NEW YORK STATE | Commission of Correction

Final Report of the New York State Commission of Correction:

In the Matter of the Death of

William Henley, an incarcerated individual of the Erie County Holding Center

September 25, 2024

To: Sheriff John C. Garcia
Erie County Sheriff's Office
10 Delaware Avenue
Buffalo, New York 14202

Allen Riley
Chairman

Yolanda Canty
Commissioner

Elizabeth Gaynes
Commissioner

GREETINGS:

WHEREAS, the Medical Review Board has reported to the NYS Commission of Correction pursuant to Correction Law, section 47(1)(d), regarding the death of William Henley, who died on November 27, 2022 , as a result of circumstances which occurred while an incarcerated individual in the custody of the Erie County Sheriff at the Erie County Holding Center, the Commission has determined that the following final report be issued.

FINDINGS:

1. William Henley was a 57-year-old male who died on 11/27/22 due to blunt force injuries of the head and neck that occurred from an assault prior to his arrest and incarceration at the Erie County Holding Center while being in the custody of the Erie County Sheriff.

2. Henley was born in Buffalo, New York. Henley finished the 7th grade but did not pursue his GED. Henley was unemployed. There was no further demographic or social history available to the Commission for Henley.

3. [redacted].

4. [redacted]

5. [redacted]

6. [redacted]

7. Prior to Henley's arrest, on 11/25/22 at approximately 11:00 a.m., Henley was assaulted in the lobby of his apartment building by a neighbor who resided within the same building. The two men were involved in a fight regarding a burglary that occurred at the neighbor's apartment building on the previous day. The assault was not reported to the police. Approximately 12 hours later on the same day, another resident from the apartment building called 911 to report an attempted burglary in her apartment. Prior to the police arriving at the scene, there was evidence that a second fight occurred between Henley and a neighbor in Henley's apartment building. From a review of the video recording of the apartment building by Commission staff, Henley and an unidentified male were observed having a physical altercation in the hallway of the apartment building. During the altercation, the unidentified male picked Henley up off of the floor by the clothing on Henley's shoulder and hip area, putting Henley in a horizontal position. The unidentified male then pitched Henley headfirst into a metal electrical panel on the wall that was approximately three feet up from the ground. The altercation continued between Henley and the unidentified male. An unidentified female was

observed handing the unidentified male a steel toed boot and the unidentified male continuously hit Henley on the head and torso with the tip of the boot. After the altercation, Henley was observed getting up off of the ground and walking away out of the video recording view.

8. On 11/26/22 at 2:35 a.m., Henley was arrested by the Buffalo City Police Department and was charged with Criminal Use of a Firearm 1st Degree, Criminal Possession of a Weapon 2nd Degree, Attempted Burglary 1st Degree, and Criminal Mischief. Henley was arraigned in Buffalo City Court and remanded to the custody of the Erie County Sheriff at the Erie County Holding Center without bail.

9. On 11/26/22 at 11:34 a.m., Henley was admitted to the Erie County Holding Center by Deputy W. after being charged with Criminal Use of a Firearm 1st Degree, Criminal Possession of a Weapon 2nd Degree, Attempted Burglary 1st Degree, and Criminal Mischief. Henley scored a “one” on the Suicide Screening for answering “yes” to having financial problems due to not receiving his unemployment.

10. 

11. On 11/26/22 at 3:05 p.m., Deputy A.R. documented in the Bravo Long logbook that Henley arrived on the unit and that he was assigned to cell # 27. Security tours on Bravo Long are completed every 15 minutes.

12. On 11/26/22 at 4:00 p.m., Deputy A.R. documented in the Bravo Long logbook that meal trays were on the unit. All trays were served with no refusals.

13. On 11/26/22 at 4:35 p.m., Henley made a phone call to a female recipient that lasted 10 minutes. A review of the audio recording of the phone conversation by Commission staff

identified that at no time during the conversation did Henley report that he had any injuries or that he was experiencing having any pain.

14. On 11/26/22 at 11:00 p.m., Deputy K.S. documented in the Bravo Long logbook completing a general supervisory tour with a head count of 13 Incarcerated Individuals (II).

15. A review of the unit logbook by Commission staff found that between the hours of 11:00 p.m. on 11/26/22 through 4:45 a.m. on 11/27/22, Deputy K.S. documented completing 15-minute tours on the unit with no specific logbook entries made for Henley.

16. On 11/27/22 at 5:00 a.m., Deputy K.S. documented in the Bravo Long logbook that meal trays were offered, and that cell # 27, Henley, refused.

17. On 11/27/22 at 6:45 a.m., Deputy K.S. documented in the Bravo Long logbook that a general supervisory tour was completed, and it was the end of the tour.

18. On 11/27/22 at 7:00 a.m., Deputy C.A. documented in the Bravo Long logbook assuming the duties of the unit and completing a general supervisory tour with a head count of 14 II. During an interview with Commission staff, Deputy C.A. reported that during the first tour on the unit, “I’m counting the IIs to make sure that they are there and making sure no one is hanging”.

19. On 11/27/22 at 10:15 a.m., Deputy C.A. documented in the Bravo logbook that a general supervisory tour was completed.

20. On 11/27/22 at 10:30 a.m., Deputy C.A. documented in the Bravo logbook that a general supervisory tour was completed.

21. On 11/27/22 at 10:45 a.m., Deputy C.A. documented in the Bravo Long logbook that a general supervisory tour was completed. During an interview with Commission staff, Deputy C.A. was asked if she noticed anything unusual about Henley. Deputy C.A. reported, “Not at the time. For a Sunday, a weekend with no programs, it’s not uncommon for them to sleep late, so sleeping until lunch was not unusual.

22. Deputy C.A. documented in a written report from the Erie County Sheriff’s Office, “At approximately 10:42 hours, chow arrived at the housing area. While serving trays to the high side, Deputy D.A. was conducting the 10:45 a.m. general supervisory tour. He notified me that II Henley did not get up for his tray. After multiple attempts to awaken II Henley, I locked the high side II in, and Deputy D.A. entered the gallery to attempt to wake II Henley. Deputy D.A. then notified me II Henley was unresponsive. I immediately radioed a “10-62”.

23. Deputy D.A. documented in a written report from the Erie County Sheriff’s Office, “I was assisting Deputy C.A. with meal service and a GST(General Supervisory Tour). I noticed II Henley did not wake up to receive his lunch tray. After multiple attempts to verbally wake II Henley I notified Deputy C.A. that he was unresponsive. At this time the high side was locked in, and I entered the unit to wake II Henley. When he did not respond a 10-62 was called and the Sergeant (Sgt.) and response team arrived on the unit.” After a review by Commission staff of the Bravo Long logbook and written statements by Deputy C.A. and Deputy D.A., it was noted that Deputy C.A. documented completing the 10:45

a.m. Bravo Long tour, not Deputy D.A. This is a violation of 9 NYCRR §7003.3(j)(2) which states:
All written records pertaining to facility housing supervision required pursuant to this section shall be recorded in ink in a bound ledger of consecutively numbered pages which shall be maintained in each housing area. Such records shall include, but not be limited to the following information: the name (s) of facility staff conducting the supervision.

24. On 11/27/22 at 10:46 a.m., a Medical response was called to Bravo Long housing unit.

25. On 11/27/22 at 10:47 a.m., Advanced Cardiac Life Support (ACLS) ambulance was confirmed to have been requested by security.

26. On 11/27/22 at 10:49 a.m., medical arrived at Bravo Long cell # 27 that housed Henley. [redacted]

27. At 11:05 a.m., American Medical Response (AMR) arrived at the scene and assumed the care of Henley. [redacted] The Medical Review Board opines that Henley had obvious sings of advanced rigor mortis when found indicating that his death had occurred at least four hours prior to discovery. The Board opines that ACLS measures along with the LUCAS device should not have been initiated on Henley who had obvious signs of death.

28. On 11/27/22 at 1:19 p.m., Licensed Master Social Worker (LMSW) did attempt to see Henley to complete a mental health assessment but was unable to enter Bravo Long due to the “Code” that locked Bravo Long down.

29. [redacted]

[redacted]

The Medical Review Board has found that the manifestation of injuries on Henley, which were ultimately terminal, were not identified by the facility nursing staff who performed Henley's intake assessment on 11/26/22. The Board opines that had these injuries been able to be potentially identified the necessary medical treatment could have been obtained.

30. On 9/13/23, 28-year-old B.H. plead guilty to one account of Assault 2nd Degree regarding the assault of Henley. B.H. is serving a three-year sentence in the New York State Department of Corrections and Community Service.

ACTIONS REQUIRED:

TO THE ERIE COUNTY SHERIFF:

1. The Sheriff shall conduct an inquiry into the conduct of the correction officers who were responsible for Henley's supervision in view of the fact that obvious post-mortem changes indicate that his death occurred at least four hours prior to his discovery. Administrative action should be taken if staff were found to be in violation of facility policy and procedures.

2. The Sheriff shall conduct an inquiry into the conduct of the correction officers who were responsible for documenting tours in the logbook. Administrative action should be taken if staff were found to be in violation of facility policy and procedures.

A report of the findings and any corrective actions taken shall be provided to the Medical Review Board upon completion.

TO THE ERIE COUNTY JAIL PHYSICIAN:

The Jail Physician shall conduct a quality assurance review with the nurse who performed the intake assessment for Henley on 11/26/22 and review why significant traumatic injuries were not identified and addressed.

A report of the findings and any corrective actions taken shall be provided to the Medical Review Board upon completion.

In a response dated 8/12/24 to the Commission's preliminary report, the Erie County Attorney indicated that a comprehensive investigation was completed by jail management and correctional health services into Henley's death, with no findings of any policy violations. The Medical Review Board remains affirmed in its findings and actions required.

TO THE MEDICAL DIRECTOR OF WYOMING-ERIE REGIONAL EMS COUNCIL:

The Board requests that the Medical Director conduct a quality assurance review with the AMR EMS staff that initiated ACLS measures on Henley who had obvious signs of death at least four hours prior to their arrival at the scene.

A report of the findings and any corrective actions taken shall be provided to the Medical Review Board upon completion.

TO THE CHAIR OF THE ERIE COUNTY LEGISLATURE:

As the appointing authority for the delivery of jail incarcerated individual health services pursuant to Correction Law section 501, the County Legislature shall review the above findings and conduct an inquiry into the fitness of the currently designated provider.

WITNESS, HONORABLE YOLANDA CANTY, Commissioner, NYS Commission of Correction, Alfred E. Smith State Office Building, 80 South Swan Street, 12th Floor, in the City of Albany, New York 12210 on this 25th day of September 2024.

Yolanda Canty
Commissioner
Commission of Correction

YC:BB:vc
2022-M-0133
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