pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE FATALITY OF:

Michael Ayers

Date of Birth: 09/08/2010
Date of Death: 03/23/2013
Date of Oral Report: 03/25/2013

FAMILY NOT KNOWN TO:

Huntingdon County Children and Youth Services

REPORT FINALIZED ON: 10/31/13

Unredacted reports are confidential under the provisions of the Child Protective Services Law and cannot be released to the public.
(23 Pa. C.S. Section 6340)

Unauthorized release is prohibited under penalty of law.
(23 Pa. C.S. 6349 (b))

Reason for Review:

Senate Bill 1147, Printer's Number 2159 was signed into law on July 3, 2008. The bill became effective on December 30, 2008 and is known as Act 33 of 2008. As part of Act 33 of 2008, DPW must conduct a review and provide a written report of all cases of suspected child abuse that result in a child fatality or near fatality. This written report must be completed as soon as possible but no later than six months after the date the report was registered with ChildLine for investigation.

Act 33 of 2008 also requires that county children and youth agencies convene a review when a report of child abuse involving a child fatality or near fatality is indicated or when a status determination has not been made regarding the report within 30 days of the oral report to ChildLine. Huntingdon County has convened a review team in accordance with Act 33 of 2008 related to this report.

Family Constellation:

Name:	Relationship:	Date of Birth:
Michael Ayers	Son (victim child)	09/08/2010
[redacted]	Mother	[redacted]1971
* [redacted]	Father	[redacted]1960
[redacted]	Step-Maternal Grandfather	[redacted]1940
[redacted]	Maternal Grandmother	[redacted]1950
* [redacted]	Paternal Grandmother	unknown

**not members of the household*

Notification of Child Fatality:

On Saturday, March 23, 2013, Michael Ayers was shot and killed by his father, [redacted], at the home of his paternal Grandmother, [redacted], located at [redacted], Petersburg, PA ([redacted] in Huntingdon County). Due to the incident occurring on a weekend, personnel from Huntingdon County Children and Youth Services and from the Office of Children, Youth and Families Central Region (OCYF) were made aware of the fatality due to various local media outlets reporting on the death of the child. On March 25, 2013, OCYF Central Region Office contacted Huntingdon County Children and Youth Services to discuss the process the agency would need to follow. The referral to the CYS agency is documented as being received on March 25, 2013. Huntingdon County CYS received initial information from [redacted].

Summary of DPW Child Fatality Review Activities:

The Central Region Office of Children, Youth and Families obtained and reviewed case records pertaining to the incident and to the [redacted] family. The County's [redacted] and the Huntingdon County's Coroner's Death Report were also reviewed. Since the family was not known to the agency prior to the death of the child, the records reviewed were from the date of referral, March 25, 2013. The Regional Office met with and consistently engaged

Huntingdon County CYS Caseworker [redacted] and Huntingdon County CYS [redacted] during the review process.

April 17, 2013, the Central Region Office of Children, Youth and Families participated in the County's Act 33 meeting. The mother of the victim child was present at the meeting and she provided information regarding the situations leading up to the event and to the actual incident. Discussion occurred regarding the father's prior involvement with [redacted], the family's involvement with law enforcement due to domestic violence and filing of Protection From Abuse (PFA) orders against the father and the custody and visitation issues that caused the mother concern. The meeting was very informative. All parties were vested in discussing the events and the potential preventative measures that could be taken in the future. The mother stated that her child's death would not be in vain in that she wants to advocate for changes in the overall system in regards to domestic violence.

Children and Youth Involvement prior to Incident:

The [redacted] family did not have prior involvement with Huntingdon County Children and Youth Services prior to the incident.

Circumstances of Child Fatality and Related Case Activity:

On March 23, 2013, at approximately 8:45am, [redacted] arrived at the home of his mother, [redacted], for a custody exchange and supervised visit with his son, Michael Ayers. [redacted] was under a protection from abuse order barring contact with his estranged wife but was allowed to go to his mother's home on Saturdays to visit his son. The father initiated a physical altercation with his estranged wife and mother of Michael, [redacted] when she arrived at the PGM's home to exchange custody. During the fight, the father pulled a 40 caliber handgun and shot the mother in both legs and right arm. It is reported that the father then grabbed his two (2) year old son and intentionally shot him to death. The father fled the scene and was later found dead of a self inflicted gunshot wound. The mother survived. According to documents received from the coroner's office, the child died as a result of a gunshot wound [redacted]. Child was pronounced dead at 9:10AM.

On 05/15/2013, through medical evidence and the agency's [redacted] report, Huntingdon County CYS [redacted] the father in the death of the child.

Current Case Status:

Huntingdon County Children and Youth Services offered the mother [redacted] resources, but she declined because of services that she had already obtained through her employment. At the time of this report, there is no formal involvement with the CYS agency and the mother. On July 18, 2013, the Regional office was notified that Trooper [redacted] with the Pennsylvania State Police notified Huntingdon County CYS that they have closed their case on the [redacted]. There is not an individual to file charges against, but it was stated that it was determined murder/homicide of a child.

[redacted] has been active raising money for the "Michael Ayers Child Access Center" with the goal of having a supervised site where custody exchanges could occur safely. The mother paired up with [redacted], a domestic violence shelter, to hold a "Walk To End Violence 2013" to raise money and the walk was held in honor of the child, Michael Ayers. The media reported that the event raise $19,000. [redacted] has also discussed her experiences with local media outlets in attempts to educate the public on domestic violence and to make people aware of how quickly domestic violence can happen.

County Strengths and Deficiencies and Recommendations for Change as Identified by the County's Child Fatality Report:

- Strengths:
  - The CYS agency arranged and conducted an effective Act 33 meeting on April 17, 2013
  - The CYS agency invited the mother of the victim child to the meeting and afforded her the opportunity to discuss her concerns, etc.

- Deficiencies:
  - No deficiencies noted

- Recommendations for Change at the Local Level:
  - A Child Access Center located in Huntingdon County would afford a safe environment for visitation when there is a custody dispute, current PFA's, or mental health concerns involving the parent(s).
  - Community agencies that work with victims of domestic violence should provide a detailed explanation of the Court system to these individuals so that they have a better understanding of how the system operates and what their rights are.
  - Mental health, agencies serving children and families, and law enforcement agencies need to communicate to see how they can share information more effectively to better serve the populations that they work with.
  - The custody court system should develop policies and procedures to ensure that a guardian ad Litem is appointed for children in which the custody dispute between the caregiver parties is not amicable to ensure that the best interest of the child is considered first.
  - During court hearings, discussions without all family members being present and having the opportunity to have a voice in all discussions needs to occur instead of "closed door meetings" between legal counsel and the Judge occurring. This would ensure that full disclosure of the issues is addressed and understood by the presiding Judge.
  - The County Court may want to consider adding stipulations to Court Orders dealing with custody that would stipulate a party (is) participate in mental health treatment if deemed necessary.

- The CYS agency may want to review how notifications are handled in situations that may mirror the death of Michael Ayers. It was stated that notification time frames and the use of standard notification templates was viewed as insensitive in relation to this specific incident. Due to the mother's hospitalization, the agency's face to face access was limited and the agency's fear of receiving a citation from the Regional Office resulted in a template letter being sent to the mother while she was recovering from her injuries.

- Recommendations for Change at the State Level:
  - No recommendations identified

Department Review of County Internal Report:

The report from Huntingdon County CYS was received by the Regional Office on May 24, 2013. The report details the topics that were discussed during the Near Death Review meeting held on April 17, 2013. There were no deficiencies noted.

Department of Public Welfare Findings:

- County Strengths:
  - The Children and Youth Services agency demonstrated the ability to bring together a cross section of professionals during the Act 33 meeting
  - The agency invited and allowed the mother of the deceased child a forum to discuss her experiences with the mental health and county court system
  - The Agency was effective in communicating updates to and in supplying specific requested information to the Regional Office.

- County Weaknesses:
  - There were no identified weaknesses with this respective case

- Statutory and Regulatory Areas of Non-Compliance:
  - Huntingdon County Children and Youth Services [redacted] in the death of the child. Since the family was not known to Huntingdon County Children and Youth Services, there are no identified compliance issues involving the death of the child.

Department of Public Welfare Recommendations:

All regulations regarding CPS investigation and subsequent county requirements were followed.