commander
    3. HNT commander
    4. Public information officer
    5. Ranking member of the New York State Police or other established partner agency.
    6. Fire/EMS representative
    7. Note taker/ scribe
    8. Other personnel as needed in charge of perimeter, logistics, personnel.
- The topics that could have been addressed in the command post during the Knoxboro Road incident would include but not be limited to:
    1. An assumption that a suicidal subject should generally be considered homicidal. The deputies in this incident were in fact subject to unacceptable risk. (See Part 2 for further explanation).
    2. Designation of functions of command post personnel, with conveyance of appropriate authority.
    3. In the absence of existing policy on the matter, establishment of life priority for tactical planning purposes and perimeter evaluation.
    4. Evaluation of the need for the evacuation of neighboring homes and planned implementation, if deemed necessary.
    5. Development of a written overall operational plan, with established goals and objectives. Continual assessment and evaluation of these goals and objectives would be necessary throughout the course of the incident.
    6. Evaluation of inner perimeter location and function at unit 462, with discussion of the feasibility of alternative options.
    7. Discussion of other possible means of communicating with Patterson other than face to face, and locations to communicate from.
    8. Discussion of other possible means of entering the residence to secure the interior of the premises and/or the additional weapons within.
    9. Discussion of bringing in additional personnel from the OCSO, including ERT members who were not called in.
    10. Discussion and evaluation of whether using less lethal with a subject armed with a shotgun would be appropriate; if so, then specific rules or limitation of engagement would need to be defined. Written policy should mandate that

any deployment of less lethal should always be done in conjunction with lethal force as direct cover.

11. Discussion of having non ERT patrol officers comingled on the inner perimeter with ERT personnel and a replacement plan developed, if deemed necessary. Whether patrol officers have been trained in this type of assignment can be determinative to this issue.
12. Discussion of requesting from the NYS Police their Bearcat armored vehicle, their ERT, and or any other equipment or resources they could supply earlier in the incident. Other resources could include the Utica Police Department tactical team.
13. Once personnel are assigned as command post personnel, they are to remain there unless relieved and the change acknowledged by the incident commander, and the appropriate notation made by the incident note taker.
14. Some of the responsibilities discussed in the preceding bullets could also be addressed in an established Tactical Operations Center (TOC), which will be addressed in the ERT section to follow.

- Post incident debriefings should be conducted after all incidents that warrant the activation of the ICS, ERT and/or HNT.
- If it is foreseeable that deputies assigned to patrol may have to be used in inner perimeter assignments, then it is suggested that these deputies should be trained and familiarized with ERT operations. This will help them to understand what is expected of them, and what the ERT members can be expected to do. For purposes of this discussion, the inner perimeter being described is one as in this incident, where the assigned patrol deputies (non ERT) were in direct contact with the suspect. Ideally, ERT members would be deployed as a rapid deployment team to alleviate this issue by ensuring they would likely be the ones to engage the suspect should the situation arise. Inner perimeters can of course vary in size, configuration and scope, as all situations are different. But the key is that it is not advisable to have non ERT and ERT personnel mixed together, in positions of primary suspect contact, unless they have previously trained together.

D. ***THE RESPONSE: EMERGENCY RESPONSE TEAM***

Emergency Response Teams (ERT), also known as SWAT teams, can be valuable assets to a law enforcement organization. Members of such teams are typically highly trained and well disciplined. Such teams, however, need more than training to be effective. They need to be properly structured and deployed, and properly managed while deployed.

Findings:

1. The OCSO ERT has members trained as Tactical Emergency Medical Technician (EMT's) who are fully equipped to provide trauma care during an incident. Having actual ERT operators serving in this function is a valued capability which not all tactical teams can provide. Rapid medical response can make all the difference for severe injuries.
2. ERTC was the designated ERT team leader, but due to the lack of a designated tactical commander, he was essentially filling both roles. In addition, the team lacked a second team leader, as required by BMP – 45.01.
3. The lack of a previously designated tactical commander led to two results. First, ADM3 was made tactical commander for this incident due to his prior ERT experience. He had not, however, been a member of ERT for some time and did not previously train with the team or supervise their training, as required by policy. Second, as the only team leader, ERTC was forced to remain at 462 as the direct ERT supervisor.
4. Being forced to be the on-scene direct ERT supervisor caused ERTC to become, by his own admission, too focused on Patterson in the garage. As a result, any meaningful tactical operation planning did not occur. There was also no follow up to the plans that were implemented, such as sending the team to attempt to enter the house through the front porch. There was need for an immediate action plan to be ready while a deliberate action plan was developed and rehearsed.
5. Only half of the ERT members were initially called in. The remaining members could have provided the opportunity for additional relief and for tactical operational planning.
6. ERT members were not equipped with Taser's, causing ERTC to advise Deputy Wyman that, should they ultimately move towards Patterson, he would be required to follow the rear of the team and be available to deploy his Taser, if needed. When advised of this, Deputy Wyman responded by drawing his Taser and activating the laser sight, pointing it at Patterson. This action, under these circumstances, was disturbing. If Patterson had perceived the red dot on his body, it could have provoked some type of response. This action may have been an indicator to ERTC that Deputy Wyman was not the appropriate person to fulfill this function.
7. The ERT members who were deployed to the front porch remained there for most of the incident. Once they determined the front door was locked, the purpose of their

mission was over. They were not equipped with a ram, so could not have forced entry even if the decision was made to risk the noise it would cause. The ERT members could see Patterson in the garage through a window in the porch. But their field of vision was very limited by the interior door leading from the kitchen to the garage. These deputies were in a difficult position, with no clear mission and no guidance on use of force, should Patterson attempt to enter the house without threatening anyone. The window and exterior kitchen wall would also probably not have prevented penetration of rounds fired from Patterson's shotgun, should he decide to shoot at them. ERT4 was eventually redeployed to unit 462 with the less lethal gun. ERT5 and ERT6 remained on the porch, and when Patterson opened fire, ERT6 fired three rounds through the porch window. These rounds were ineffective. (see Appendix C for the forensic reconstruction of the scene)

8. There were two ballistic shields deployed at the scene, but these appear to have been underutilized. This may have been due to the feeling Patterson was suicidal, and therefore more a threat to himself. Again, suicidal subjects should be generally considered homicidal.
9. While the ERT has members trained as snipers, they were not deployed.

Recommendations:

- CRITICAL: The designated tactical commander should train with the ERT and participate in scenario training. This would help to facilitate effective communication between the team leader and tactical commander.
- All commander and team leader appointments required by policy need to be made. The OCSO may also want to consider changing the command structure to a tactical commander, one team leader, and two assistant team leaders. This would provide some redundancy and increased availability of a supervisory ERT member. In addition, each assistant team leader could be placed in charge of a sub team or unit which could provide two separate entry teams for deployment. At the scene of an incident, one sub team could be deployed as an immediate action team and the other remain available to develop and/or train for a deliberate action plan.
- With two assistant team leaders and one team leader, the OCSO ERT should consider utilizing an incident Tactical Operations Center (TOC) where tactical planning and intelligence gathering could be conducted. Some of the roles pertaining to immediate intelligence gathering could be relegated to the TOC and would be separate from, but still reporting to, the overall incident command post.
- The TOC is where most or all of the tactically important information should be gathered and distributed. Persons designated as information handler(s) and intelligence officer(s) would have a critical role in the TOC. Some SWAT teams will use former team operators to staff these roles so as to not deplete the number of

members available for deployment. The use of investigators could also be considered for these roles. There is just too much information available during incidents like that at Knoxboro Road for the team leader(s) to absorb and process on their own. A member of the HNT would also have a role in the TOC.

- With ERT members of one sub team deployed as an immediate action team, and under the supervision of one assistant team leader, the proper use of a TOC would allow for the discussion and development of tactical operational plans by the second assistant team leader and the team leader. After such development, rotation of the deployed assistant team member and operators would then allow them to be briefed on the plan. An immediate emergency response plan should be developed as soon as possible after the team is deployed, and modified as necessary throughout the course of the incident.
- Sniper/observer teams should be deployed whenever possible. They can be used for intelligence gathering and for an added layer of protection for members of the inner perimeter.
- ERT members should be trained and equipped with Taser's when deployed.
- All ERT members in any leadership position should attend some form of SWAT leadership, supervision and/or tactical decision making course. Such courses are offered by both the National Tactical Officers Association (NTOA) and the New York Tactical Officers Association (NYTOA). In general, both of these organizations are good sources of information, training and other resources. The NYTOA has conducted annual training conferences in Oneida County at the NY State Preparedness Training Center.
- All members of the Hostage Negotiations Team should also attend an initial training course and subsequently attend in-service training.
- Whenever possible, face to face negotiations should be avoided in favor of phone, or preferably, throw phone communication.
- A mutual aid agreement should be considered with the NYS Police tactical team and or the Utica Police Department, or any other regional tactical teams. Such agreements would include that agencies hostage negotiators. Joint training should periodically occur with the agencies. There is no statutory authority to allow for a formal mutual aid agreement with the state, but a memorandum of agreement could be considered.
- Post incident ERT/HNT specific debriefings should occur with all members involved in the incident. This would be in addition to and separate from any overall incident debriefing. The ERT should also do debriefings after completing scenario based training exercises.

E. *THE RESPONSE: EQUIPMENT CONSIDERATIONS*

At both the patrol deputy and ERT level, having the appropriate tools to accomplish the task at hand is invaluable. While it would be impossible for all law enforcement organizations to own every piece of equipment that could reasonably be required, cooperative efforts with other agencies can help. The equipment also needs to be trained with to ensure familiarity and competency when needed.

Findings:

1. The OCSO did own several pieces of equipment that could have been used that night, but were not for various reasons.
    a. First and foremost was a "throw phone", used for negotiations by hostage negotiators. Apparently the negotiators asked Patterson if he would talk on the phone and he stated he would not. So the idea was not revisited again.
    b. Members of the ERT indicated that while they had access to night vision goggles, they had never trained with them so they were not deployed. The deputies remained completely dependent on the spotlight of Unit 462 and their own flashlights to keep Patterson in view.
    c. While the deputies assigned to patrol had Taser's with them, the members of the ERT were not deployed with them. Had they been it could have eliminated the need for Deputy Wyman to stay within the inner perimeter.
    d. The ERT had two ballistic bunker style shields that were in fact deployed, but they did not appear to have been used to their full potential. Numerous deputies were crowded around 462 through the course of the evening, providing questionable cover for them. Use of the bunkers could have possibly enhanced the cover provided by the police unit.
    e. Noise flash diversionary devices should have been available to both the members of the inner perimeter and the team deployed to the front porch.
2. Other equipment was either not possessed, or not possessed in sufficient numbers, by the OCSO at the time of the incident, which could have been useful.
    a. Sufficient portable radios for all deployed members to use. Not all members had radios so were not fully aware of all that was happening.
    b. A portable, powered lighting system would have been beneficial to help light up the scene and the garage.
    c. The New York State Police had a Bearcat armored vehicle available for use by the OCSO. While it could have taken a little time to arrive, if requested soon enough it may have been effectively used. The thought of calling for it, however, did not occur until late in the incident.

Recommendations:

- The *SWAT Team Certification Standards Guide*, produced by the State of New York Division of Criminal Justice Services, Office of Public Safety (2010) and adopted by the Municipal Police Training Council can once again be a resource for the OCSO. The document lists what equipment should be possessed by both the individual ERT members, and also possessed by the team. This list was formulated by subject matter experts.
- Once the proper equipment is obtained, and or made available by mutual aid agreement(s), training should be sufficient to ensure competency.

PART 2: LESSONS TO BE LEARNED

A. OVERVIEW OF HUMAN DYNAMICS IN STRESS EVENTS

1. General Issues and Considerations:

The purpose of this section is to give a general overview of the physiological effects of events in policing that can create significant levels of emotional intensity in responding officers. These general principles will be then discussed in light of the facts of the Knoxboro Road incident. As stated in Part 1 of this report, one of the primary purposes of the incident review, and this report, is for learning from past incidents to help officers prepare for future ones. To that end, the principles discussed in this section are important for officers to understand. Inclusion of these principles in this report, however, is not to imply that they should have been known and applied by members of the Oneida County Sheriff's Office on the night of June 6-7, 2011. Many of these principles have only recently started appearing in mainstream police training, while others have been applied, but only been partially understood. Their inclusion in this report is an indication of their importance to the committee members, and the administration of the Sheriff's Office, in the fulfillment of the purpose of the incident review. This is a very basic overview of the principles, as relevant to this incident, and is not intended to be a comprehensive review.

2. Impact of a High Stress Encounter:

All human beings have three primary survival systems: motor performance (physiology); vision (perception); and cognitive/ behavioral processing. During periods of extreme emotional arousal, all three systems begin to interfere with our ability to defer to rational thought and full consideration of all the circumstances, including policy and law. Instead, the default shifts to self-preservation. High levels of arousal can compromise an officer's fine and complex motor skills. In addition, during such periods of extreme arousal, an officer will stop using their higher brain (the pre-frontal cortex) and will rely on the primitive midbrain (the amygdala), which is also known as the emotional center of the brain. This can lead to reflexive, subconscious actions officers may have given little or no thought to prior to doing them. This subconscious reaction is a survival system our species has developed to survive life threatening encounters. The problem with this system, however, is that since some actions will bypass normal cognitive processing, errors can occur. These mistakes can be both in judgment and performance of a task(s). Understand that this survival system applies to all people, not just police officers. The converse of this concept is critical; police officers are not immune from the automatic subconscious response, and, by the nature of their profession, are more likely to be placed in such a situation than most civilians.

Officers will revert to what they have been trained to do, or are most comfortable with. This is frequently called the "muscle memory" response. Constant repetition of a task, to the point where it is ingrained into the midbrain, is necessary to ensure proper application of the task in a period of high emotional arousal. The most basic example is that of range training. The constant repetition of an officer drawing his or her service weapon from their holster will, over time, allow that task to be performed without thinking about it. This allows the officer to concentrate their attention on things other than drawing their weapon, like where a potential threat is and what they are doing. If an officer does not practice repeatedly with all equipment and weapons made available to him or her, then during a period of high stress it is likely they will not subconsciously be able to perform the specific task successfully. In such cases, the officer will have to use valuable time and attention to consciously figure out the process, or just not be able to perform it at all.

The subconscious response does not just apply to the performance of a specific, mechanical task. It can also apply to the actual type of response. For example, an officer that is well skilled and confident in defensive tactics may reflexively engage in physical combat with a threat, when a lethal force or weapon based response may have been more appropriate.

Another related type of potential error associated to the concept of "muscle memory", is that of a "slip" or "slip and capture" or error. An example may be the best way of explaining this concept. A police officer has been driving Ford Crown Victoria's for her whole career and now they are no longer available. So that same officer is now assigned to drive a new Dodge Charger. The very first day the officer needs to turn on her windshield wipers and she fails, instinctively reaching for the Ford controls, not the more recently learned Dodge. So, the officer "slipped" while intending to do the less familiar action, and instead falls back on the more practiced method. This happens all the time to people, but it typically is of little if any consequence. Put an officer in a high stress encounter, however, where every action taken is critical, the results could be disastrous.

The best way to avoid such issues is to try to create distance between the officer(s) and the potential threat. Distance can create time to respond, and time to respond will increase the likelihood the specific response chosen by the officer will be while their conscious, cognitive functioning is controlling. Creating distance can also mean that officers need to be cognizant of the fact they may have to transition from their handgun to a long rifle. But this again involves training and contemplating these issues *before* becoming immersed in such an incident. When an officer does not have discretionary time, the subconscious survival system takes over – for better or worse. Long term training and incident situational awareness can help officers respond in a manner where they can increase the likelihood of having discretionary time.

The concept of "mastery" versus the reality of policing:

It is commonly believed that it takes approximately 10,000 hours of practice of any task in order to master it. It is impossible for officers to come even close to this level of training in *all* critical tasks they may be called on to perform during a period of high emotional intensity. There are officers in certain special assignments, such as those assigned to tactical teams, who do, or should, receive higher levels of training and are able to master certain tasks. But they are the minority of officers and this discussion is geared towards the majority of police officers.

The 2012 summer Olympic Games provided a good example of the concept of "mastery" of a task, and the societal disconnect between the result of a temporary failure by an athlete or civilian, and a police officer. Olympic athletes spend more time training and conditioning for specific tasks than most officers spend working in a year (over 2080 hours per year). An American female gymnast performed an event flawlessly during the team competitions, helping to secure a Team Gold Medal. The very next night, the same athlete performed the very same event, her specialty, in the individual competitions. On her last jump she fell, landing on her behind. The end result? She won a Silver Medal in the event. No disrespect is intended towards this athlete, who is truly gifted and one of the world's best gymnasts. The point is that it is *expected* that such elite and incredibly gifted and trained athletes will occasionally make a mistake, and the scoring system allows for this to be compensated by prior exceptional performances.

Police officers are expected to make complicated decisions and flawlessly execute complex physical tasks during periods of high stress, all while potentially making life or death decisions. If they make an error, they could face criminal or civil liability and/or lose their careers. And most officers will *never*, even if they work for 30 years, come close to the hours of training necessary to master all the tasks they may need to perform, during that period of high stress, which a professional athlete will undergo in just *one year*. To further complicate this matter, studies have shown that members of law enforcement use force in less than 1% of all calls for service, and even when force is used, it is commonly lower levels of force. (IACP 2001). The result is that not only do we have officers who receive limited training, but we also have officers who do not face frequent use of force situations since the vast majority of their calls do not involve the need for force. This makes the need for training all the more important.

With the New York State 2% tax cap and the recent recession and resulting downsizing of many agencies, administrators are having a difficult enough time keeping sufficient road and investigatory coverage, let alone being able to increase training time. Yet in spite of this overall societal acceptance of occasional mistakes, at least one study has shown that 90% of civilian participants, who *chose to shoot* when faced with an armed perpetrator, felt it would be *inappropriate* for an officer to shoot in the *same* situation. (Sharps, 2008 & 2010)

CRITICAL: In sum, the reality is that most police officers do not, and cannot for time and fiscal reasons, receive sufficient training to truly master all of the tasks they are called upon to perform. In addition, 99% or more of all police/citizen contacts do not involve the use of force and therefore probably do not cause high emotional arousal. This results in officers facing high risk situations that they do infrequently and with limited training. Then, when thrust into such a situation where a critical decision and response must be made in very little time, citizens are not prepared to accept that such errors can occur by police officers, but are willing to accept them in other societal venues. As all of these concepts are not likely to change anytime soon, that leaves us with one of the goals of this report: educating officers and attempting to modify their decision making process *before*, when possible, getting into a situation where the subconscious may take over. This involves continuous situational awareness and proper tactical decision making before and during a potentially high risk incident.

Implications Related to Knoxboro Road for similar future situations:

As was discussed in Part 1 of this report, the members of the Oneida County Sheriff's Office behind Unit 462 were relatively close to Patterson for the entire incident. If Patterson were to take some type of sudden action, threatening or otherwise, the deputies would have very little time to evaluate and process a cognitive response. Instead, the result of such proximity would more likely lead to automatic, subconscious reactions. To further complicate the issue, there were numerous deputies attempting to use one vehicle as appropriate cover, which is difficult, if not impossible, to do at that proximity. Such subconscious reactions may have manifested themselves in the actions of at least three deputies.

First, Deputy Wyman, due to the fact he had a Taser Electronic Control Weapon (ECW), was integrated in the inner perimeter with members of the Emergency Response Team. This was a circumstance he had not been trained for. When the opportunity quickly arose that instigated the application of the less lethal munitions, the incident quickly escalated. This, in all likelihood put Deputy Wyman in a high state of arousal, apparently leading him to subconsciously react in a split second. This decision, while most likely based on his desire to end the standoff with little or no injury to Patterson, turned out to be a tragic mistake, made without cognitive processing of the full implications of the potential danger. To keep this again in proper context, this is not to say that Deputy Wyman's ultimate action was or should have been foreseeable by his supervisors. This is just an example of what *could* happen when officers of different backgrounds and experience are placed in close proximity to a dangerous suspect, who has his own experiences and perceptions. Situations such as this one are dynamic with an infinite number of variables involving the suspect, the officer(s) and the overall circumstances. How the suspect and each of the involved officers will perceive and react to unfolding circumstances is unpredictable, and sometimes deadly. This is known as the "deadly mix". (Pinizzotto, 2006 &

2012). Further possible impact of Deputy Wyman being in a state of high emotional arousal is in the fact that NEG2 yelled "no" to Deputy Wyman when he saw him moving forward. It is entirely possible, and likely, that Deputy Wyman never heard NEG2 yell, due to the auditory exclusion that frequently occurs in high stress situations.

During the final seconds of the incident, after Patterson had already fired at Deputy Wyman, DEP3 attempted to fire his AR15 patrol rifle at Patterson, but it failed to discharge. He then cleared a round and tried to fire again, with the same result. As part of the post incident investigation, the rifle was brought to the range and a significant number of rounds were fired through it with no malfunctions. This leads to the question of whether this truly was a weapon malfunction, or whether it was a result of using a weapon that DEP3 had not used enough to allow for the subconscious use of it in a high state of arousal. The authors are not saying the latter situation is definitely what happened since we were not there and we will now never know. Training documents and interviews, however, indicate that it had been some time since deputies used the AR15 in training, and that overall training with it was sporadic at best. What is important going forward for all law enforcement to understand is that such inability of an officer to successfully take the weapon off safe and discharge it while under stress *could* have happened, and in fact, does happen. Under the circumstances of the hours that had passed and the number of deputies crowded behind 462, it is more than likely that that AR15 was taken on and off safe a number of times. A careful review of how patrol rifle training is conducted is critical. Is taking the weapon off safe burned into the deputies muscle memory? Or are they allowed to "cheat" with the safety in between shooting drills? In other words, do firearms instructors allow officer to leave the rifle safety "off" between shooting drills to make the drills easier or to reduce time? Any weapons officers are deployed on the street with, must be trained with to the point of performance with minimal or no attention necessary to complete the task from start to finish. All steps necessary to perform the task on the street *must* be performed in training repetitively.

In the final moments leading up to the shooting, NEG1 was instructed to move Unit 462 forward slightly so the vehicle spotlight could be better positioned on Patterson. NEG1 is an investigator who has his own vehicle assigned to him, which was a completely different type of car than 462. While NEG1 was still inside 462, the less lethal rounds were fired; Deputy Wyman advanced and was shot by Patterson, who then proceeded to shoot additional rounds. NEG1's automatic response was to reach for the door handle to get out of the car since he was directly in the line of fire (see Appendix C for the forensic breakdown of the trajectory traveled by the shotgun rounds). The problem was, however, that NEG1, now in an understandable high state of arousal, tried to open *his* car, which was the more familiar action to him. As a result he could not get the door open at all and instead had to draw his weapon and return fire through the

windshield. This slip error caused NEG1 to remain in harm's way, which fortunately did not have tragic consequences for him.

3. Schemas –Mental Templates:

Another trait common to all people is the constant use of schemas in everyday life. A schema is a sort of mental blueprint of "things" or common situations that arise. We are surrounded by massive amounts of information about our environment, and schemas allow us to organize and categorize such situations. Schemas are essentially packets of information that we assimilate over time and experience about both objects and situations, and we create default values or inferences about them. Thus, we can interpret objects or pass through situations without having to re-process all facets of it over and over again. This process starts as a child, and is constantly modified through life. For an example of an object, if someone states they live in a house, the general schema a person would apply to help them interpret this fact would be a building with a roof, walls, rooms, made with certain types of materials, and typically up to a certain size.

As for situations, a simple example is that of a busy intersection governed by four stop signs. Significant mental processing is involved in the first few encounters with such intersections. But they soon become relegated to "routine" status, governed by the newly created schema (plural "schemata" is sometimes used).

Schemas can be partially based on pre-existing beliefs, which can lead to the creation of stereotypes, which are essentially stronger versions of schemas. The existence of a schema, and/or a stereotype, can lead to the application of inductive reasoning to a current or future similar situation. Inductive reasoning relies on what is *likely*, as compared to what actually *is*. The resulting inference is that since some of the expected default values exist, the resolution of the new situation will be similar to the past ones. If a particular situation deviates from a particular schema, or blueprint, a typical subconscious reaction is to ignore the factors that make it different and instead only focus on those that are consistent with the original schema. This can actually prevent or impede a proper solution to the current situation.

In terms of the four way intersection example above, the schema works well when all of the drivers at the approach of the intersection have the same schema. Trouble can arise, however, when one driver approaches his stop sign aggressively, making it clear he is not considering a full stop. If another driver steadfastly sticks to his or her schema, and the resulting inference of other driver's behavior, because it is their turn to proceed, an accident could occur that may have been prevented. This can be both beneficial and troublesome in policing. As officers gain experience and handle a wider variety of situations, they can develop schemas that can help them be more efficient and effective in similar situations in the future. They can also be

troublesome if the officer fails to ignore subtle differences in a future encounter. If an officer's situational awareness in a given situation is tied to an inappropriate schema, such as an assumption that "this one" will end just like all the "other ones", a flawed threat assessment could result. This can, and does, go both ways in that the officer may under react or over react. Mere awareness of this concept can help officers to overcome it.

Implications Related to Knoxboro Road for similar future situations:

Throughout the entire incident there appeared to be a reliance on a number of presumptions, or schemas, which were applied at all levels of the response. Barricaded subjects are not uncommon in law enforcement, and they are something that the Oneida County Sheriff's Office has dealt with in the past. From the interviews, statements, testimony and actual actions, or inactions in some cases, the following schemas seemed to dictate, or at least contribute, to the decision making process:

1. This was just another barricaded subject where the subject would, at some point, most likely decide to put down his gun and surrender. If this were not the case, then:
2. Patterson was depressed and suicidal and that if he did not surrender then he would either use the shotgun on himself, or use it to provoke lethal police response as "suicide by cop".
3. These first two schemas apparently led to the inference that Patterson was more of a threat to himself than the officers, leading to the next schema. The officers located at 462, therefore, were reasonably concealed from Patterson's view and were not in any immediate risk. Or at least were not at "unacceptable risk" as one command level deputy stated during an interview with the committee.
4. Keeping Patterson from entering the house and away from the additional weapons inside the residence was the primary, and apparently the only, established priority. Entry into the residence would have also impeded any further communication with Patterson.

It is not the intent or purpose of this section to prove or disprove whether the above schemas were actually supported by the facts and circumstances of the incident. To attempt to do so now would be unfair, and very difficult, due to the influence of hindsight bias. In other words, since the outcome is already known, any review of Patterson's actions and of the dialogue, or lack of dialogue, between he and the negotiators could now lead to the biased conclusion that the deputies *should* have known that Patterson was not suicidal and was a direct threat to officers. Because of hindsight bias, ambiguous behavioral indicators that occurred during the incident would now tend to be interpreted as unambiguous supporting the known result. This is not fair to the deputies who were in the midst of a tense and stressful situation. The concept of hindsight bias has been the subject of much research and the topic of many articles in a number of professional disciplines. Lack of awareness of the tendency towards hindsight bias

can and has adversely and inappropriately impacted decisions made by police administrators, attorneys, juries and the public.

This discussion is instead geared towards one of the stated purposes of this report – to guide future law enforcement officers in similar future situations. To that end, the purpose of this section is to make law enforcement officers aware of the existence of schemas and the subconscious reliance on inductive reasoning; what is *likely* as compared to what *is,* which can result from deductive reasoning. Since what *is;* in the context of dynamic situations members of the law enforcement community encounter, is difficult to know for sure, law enforcement must then instead focus on what *could be.* In situations like this, where there is time to plan a response, assume the worst case scenario, mitigate the effect of inferences, and adjust the response accordingly.

Think of the concept of schemas as a matter of perspective. In this incident, the deputies had no apparent prior knowledge of Patterson. Instead they were basing the entire response on the inferences flowing from what limited information was available to them from the 911 call, the complainant and from Patterson himself. Again, whether those inferences were correct, in light of hindsight bias, is irrelevant to this discussion. Now change the whole perspective of the incident; assume that Patterson was known to the deputies and that in a prior incident he had threatened to shoot an officer rather than allowing himself to be arrested. A whole different set of schemas may then apply, which would mean in all likelihood the inner perimeter would have been considerably farther from Patterson and 462 would probably have not been in the driveway in the first place. This prior knowledge might have eliminated schemas (1) and (2) above, and (3) would have been dramatically modified in that any unit used for cover would have been significantly farther away. Finally, (4) would also be completely changed to reflect what could have been given more consideration in the incident, and that is that the shotgun possessed by Patterson was in fact a deadly, long range weapon in and of itself, regardless of whatever other weapons were within the home. Understand the significance of the reliance on schemas that were in part the result of the *lack* of prior knowledge of Patterson's potential intent. The fact the officers had no prior knowledge of Patterson does not mean that he did or did not have malicious intent towards officers. This leads to the critical point of this entire section. Officers that are aware of the potential impact of a schema can consciously attempt to negate it by mentally changing the *perspective* an incident is being viewed in. As applied here, it would mean focusing on what *could* happen, and asking "what if Patterson actually wants to shoot a police officer, are we handling this situation in a manner that will minimize the likelihood that will happen?"

As discussed in the main body of this report, there was no command post following NIMS/ICS protocols established during the incident. If one had been established, it could have led to the

presumptions listed above being challenged, discussed, and possibly compensated for. A well functioning command post, where there is active discussion and exchange and evaluation of ideas, can be the most effective way to combat the possible negative side effects that the reliance on inappropriate schemas can bring. Everyone has their own schemas that are based on their own experiences and expectations. Allowing the free flow of ideas which reflect the resulting individual schema differences is critical in such incidents, and can allow the perspective to shift from what inferences indicate is *likely,* to what *could be.* Such appropriate command decision making is much more likely to occur when it is the product of the experience and perceptions of all those involved, rather than just one person. The free flow of ideas should also include encouragement to voice disagreement when appropriate. The role of a devil's advocate can help to expose potential weaknesses in a developing plan. No one person can be expected to know everything.

4. Reaction/ Response Time:

A person can act faster than another person can react. The typical example given is that a person who has a gun in their hand will be able to shoot it before, or sooner than an officer with a gun, already pointing at the suspect, can fire in response. The reason for this is somewhat straightforward. The time it takes an officer to respond to a threat can be summed up as follows: the mental sequence (reaction time) plus the physical sequence (movement time) equals the response time. Reaction time is further broken down into essentially three components: stimulus identification (see what is happening), response selection (interpret what is happening and choose) and response programming (send signal to body to react). The officer, reacting to the action of the suspect, is at a tremendous disadvantage since he has to go through this entire process. The suspect, or actor, does not since they have already assessed the situation and decided on an action, all without the officer's knowledge. So all the actor has to do is complete the physical action of firing his weapon. The following charts will attempt to visually explain this concept.

Figure 10: OFFICER RESPONSE TIME

Figure 10 is a simplified depiction of this process. All four steps must be accomplished in order for a police officer to physically respond to a subject's action.

Figure 11, however, depicts the advantage possessed by the subject taking the action. The first three steps taken by the subject are grayed out since these happen without the officer's knowledge.

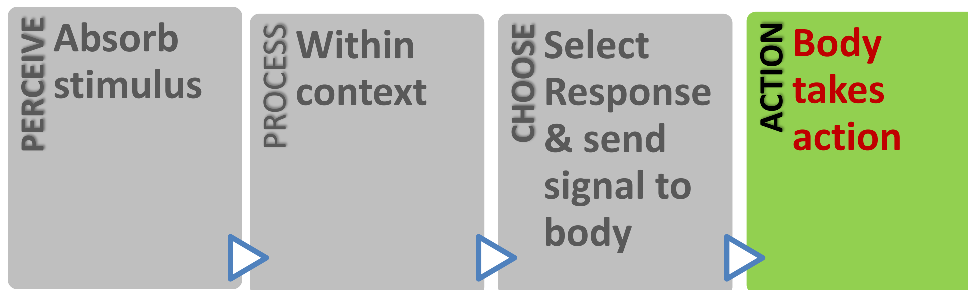

Figure 11: SUBJECT ACTION TIME

This is a concept that has long been taught in police training classes and still should be. It is not, however, taught alongside of all of the concepts discussed in the preceding sections of this report. If an officer or deputy is thrust into a situation requiring a response they are not properly trained for, their response time could be significantly increased. Complexity of a given situation and the possibility of multiple available responses can also lead to increased response time. Fatigue can also increase reaction time. If a deputy is inappropriately applying a specific schema to a situation, reaction time will again be increased while the deputy's brain wastes valuable time realizing it was wrong. A decision on how to react will still have to be made, along with the time necessary to perform the functions necessary. Anticipation can help to reduce reaction time as the officer may be more prepared for the action. This, however, brings the possibility of an officer acting too quickly, creating the risk of subsequent scrutiny if the situation ends up not being what it may have appeared to be.

The Force Science Institute Ltd. has done significant research into police reaction times. (This information can be found at their website www.forcescience.com and in articles listed in the reference section at the end of this Appendix) The research findings of the Force Science Institute were also more recently supported in other research (Blair, 2011).

Of the senses of touch, sound and sight, touch leads to the fastest reaction times while sight leads to the slowest. This is primarily because of the large amounts of vision data the brain must process. The more complex the visual stimulus is, the slower the overall response will be. Distance, along with available cover, can again be important in dealing with this concept.

Implications Related to Knoxboro Road for similar future situations:

The majority of this incident took place during the nighttime hours. The primary source of light upon Patterson came from the spotlight of Unit 462. Because of the angle of 462 in relation to the garage opening, if Patterson were to move back a short distance the deputies view of him would be compromised. For the ERT officers posted on the front porch, they already had a very limited angle in which to view Patterson.

Applying the concepts discussed in the prior section dealing with schemas, the situation needs to be viewed in light of what *could* have happened. If Patterson decided to fire on the officers, he could have moved quickly backwards into the garage, and therefore out of the light provided by the spotlight of 462. Since Patterson would have already made the decision to move backwards and then fire his shotgun, all the deputies would observe would be his action of doing so. The impact of schemas, the darkness, the fatigue the deputies must have been experiencing, and the normal factors impacting a response time, all together may well have resulted in Patterson being able to fire multiple shots in the direction of 462 before any return shots could have been fired. Because of the number of officers taking cover behind 462, and the fact that many portions of a vehicle will not stop a shotgun slug, one or more deputies would have been at risk. In fact, one of the three shotgun slugs ultimately fired by Patterson impacted in a gas grill that was in between him and unit 462. The trajectory of the bullet was such that if the grill was not there, the slug would have continued on into the passenger compartment of 462, where NEG1 was located at the time. (See Appendix C).

The culmination of this section leads to what officers and deputies in similar future situations must do: focus on the perspective of what *could* happen. This process can help to give officers and deputies the opportunity to use their cognitive processing rather than a subconscious, emotional response; to be aware of and not rely on potentially inappropriate schemas; and to be able to compensate for the natural disadvantage officers face with the reality of the action versus reaction quandary.

5. Impact of Officer Fatigue

Fatigue can play a negative role in everything discussed in this portion of the report. A fatigued officer may be more susceptible to a higher level of arousal than they normally would have, potentially compromising their motor skills. An officers overall ability to discern deviations from their interpretation of the situation, or their schema, may also be compromised by fatigue. Finally, fatigue will also impair an officer’s overall reaction and response time. The discomfort experienced by the deputies because of the gravel driveway would potentially exacerbate their fatigue. The combination of fatigue and discomfort can also lead to taking unnecessary risks, and making tactical decisions that may not be wise in order to just get the

incident over with. A long term, stressful situation can also exacerbate the normal fatigue experienced by an officer or deputy.

There exist numerous studies, articles and research about the negative impact of sleep deprivation and fatigue. Much of this research involves not only the impact on law enforcement, but also on other disciplines, such as the military, the medical community and airline crews. The Police Executive Research Forum commissioned a project funded by the U.S. Department of Justice, in which the impact of fatigue on police officers was studied. (Vila, 2000). Shift work, overtime and irregular sleep patterns all lead to widespread fatigue in police work, which impairs performance. Many people who are suffering from sleep deprivation are frequently not aware their performance is impaired. Studies have shown that being awake for 17 hours leads to a performance equivalent of a blood alcohol concentration of 0.05%. Increase that period of wakefulness and the performance deficit is equivalent to a blood alcohol concentration of 0.10%. (Dawson, 1997; Vila, 2000).

Implications Related to Knoxboro Road for similar future situations:

Of the members who comprised the primary responders to the Knoxboro Road incident, ten or more of them had already worked their normal day shift and had been recalled. Most were recalled between the hours of 8:00 pm and 9:00 pm on the night of June 6, 2011, and the shooting occurred at approximately 2:02 am on June 7, 2011. All leadership members of the OCSO present at Knoxboro Road are included in this recalled group. This means, in all likelihood, that most or all of those recalled had been up for approximately 20 hours at the time of the shooting.

Inclusion of this analysis is designed for awareness purposes and for support of other findings and recommendations within this report. When dealing with a part time Emergency Response Team, which is what most tactical teams are, it would not be feasible to prevent a situation where a significant number of responders have been awake for long periods of time. The members are who they are, and they must respond when needed. Overall, sleep schedules are beyond management control. Some control can be established by watching how much overtime is worked by officers, but this can be difficult because of coverage demands. What is within immediate control, however, is having sufficient manpower to ensure that the same deputies do not need to be in critical response positions for extended periods of time. The stress of such assignments can significantly add to the impact of normal fatigue. Having enough qualified manpower to provide a regular relief schedule can make a substantial difference. Having all available team members from the start can assist in this relief process.

From a decision making standpoint, the proper use of the Incident Command System can help to ensure that decisions are made for the right reason and are appropriate. The checks and

balances that naturally flow from the command post interactive process will assist in this process.

Finally, use of mutual aid agreements can provide additional avenues of relief by providing assistance from another tactical team. There are not many law enforcement agencies that have the resources to handle long term incidents on their own. This must be understood and accepted, and it is not a sign of weakness that an agency needs logistical assistance in such situations. The nature of such agreements is that they are reciprocal, meaning the need for assistance can and will go both ways.

6. Role of Interpersonal Communications

The origins of this section can be found in research related to airline crews and crew related accident investigations. When an airliner crashes, there are typically numerous cumulative factors that contribute to such a disaster. For purposes of this report, however, one specific category of error is applicable and relevant to law enforcement involved in on-going incidents. The specific type of error is called that of a “monitoring/challenging” error. (NTSB, 1994) Essentially, a flight crew has the obligation to monitor not only their own personal actions, but also the actions of the other crew members, including the captain. When one crewmember is perceived to be making an error, the other crewmembers are obligated to challenge that member and the error. The system is designed for redundancy and does not place all responsibility on one person. In practice, however, it has not always worked. In the NTSB study, of the 37 accidents examined, 31 accident sequences, or 84%, identified monitoring/challenging errors as one of the contributing errors. For whatever reason, the crewmembers did not effectively communicate with each other, even though this process is an affirmative obligation on them. In 19 of the 37 accidents, such an error came after the last primary and causal error which may have been corrected if an effective challenge occurred. Again, this is a complex area and this brief overview is not designed to be an exhaustive discussion of all the concepts involved. But one of the reasons for this failure to challenge can be found in law enforcement as well as the cockpit of a plane. It stems from a concept called mitigated communication, or mitigated speech. This involves the use of deferential or indirect speech, effectively downplaying what is being said. A first officer of a plane is more likely to use this type of speech than the captain is due to the class hierarchy that comes with rank. In fact, this can cause some flight crew to fail to challenge a superior officer at all, let alone use mitigated speech. In either case, crashes have occurred because one pilot failed to succeed in effectively communicating their concerns to the other pilot. (Fischer, 1999). In sum, total, or even partial, deference to another’s rank and/or authority, can, under some circumstances, lead to deadly and devastating consequences.

Rank obviously exists in law enforcement as well. Inclusion of this information within this report is not intended to imply that law enforcement officers should have free reign to challenge the orders of superior officers. The following discussion is only intended for slow developing and on-going incidents like that at Knoxboro Road. When an immediate emergency exists, orders must be followed.

Further information is needed to explain the concept of failure to appropriately challenge. Research done by Fischer and Orasanu used six degrees of mitigation which are used to make suggestions to authority figures. From the most direct to the least, they are: Command ("This is going to be done"); Team obligation statement ("*We* need to try this"); Team suggestion ("Why don't *we* try this?"); Query ("Do you think this will help *us* here"); Preference ("Maybe we should take a look at this or that"); and Hint ("I wonder if we will be ok if we stay this way"). Their studies found that most first officers used Hints, the most mitigated speech, thereby using the most minimal challenge to the pilots' status. The *least* effective method, according to the groups in the study, was the Command. The most effective communicative techniques were found to be the team obligation statement, team suggestion and preference statements. The reason for this, which is also relevant to law enforcement, is that these methods explicitly state what should be done and *they address the problem without disrupting the team concept.* Compliance is sought by appealing to an obligation shared by all involved in the situation and do not rely on status differences. In other words, concerns about on-going situations can be addressed by members of all rank who have a stake in the outcome of the situation, can be conveyed professionally, effectively and while maintaining proper decorum.

Implications Related to Knoxboro Road for similar future situations:

Many of the deputies interviewed by the committee indicated they were not comfortable with their proximity to Patterson during the Knoxboro Road incident. These deputies felt Patterson was a real threat to deployed officers, regardless of whether he was primarily suicidal or not. At least one deputy properly quoted the action versus reaction problem discussed above. The problem was that these deputies did not convey their concerns to anyone during the course of the incident. As discussed in Part 1, this is primarily because of the lack of a proper forum for such discussions to be had, and concerns to be raised. The creation of an incident command post and/or tactical operations center would, or should, have created the proper environment for such concerns to be raised. But another reason this lack of communication occurred is likely attributable to the fact that ADM3, who did not work with the ERT or train with them, was running the incident directly. As previously stated, ERTC was essentially trapped by circumstance at 462, focusing primarily on Patterson and the negotiations. Not only did this create an environment that did not facilitate discussion, but it violated the normal culture associated with a SWAT team. As a result, the deputies were deferring to ADM3's authority,

and ERTC's preoccupation with the immediate interaction with Patterson, keeping their concerns to themselves.

Normal rank is meaningless within a SWAT team. Leadership positions are based upon training, experience and capability. So it is not uncommon for one team member to be the sergeant of another deputy while doing their normal duties, but have the situation completely reversed while operating as a SWAT team. In addition, the culture is such that the team concept is highly emphasized and valued. The true strength and effectiveness of a SWAT team flows from the members working as a group, with a shared stake in the outcome, and not as individuals. Those who cannot adapt to this do not remain as members of SWAT teams. Critical to this team culture is effective communication between members. As airline flight crews who frequently fly together have fewer mitigation and challenge problems, the same holds true with tactical teams who work together on a regular basis. Interjecting a ranking figure who the team members are not used to working with under such circumstances, and absent a command post and/or TOC, challenge problems will predictably occur. Encouraging the exchange of ideas can provide the entire agency with the opportunity to make that cultural change that invites communication, not to the level of insubordination, but one of providing everyone with total situational awareness.

7. Interplay of these concepts with the law.

One final concept must be discussed before concluding this section. In addition to the fact that detailed knowledge of the concepts discussed in the previous sections is not yet prevalent in policing, it is also important to understand the law. Neither federal nor state law requires an officer to be second guessed in the handling of an incident leading up to the use of force. Any use of force by an officer must meet the standard of objective reasonableness, based on the threat as perceived by the officer at the time the force is used. As a general rule, the courts will not apply 20/20 hindsight to all prior steps and decisions taken by an officer in such a situation. Understand that the concepts discussed in this portion of the report, are designed first and foremost for the benefit of the survival of the officer. It is not uncommon, however, for officers and deputies, whether consciously or subconsciously, to put the safety of the suspect over their own. In fact, there is some evidence that many officers have faced situations where they believed they could have used deadly physical force, but they chose not to, potentially placing themselves at enhanced risk. (Pinizzotto, 2012)

It is generally the police reacting to a suspect who has chosen to act in a manner which threatens the officer or another person. It is typically the armed subject driving the situation, not the officer. Failure of an officer to adhere to the principles discussed in this appendix, or any related principles, creates no duty to perform in a certain manner towards a suspect. To the contrary, it can actually mean officers are putting themselves at risk should they not apply

them. Clearly there are secondary benefits to be gained by an understanding and application of the principles, but they create no standard of duty to act by police officers. For a person who chooses to brandish a weapon at or near police officers or innocent bystanders, they have but one clear option – put the weapon down. If the subject chooses to use force on an officer or a third person, or objectively reasonable force is used on him by a police officer, then that subject is responsible for the outcome.

B. *POST INCIDENT SELF INITIATED ACTIONS OF THE O.C.S.O*

To the credit of the members of the Oneida County Sheriff's Office, its leadership and members, immediately after this tragedy and in an effort to improve operations and prevent similar situations, the OCSO initiated a number of actions and implemented changes. Some of these are still on-going. The following procedural changes were implemented prior to or during this review being conducted:

1. Mandated monthly training schedule for the Emergency Response Team.
2. Reconsidered the manner of utilization of less lethal munitions in situations where a suspect armed with a deadly weapon is a potential threat.
3. Require a minimum of three negotiators on scene when working in that capacity.
4. Required the use of a "white board" NIMS/ICS standards of accountability at all critical incidents.
5. Upon ERT taking tactical command of a scene, no ancillary or support staff is allowed within a designated inner perimeter without proper training.
6. Members of the OCSO are assigned to definitive roles at critical incidents, and are not serving in multiple capacities, depending on the size and scope of the situation, as required by proper use of the Incident Command System.
7. The OCSO is currently in the process of purchasing an armored vehicle.
8. The OCSO recently purchased a Robotex surveillance tactical robot.
9. The standardized use of a drop phone for negotiations.
10. The acquisition of a new, improved and updated drop phone unit.
11. The acquisition of powered portable lighting systems.
12. Early request / notification for mutual aid in critical incidents with an understanding that it is virtually impossible to be able to handle all situations without assistance.
13. Reevaluated and made revisions in the use of certain types of ammunition.
14. The OCSO now conducts post incident debriefings.
15. The members of the OCSO now qualify with department issued shotgun and AR15 twice a year.
16. The OCSO now has members trained in Critical Incident Stress Management (CISM) and Peer Support and have established an agency team.
17. The OCSO is currently in the process of purchasing a self-contained mobile command post.
18. Following the incident, the OCSO took the following actions in regard to the members involved in the incident:
    - All involved were placed on a mandatory 48 hour administrative leave from their duties.

- Some members were given extended paid leave by the agency.
- The services of the NYS Police Peer Support Team, the County Employee Assistance Program (EAP), and local clergy services were utilized.
- A spousal support meeting with the county EAP was arranged
- Group and individual support meetings were held.

This information was provided by the OCSO Administration and was not independently developed and/or verified by the members of the committee.

C. *OTHER CONSIDERATIONS: POST INCIDENT RESPONSE*

The Oneida County Sheriff's Office, as well as all law enforcement agencies, should consider adopting policies and procedures to deal with the possibility of the death or serious injury of an officer or deputy. In addition, officer involved shootings, where an officer or deputy is not injured or killed, are traumatic events standing alone. The manner in which an agency handles the immediate and long term aftermath of such situations can have a direct impact on the emotional state of the officer or deputy. While the OCSO did provide some of the services mentioned below, established policy should dictate the procedures to be followed. The aftermath of such an incident is not the time to begin attempting to figure out what needs to be done.

All law enforcement agencies should consider addressing some or all of the following topics through the adoption of policies and procedures:

1. Participation in and active encouragement for members to utilize the resources of an Employee Assistance Program.
2. Dealing with a line of duty, life threatening situation or death of an employee. This would include procedures for notification to families and the role of all members of the agency, from the first line supervisor to the command staff.
3. Dealing with a member who has been involved in a shooting, or other type of use of force, which causes the injury or death of a person. Such a policy should include how the member is to be treated from the moment of the occurrence to his or her return to duty. Considerations should include but not be limited to, treatment of the officers weapon and its replacement if secured, assignment of a fellow member for support, limitations of initial probable cause/ public safety statement, consideration of collective bargaining restrictions, if any, on conducting a formal interview of the member, attendance expectations of the member (i.e. administrative leave, desk duty, full duty) pending internal affairs and grand jury review (if applicable), designation of procedure that will be used to keep the member abreast of the status of the investigation if out on administrative leave, and process for return to duty.
4. Consider mandating physiological evaluation and counseling for members involved in traumatic events. If it is mandated then the possible stigma of an officer asking for help can be avoided. There are many officers that likely could use such assistance, but refuse to do so because they do not want to appear weak.
5. Use of a member emergency notification database.
6. Development of a peer support program.

Additional resources and information can be found in at least two areas. The New York State Division of Criminal Justice Services, Office of Public Safety, has developed and coordinated a training class entitled *T.R.A.U.M.A.: Trauma Resources and Unified Management Assistance.* Officers and deputies who have been involved in traumatic incidents are used as presenters. This class is offered at various times in various parts of the state and information on dates and locations can be found through the D.C.J.S. website at:
http://www.criminaljustice.ny.gov/training.htm

This class covers many of the topics identified in the previous paragraphs, plus deals with officer suicide, and the signs and symptoms of Post-Traumatic Stress Syndrome. A resource disk is given to all attendees.

The International Association of Police National Law Enforcement Policy Center also has model policies available for purchase. Specifically, they have research based position papers and model policies available on the following relevant topics: Post Shooting Personnel Support, Employee Mental Health Services, Death Notification (not law enforcement specific, but relevant), and Line of Duty Death and Serious Injury.

A final consideration for this section is in the internal investigation conducted by the agency during an officer involved shooting or other use of force. This is another area where policy should be considered and made prior to an incident actually occurring. The impact of high stress encounters, and the high state of emotional arousal they can cause in officers and deputies, has to be understood and considered before and during the investigation. First, the physiological effects of high stress encounters described in Part 2 (A) can vary from officer to officer. Memory gaps in officers are common, and time is needed for some memories to fully form. The more stress experienced by a particular officer, the more likely initial memory gaps will occur. Officers with a high level of training and experience, especially in high stress encounters, may not be impacted as much as others. What this can lead to, however, is that investigators may find that the recollections of the officers' involved may differ. This is to be expected, as it is when dealing with civilian witnesses to incidents. Policy should take into consideration when an officer will be asked to give a formal statement. As sleep is a beneficial period for memory development, the general rule now is to provide the officer with at least one sleep cycle. Some agencies have taken that even further and allow for 48-72 hours before the formal interview is conducted. All officers involved in force incidents must give at-scene, probable cause/public safety information to other responding officers. This brief interview is limited to information required to apprehend the suspect(s), determine if there may be other victims, and possible location(s) of relevant evidence. The ultimate goal of any investigation is to determine the truth of what happened, whenever possible. Rushing to a formal interview of an officer who has just been through a traumatic event may not fulfill that goal.

D. *SPECIAL RECOGNITION AND ACKNOWLEDGEMENTS*

The committee would like to recognize one member of the Oneida County Sheriff's Office for his efforts to help other law enforcement officers after the death of Deputy Wyman. Investigator David Nowakowski heard of the T.R.A.U.M.A. class being developed by D.C.J.S. and volunteered to speak about his experience during the class. Inv. Nowakowski was fully involved in the Knoxboro Road incident, which has left a lasting impact on him. He freely and openly shares how this incident affected him, both in the short term and long term. His presentation is compelling and thought provoking, helping to break down the dangerous walls possessed by many in law enforcement – "I am too tough for that to bother me; that just happens to others." This denial can lead to long term stress and emotional damage. His courage in both recognizing and accepting this fact, and his willingness to share it with others, is to be commended.

This report is, by necessity, critical in nature in order to fulfill the stated objectives of the independent review. Sugar coating issues and ignoring identified areas of deficiency would make this a useless endeavor, providing no value to the Oneida County Sheriff's Office or other law enforcement agencies. The willingness of the members of the OCSO to request and undergo such scrutiny must again be recognized. What cannot be overlooked by the reader is the willingness of all the members of the OCSO, their ERT and all members of law enforcement everywhere to voluntarily place themselves in situations such as occurred on Knoxboro Road, as well as many other dangerous situations. This occurs every day, and the deputies of the OCSO, in the aftermath of this tragedy, have continued on performing their duty.

On a final note, the incident at Knoxboro Road has had lasting detrimental impact on two families, the members of which had no control over the final results. The first is the victim of the initial incident of domestic violence and her son, who is also the son of Christian Patterson. They are without blame in this incident, yet must endure the aftermath. The committee requests that all readers of this report respect their privacy.

The second is the wife, son, daughter and other family members of Deputy Sheriff – husband - father – son - Kurt Wyman. They have had to deal with the impact of this tragedy every day of their lives. This has been made worse by having to deal not only with the immediate aftermath, but then the subsequent trial and appeals. Now, this report will once again bring the tragedy to the forefront. Their patience and understanding of the importance of this review is greatly appreciated. We ask that their privacy be respected as well.

Appendix A. References and Bibliography

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Part 2: References

The following references were either used at least in part for the content of Part 2, or are provided because of their relevance should the reader choose to do further research. Some of the resources are not directly related to law enforcement, but the principles remain relevant. The reality is that many of the specific topics, such as schemas, hindsight bias, and slip and capture errors, have not been researched to any significant degree in the context of law enforcement. The Force Science Institute includes these topics in their certification classes, but additional research must turn to other disciplines. The sources are listed by the section they were primarily used in, although many of the sources overlap other sections as well.

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See also Blair (2011) and Davis (2012) above, for an overview of the legal standards regarding the use of force.

Appendix B. Incident Personnel Chart with report codes

Report Code	Duty at time of Inc.	Primary Scene Assignment	Secondary Scene Assignment	Weapons/ equip, assigned
Dep. Wyman	road patrol	initial responder/ at 462	Taser operator	Handgun, Taser
DEP1	road patrol	2nd arriving officer/ at 462	Relieved from 462 imm prior	Handgun/shotgun
SGT1	road patrol	1st sup., started perim. 451		Handgun/
DEP2	road patrol	position at NW corner of house	0030 moved to traf. Control	Handgun/ ?
DEP3	road patrol	at 451/ then did recon	joined others at 462	Handgun/ AR15
NEG1	working	moved to 462, began NEGO's	at 462 entire incident	Handgun
ERT1	road patrol	at 451	joined others at 462	Handgun/ AR15
DEP4	road patrol w/ERT1	Dropped ERT1, did traffic cont.		Handgun
DEP5	road patrol	interviewed DV Victim	positioned at 451	Handgun
Sheriff	at mtg in Verona	positioned at 451	at 451 entire incident	Unknown
ADM1	OD, called in	positioned at 451	at 451 entire incident	Unknown
ADM2	OD, called in	positioned at 451	at 451/went to LEB for equip	Unknown (also is PIO)
Usheriff	OD, called in	positioned at 451	at 451 entire incident	Unknown
ADM3	OD, called in	Briefed at 451, then to 462	back and forth 462/451	Unknown (TACT COMMAND)
NEG2	Off duty/called in	moved to 462 with NEG1	at 462 enitre incident	Handgun
ERT2	OD, called in	at 451 whole inc (gear in 462)	did EMT on Wyman	Handgun/ medical gear
ERT3	OD, called in	did recon, at 462 rest of time	fired LL 40mm at CP	Handgun/LL shotgun, 40mm
ERTC	OD, called in	at 462 or staging area		Handgun
ERT4	OD, called in	Staging, then front porch	moved to 462 with LL 40mm	Handgun/ 40mm LL
ERT5	OD, called in	Staging, then front porch	stayed on porch/in entry	Handgun/ ballistic shield
ERT6	OD, called in	Staging, then front porch	stayed on porch at window	Handgun. MP5
ERT7	OD, called in	Staging, then to 462 w/shield	at 462 enitre incident	Handgun, shield, shotgun

Numerals are assigned to rank abbreviations based upon approximate arrival at scene.

ADM = Department administration; OD = Off Duty

fired weapon

attempted to fire weapon

Appendix C: Forensic Reconstruction of Incident

The following is a revised version of the Forensic Reconstruction Report prepared by the Utica Police Department Crime Scene Unit:

On June 7, 2011 a request was made to the Utica Police Departments (UPD) Crime Scene Unit (CSU) from the Oneida County Sheriff's Office (OCSO) to assist them in the processing of a homicide scene involving the murder of Deputy Kurt Wyman. UPD agreed to help and responded to the Oneida County Law Enforcement building where they met with the OCSO Crime Scene Unit. They were awaiting a search warrant for the scene on Knoxboro Road. Once the warrant was issued, members of UPD and OCSO proceeded to the scene.

The CSU team arrived at approximately 1000 hours and walked through the scene; OCSO members explained that while officers were negotiating with a suspect, Christian Patterson, regarding a domestic incident, Patterson opened fire with a shotgun. One of the slug rounds fired by the suspect struck Deputy Wyman in the neck. CSU investigators were told that once the suspect opened fire, deputies returned fire from various positions that they had taken up during the negotiations. Several observations were made during this initial walkthrough and noted that many points of evidence were already marked with yellow placards. The scene was a single family home that sits back from the road at the end of a 170' gravel driveway. The house and garage can be described as 'L' shaped with the two stall garage running parallel to the driveway. The northern most garage door was open while the center entrance and western garage doors were closed. The shooting occurred in the garage and driveway, with the suspect firing from inside the garage to the outside driveway in a northeasterly direction.

After reviewing the scene UPD was asked to assist with two parts of the investigation, the forensic mapping of the garage and exterior grounds and to examine and document the trajectories of the bullets fired at the scene. UPD CSU began and determined that a total of five people at the scene (4 deputies and the suspect) fired or attempted to fire rounds during the exchange of gun fire. Also determined were the following locations where deputies were positioned when the gunfire erupted. While this investigation was able to determine most of the trajectories, it was unable to establish the sequence or order in which any of the bullets were fired.

ERT 6, armed with a 9mm MP-5, was standing in the breezeway on the north end of the house. From this position he was able to look through a window into the kitchen and garage. During the exchange ERT 6 fired three times from the breezeway, thru the window towards the garage. Two of the bullets struck the Samsung refrigerator in the kitchen and were labeled #19 (upper) & #20 (lower) while the third bullet was later found on the garage floor. The 9mm casings were located in the breezeway and collected as items #22,23 &25.

Bullet #19 passed thru the breezeway window and traveled 10’10” at a 2 degree upward angle where it hit the exterior of the refrigerator. The bullet passed thru the door, upper tray and a bowl of food where it shed the copper jacketing and eventually struck the back wall. The bullet and copper jacketing were later recovered.

Bullet #20 passed thru the breezeway window traveled 10’10” at a 1 degree downward angle until it also struck and passed thru the refrigerator door. Once inside the refrigerator the bullet damaged the right (west) side of the plastic wall. The projectile was later recovered in the right side of the refrigerator.

The third shot fired by ERT 6 passed thru the breezeway window and traveled 46’7” at a 10 degree downward angle and entered the garage where the projectile and copper jacketing were found on the floor. This projectile was collected as item #29 (lead projectile) and item #30 was the copper jacketing.

NEG1 armed with his 40 caliber service handgun was sitting in the driver’s seat of Oneida County Sheriff’s Patrol vehicle 462. The car was pulled near the end of the driveway and was being used as cover for the deputies while they negotiated with the suspect. When the gunfire erupted NEG1 fired three rounds from inside the patrol car towards the garage. These three rounds were located and accounted for. Two of these rounds passed through the windshield and were labeled B &C. The third round was later found at the base of the windshield on the interior side.

Bullet “B” passed thru the windshield at a 15 degree downward angle and traveled approximately 9’ where it struck a rock on the ground. The bullet then broke into two pieces. Piece #1 was later found and labeled evidence #8. We found that as this piece left the rock it was redirected upwards 14’ 1 ½” at a 33 degree angle until it hit and broke the glass pane of an exterior light before falling to the ground. Piece #2, later labeled evidence #24, left the rock at a 50 degree upward angle for 3’5” until it struck the northeast corner of a barbeque grill that was between the patrol vehicle and the suspect. The bullet hit the corner and was deflected 13 degrees downward for 10’3” where it was found in the driveway.

Bullet “C” passed thru the windshield and traveled for 11’11” at a 3 degree downward angle striking the northeast portion of the barbeque grill. The bullet continued for 1’6” and exited the front of the grill at a 28 degree upward angle for 12’3” until it entered the exterior wall above the north garage door.

The third round fired struck the interior of the windshield and did not exit, instead it followed the curvature of the glass and went between the windshield and dashboard. The

windshield was later removed and the projectile was recovered. All three of NEG1's 40 caliber casings were recovered from inside OCSD car 462 and were labeled #1,21 & 130

DEP3 was standing along the driver's side of sheriff's patrol car 462 in the driveway armed with a 223 caliber patrol rifle. When the shooting began DEP3 experienced a misfire as his weapon would not fire the chambered round. As part of his training he ejected the round and attempted to fire the next round. This round also would not fire and as a result DEP3 never fired this rifle. This live 223 round was labeled M and later collected.

ERT7 was also standing along the driver's side of the sheriff's patrol car 462 in a more southerly direction. He was armed with a police issue Remington 870 shotgun loaded with 12 gauge 00 buckshot. ERT7 returned fire with this weapon shooting twice. The buckshot loads hit the suspect, the suspect's shotgun and the west wall behind the suspect. The Winchester shotgun shells were later located and labeled N&O.

Christian Patterson, the suspect, was seated on a stool that was 1' ½" tall as the negotiations were taking place. As reported to the CSU, the suspect was either in this seated position or on the floor when he began shooting. The evidence shows the suspect fired three times, firing 12 gauge slug rounds each time. Two shotgun shells were found on the garage floor and labeled H&V. A third shotgun shell was found in the suspect's weapon, a Remington 870 pump action shotgun, partially ejected. This shell was labeled #34 and collected. While the sequence or order of these three rounds could not be determined, the trajectories were determined and are as follows.

A round was fired by the suspect towards OCSD patrol vehicle 462. The round originated approximately 1'1" above the floor and traveled 26'10" in a northeast direction before it struck the barbeque grill and became lodged. The entry hole and projectile were labeled L and the projectile was later recovered. As part of the investigation, the string method was used to determine the path of the projectile. This string was also used to determine the path this projectile would have taken if it had not been stopped by the barbeque grill. During the reconstruction a wooden stake was used to maintain the entry position of the projectile into the grill. The string was attached at the point of origin and tacked to the wooden pole at the entry point of the grill, 26'10" at a 3 degree upward angle. The grill was then removed from its position and continued the projectile trajectory 11'2" at the same 3 degree upward angle. It was determined that this trajectory path would have taken the projectile into the windshield of Oneida County Sheriff Patrol Car 462 that NEG1 1was seated in. The bullet would have struck the windshield 4'2" up from the ground and 5 inches east from the edge of the A pillar.

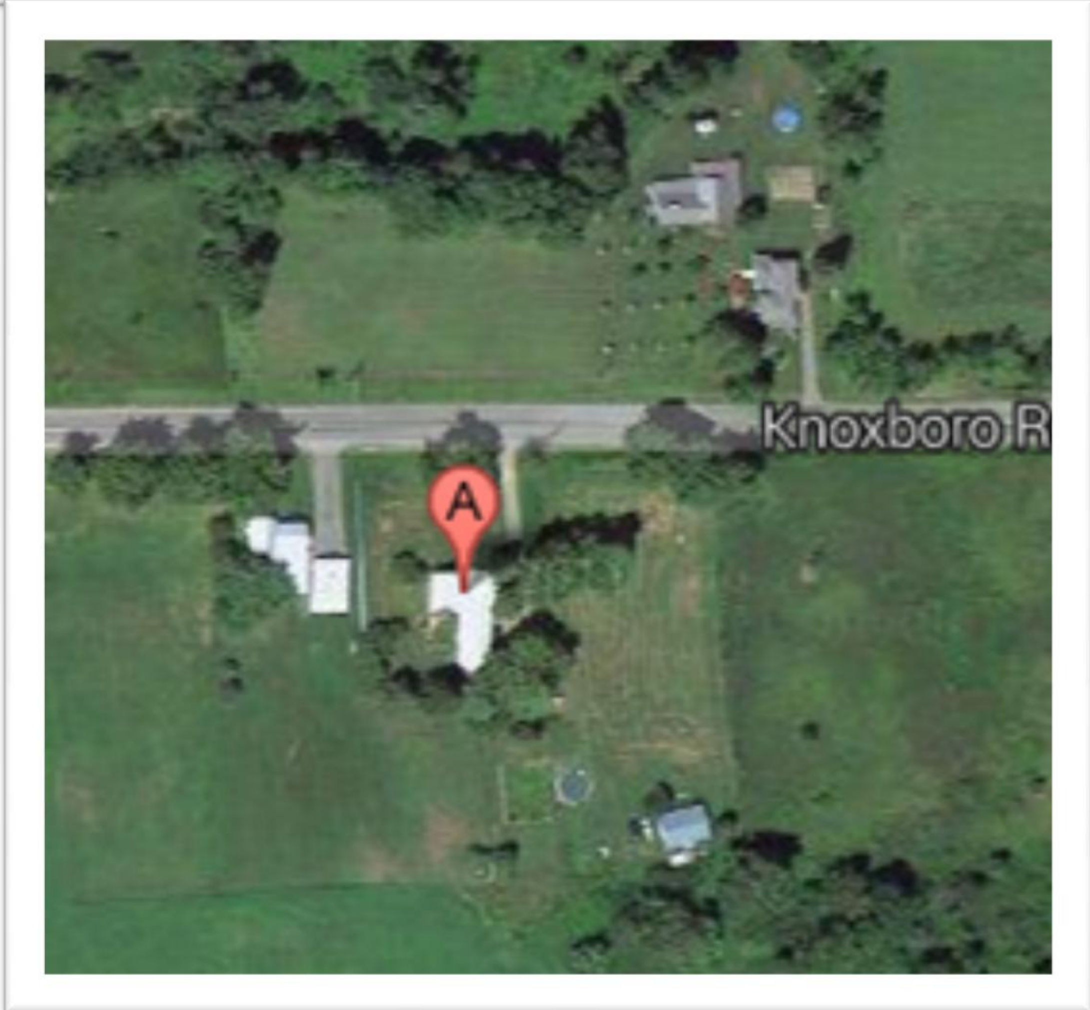
The exact trajectory path of the projectile that struck Deputy Wyman was unable to be determined due to lack of physical evidence relevant to his position when shot. We were able to determine that he was standing along the southeast corner of the open garage door when he was hit. This positioning was determined though physical evidence at the scene and witnesses statements.

A third trajectory was approximated through the discovery of physical evidence located in a field northeast of the driveway. The evidence discovered was a portion of shotgun wadding. Shotgun wadding is made of a few components such as plastic caps, compressed fiber and cardboard discs. They are all part of the shotgun shell and when fired will travel a considerable distance along the same path as the projectile. The portions of shotgun wadding found at the scene were the cardboard discs. These discs were found about 30 yards from the suspect and behind where the officers were standing in the driveway. The physical evidence located supports that this projectile was fired from inside the garage in a northeast direction, then traveled between or over the officers in the driveway and continued on while the wadding fell to the grass. It was later located and labeled 36, 37 & 38.

Once the trajectory analysis was completed CSU Investigators forensically mapped the scene recording points of evidence. They later used this electronic data to construct a diagram of the scene.

The following two pages contain a Google Map overview of Knoxboro Road, with Patterson's house marked as "A". The next page is an edited version of the scene diagram prepared by the Utica Police Department Crime Scene Unit.

North
Map
Traffic
Knoxboro Rd
Knoxboro Rd
Knoxboro Rd
Knoxboro Rd
11
11
11
A
200 ft


Knoxboro R
A

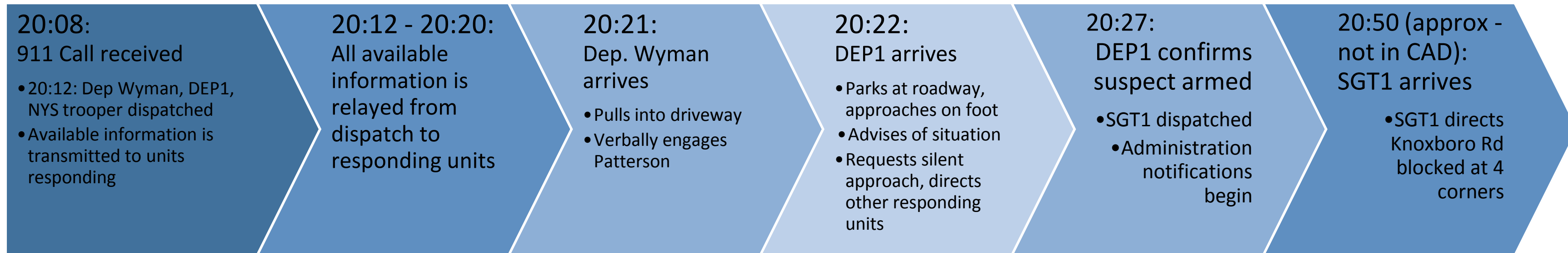
Position of 3 ERT members for most of incident

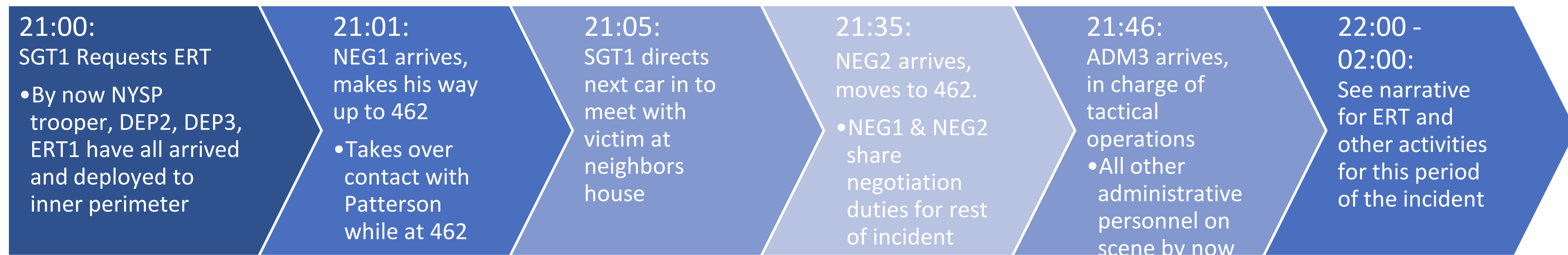
Unit 462: location of numerous members of ERT, DEP1, DEP3 & Dep. Wyman

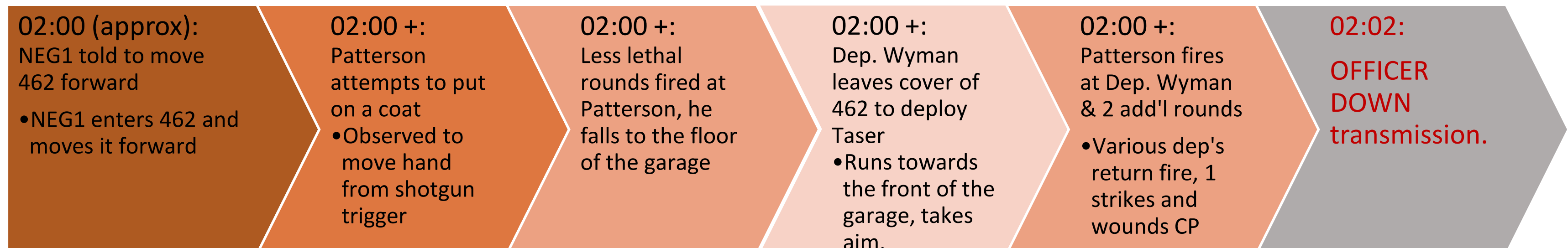
Patterson's position in garage

Appendix D: INCIDENT TIMELINE

This is a timeline of some of the most significant points of the Knoxboro Road incident, and is not a description of everything that transpired over the evening. It is intended to be read and used in conjunction with the Incident Overview.







Appendix E. Committee Member Biographies

Chief Michael D. Ranalli:

Michael D. Ranalli, JD, is Chief of the Glenville, New York, Police Department. Chief Ranalli began his career in 1984 with the Colonie, New York, Police Department and held the ranks of patrol officer, sergeant, detective sergeant and lieutenant. He was also a member of the Colonie Special Services Team (tactical team) for 12 years, the last two serving as the tactical commander. In June 2006 he was appointed Chief of Police of the Glenville Police Department.

Chief Ranalli is a frequent presenter on various legal issues including search and seizure, use of force, legal aspects of interrogations and confessions, domestic violence, wrongful convictions, civil liability and school violence and prevention. He is author of *Search and Seizure Law of NYS: Volume 1 – Street Encounters,* published by Looseleaf Law Publications, Inc. He is also the editor of *Civil Liabilities of New York State Law Enforcement Officers, 3rd Edition,* by the same publisher. He is a consultant/instructor on police legal issues to the New York State Division of Criminal Justice Services, and has taught officers around New York State for the last eight years in that capacity.

Chief Ranalli the is first vice president of the New York State Association of Chiefs of Police, a member of the IACP Professional Standards, Image & Ethics Committee, and the current Chairman of the New York State Police Law enforcement Accreditation Council. He is also a graduate of the 2009 F.B.I.-Mid-Atlantic Law Enforcement Executive Development Seminar and as of April of 2012, is a Certified Force Science Analyst.

He holds a bachelor's degree in criminal justice from the State University of New York, Utica/Rome and a Juris Doctorate from Albany Law School. He is admitted to the New York State Bar and the Federal Bar (Northern District of New York).

Chief H. Lloyd Perkins:

Chief H. Lloyd Perkins III, is the Chief of the Village of Skaneateles, New York. Police Department. Chief Perkins started his career with the Town of Camillus Police Department in 1969, and held various supervisory and command positions including Sergeant, Detective Sergeant, Staff Sergeant, Lieutenant, Captain, and was appointed Chief in 1994. In 2005 after 35 years with the Town of Camillus Police, he transferred to the Skaneateles Police Department as Chief of Police.

During his career Chief Perkins has received numerous awards and commendations that include negotiating, supervising and commanding incidents with barricaded suspects. He has also supervised and commanded tactical units and entry teams.

He was appointed by four different Governors as member and Chairman of the" New York State Police Law enforcement Accreditation Council". He led two police agencies through initial and reaccreditation. Chief Perkins is also an executive development instructor for the New York State Division of Criminal Justice Services. In 2003, he received the first ever Central New York Human Rights Award for law enforcement. In 2004, he received the I.A.C.P. Law Enforcement Civil Rights Award.

Chief Perkins served on the Board of Governors and as President of the New York State Association of Chiefs of Police. He also participates in the I.A.C.P New Chief Mentor Program as a consultant and Mentor, and has helped develop model policies and best practices for the I.A.C.P. in the area of internal affairs for smaller agencies.

Chief Joseph F. Snell, Jr.

Chief Joseph F. Snell, Jr., is the Chief of the Town of Cicero, New York, Police Department. Chief Snell began his career in 1979 as a member of the Onondaga Sheriff's Department. He rose to the positions of Executive Officer of the Uniform Bureau and was the Commander of Special Operations, which included the SWAT Team and Bomb Squad. He was named Chief of the Town of Cicero Police Department in 1995. Chief Snell also served as the East Syracuse Interim Chief of Police from October of 2000 until September of 2001.

Chief Snell has a Bachelor's of Science in Social Psychology from SUNY – Empire State College, and a Masters in Business Administration from Sage Graduate School in Albany, New York.

Chief Snell is the past president of the Central New York Chiefs of Police Association and is the current chairman of the New York State Counter Terrorism Zone 7. He has been an adjunct professor for Keuka College since 1994 and also for SUNY Morrisville since 2012.

Captain James Watson:

Captain James Watson is a Captain of the Utica, New York, Police Department. Captain Watson was hired by the Utica Police in 1993, and was promoted to the rank of sergeant in 2000, lieutenant in 2006 and captain in 2008. During his career he worked in patrol as a police officer, sergeant, lieutenant and captain. He was also assigned in criminal investigations as a sergeant and later as a captain.

He is a graduate of the NYSP Williams Homicide Course, the NYPD Homicide Investigators Course and the FBI National Academy. Captain Watson is a NYS Master Instructor and also teaches at the NYS Preparedness Training Center.

He has been an operator, team leader and team commander with the Utica-New Hartford Emergency Response Team during the past 12 years.