From: Michael Ayele
To: MO Audit; Media; Brent Bayer
Cc: Michael Ayele (W)
Subject: Sunshine Law Request
Date: Monday, April 6, 2026 4:04:20 AM

W (AACL) Date.: April 06th 2026
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Sunshine Request

Hello,

This is Michael A. Ayele sending this message though I now go by W. I am writing this letter for the purpose of filing a Sunshine request with your office. The bases for this records request are [1] the decision of President Ronald Reagan to designate the month of April 1983 as "*National Child Abuse Prevention Month;"* [i] [2] the murders of Roshelle Clayborne and Edith Campos (when they were respectively 16 and 15 years of age).

I) Requested Records

What I am requesting for prompt disclosure are records in your possession detailing your discussions about [1] the decision of President Ronald Reagan to recognize on (or around) April 04th 1983 that (i) child abuse and child neglect threaten the lives of children; (ii) the prevention of child abuse "*requires that neighborhoods and communities be attentive to the problems of families in their midst and be willing to help when help is needed*;" (iii) the prevention of child abuse "*requires the active concern of educational, medical, mental health, law enforcement, and social service professionals, and the efforts of volunteers and private citizens;"* (iv) "*the health and well-being of children underlie the future of America;"* (v) Senate Joint Resolution 21 requires civil society and government (at the local, state and federal levels) to bring to the forefront of public attention instances of child abuse in order to prevent the re-occurrence of cruelty targeting children (because of their age groups); (vi) Senate Joint Resolution 21 requires civil society and government (at the local, state and federal levels) to bring to the forefront of public attention documented instances of reverse age discrimination; (vii) Senate Joint Resolution 21 invites "*the Governors of the States; the Commonwealth of Puerto Rico and the Territories; the Mayor of the District of Columbia; the heads of voluntary and private groups; and the offices of local, State and Federal government to"* observe the month of April as "*National Child Abuse Prevention Month;"* [2] the manner in which your state government agency has commemorated National Child Abuse Prevention Month in Calendar Year 2026 (or in the years prior to 2026); [3] Roshelle Clayborn as a girl who was 16 (sixteen) years of age on (or around) August 18th 1997 when she was murdered by staff personnel of the Laurel Ridge Residential Center (located in San Antonio, Texas);[ii] [4] Edith Campos as a girl who was 15 (fifteen) years of age on (or around) February 02nd 1998 when she was murdered by staff personnel of Desert Hills Psychiatric Center (located in Tucson, Arizona);[iii] [5] the Hartford Courant as an American news media outlet which had in October 1998 recognized that (i) the forcible administration of psychotropic drugs is a factor increasing the risk of murder in psychiatric hospital settings; (ii) children below the age of 18 (eighteen) *"disproportionately bear the brunt of the misuse and overuse of restraints;"* [iv] (iii) the Joint Commission has been complicit in cases where the forcible administration of psychotropic drugs in a psychiatric hospital has led to the murder of a patient; (iv) the Joint Commission was an accessory to the June 29th 1996 murder of Gloria Huntley at Central State Hospital (located in Petersburg, Virginia); (v) the Joint Commission comforted Central State Hospital following the June 29th 1996 murder of Gloria Huntley by giving them glowing reviews;[v] [6] Cornell University as a post-secondary academic institution that defines the term (i) *"accessory"* as someone who aided or contributed to the commission or concealment of a crime; (ii) *"accessory before-the-fact"* as someone who did anything to encourage, aid, or assist in any material manner in the commission of crime, thereby participating in the design of a crime; (iii) *"accessory-after-the-fact"* as someone who, knowing a crime was committed, receives, relieves, comforts, or assists the offender or in any manner aids them to escape arrest or punishment.;[vi] [7] Michael A. Ayele (a.k.a) W as a Black Bachelor of Arts (B.A) Degree graduate of Westminster College (Fulton, Missouri) and a former Missouri healthcare employee (listed on Missouri's Accountability Portal) who has witnessed his written content on matters pertaining to abuse in psychiatric hospital settings subjected to frenzy before it was very inappropriately filtered and distorted on search engines such as AOL, Bing/MSN, Google and Yahoo; [8] the decision of ISE such as AOL, Bing/MSN to filter and distort Michael A. Ayele (a.k.a) W's written publications on matters pertaining to abuse in psychiatric hospital settings by generating unwelcome and unapproved prompts such as "*Michael Ayele Child Abuse Prevention Month,"* "*Michael Ayele schizophrenia,"* "*Michael Ayele investigation,"* "*Michael Ayele murder."* [vii]

II) Request for a Fee Waiver and Expedited Processing

The public has a compelling and legitimate interest in this information because:

1) President Ronald Reagan had on (or around) April 04th 1983 recognized that (i) child abuse and child neglect threaten the lives of children; (ii) the prevention of child abuse "*requires that neighborhoods and communities be attentive to the problems of families in their midst and be willing to help when help is needed*;" (iii) the prevention of child abuse "*requires the active concern of educational, medical, mental health, law enforcement, and social service professionals, and the efforts of volunteers and private citizens;"* (iv) "*the health and well-being of children underlie the future of America;"* (v) Senate Joint Resolution 21 requires civil society (as well as local/state/federal government employees) to bring to the forefront of public attention instances of child abuse in order to prevent the re-occurrence of cruelty targeting children; (vi) Senate Joint Resolution 21 requires civil society (as well as local, state and federal government employees) to bring to the forefront of public attention documented instances of reverse age discrimination; (vii) Senate Joint Resolution 21 invites "*the Governors of the States; the Commonwealth of Puerto Rico and the Territories; the Mayor of the District of Columbia; the heads of voluntary and private groups; and the offices of local, State and Federal government to"* observe the month of April as "*National Child Abuse Prevention Month."*
2) The requested records will help the public ascertain if your state government agency has in the past heeded the recommendation of President Ronald Reagan by commemorating the month of April as Child Abuse Prevention Month.
3) The requested records will help the public ascertain if your state government agency has in the past heeded the recommendation of President Ronald Reagan and commemorated the month of April by bringing to the forefront of public attention documented instances of reverse age discrimination.
4) The requested records will help the public ascertain if your state government agency has in the past heeded the recommendation of President Ronald Reagan and commemorated the month of April by bringing to the forefront of public attention documented instances of abuse targeting children (including those abuses that occur in psychiatric hospital settings).
5) The requested records will help the public ascertain if your state government agency has previously held conversations about the Hartford Courant October 1998 articles which recognized that children below the age of 18 "*disproportionately bear the brunt of the misuse and overuse of restraints"* in psychiatric hospital settings.
6) The requested records will help the public ascertain if your state government agency has held conversations about the circumstances that led to the murder of Roshelle Clayborn on (or around) August 18th 1997. As you may be aware, Roshelle Clayborn was only 16 years of age when she died in very suspicious circumstances on (or around) August 18th 1997.
7) The requested records will help the public ascertain if your state government agency has held conversations about the circumstances that led to the murder of Edith Campos on (or around) February 02nd 1998. As you may be aware, Edith Campos was only 15 years of age when she died in very suspicious circumstances on (or around) February 02nd 1998.
8) The requested records will shed light about the manner in which internet search engines (ISE) such as AOL, Bing/MSN, Google and Yahoo have filtered and distorted Michael A. Ayele (a.k.a) W's written publications on matters pertaining reverse age discrimination in psychiatric hospital settings.
9) The requested records will shed light upon the manner in which internet search engines (ISE) such as AOL, Bing/MSN, Google and Yahoo have filtered and distorted Michael A. Ayele (a.k.a) W's written publications on matters pertaining to abusive (and coercive) practices in psychiatric hospital settings.

Expedited Processing for this records request is justified because:

1) When designating the month of April 1983 as Child Abuse Prevention Month, President Ronald Reagan had recognized that it is the **civic duty** of local, state and federal government employees to bring to the forefront of public attention instances of reverse age discrimination they become aware of.
2) When designating the month of April 1983 as Child Abuse Prevention Month, President Ronald Reagan had recognized that it is the **civic duty** of local, state and federal government employees to bring to the forefront of public attention instances of child abuse they become aware of.
3) Michael A. Ayele (a.k.a.) W is a Black B.A Degree graduate of Westminster College (Fulton, Missouri) and a former Missouri healthcare employee who is thoroughly convinced that there was foul play in the circumstances leading up to the death of Roshelle Clayborne when she was only 16-years-old.
4) Michael A. Ayele (a.k.a.) W is a Black B.A Degree graduate of Westminster College (Fulton, Missouri) and a former Missouri state government employee who is thoroughly convinced that there was foul play in the circumstances leading up to the death of Edith Campos when she was only 15-years-old.
5) Michael A. Ayele (a.k.a.) W is a Black B.A Degree graduate of Westminster College (Fulton, Missouri) and a former Missouri state government employee who considers the abuse of children to be abhorrent and reprehensible (particularly when this abuse occurs in psychiatric hospital settings).
6) Michael A. Ayele (a.k.a.) W is a Black B.A Degree graduate of Westminster College (Fulton, Missouri) and a former Missouri state government employee who deplores the circumstances that led up to the death of Gloria Huntley when she was only 31-years-old.
7) The requested records will help the public ascertain if your local/state government agency has held conversations about the definition in use by Cornell University for what constitutes an "*accessory before-the-fact"* and an "*accessory after-the-fact."*

In my judgment, the facts presented in my request for a fee waiver and expedited processing will not bolster public confidence in the circumstances that led to the murders of

Roshelle Clayborn and Edith Campos because the murders of these two girls reveal a pattern of institutional conduct where abusive (and coercive) medical practices, poor oversight, and regulatory complicity converge with fatal consequences for children placed in facilities that are supposed to provide mental health care. For me, Roshelle Clayborn's last words – "***I can't breathe***" – (spoken as a Black girl) expose the lethal consequences of restraint practices that placed her in a prone position, thereby directly contributing to her death. That restraint choice was not an unforeseeable accident, but a decision made within a clinical setting that should have recognized the medical danger of placing a child in a prone position. When Roshelle Clayborn cried out "***I can't breathe***" after being forcibly placed in a prone position, she signaled that she was in distress and that she needed help. In that moment, the appropriate reaction from any unbiased healthcare provider would have been to recognize the pain she was feeling, release the restraint, and immediately start working on her labored breathing. However, this didn't happen, and as a direct consequence, Roshelle Clayborn ended up dying in an institution that claims to be a "*treatment center.*" Unfortunately, Edith Campos's experience at Desert Hills Psychiatric Center (Tucson, Arizona) reflects a similar failure of care to that of Roshelle Clayborn. Like Roshelle Clayborn, Edith Campos was placed in the hands of healthcare workers who (most likely had watched one too many John Wayne movies and) acted like "*cowboys*" by prioritizing control, intimidation, and aggressive enforcement (that leaves no room for reasonable compromise). Like Roshelle Clayborn, Edith Campos was also subjected to an environment where healthcare workers responded to anguish (and difficult episodes) with coercion instead of logic, compassion, empathy and kindness. The parallels between Roshelle Clayborn and Edith Campos are striking because both girls routinely engaged with totally unprofessional and incompetent healthcare workers during their stay at Laurel Ridge Residential Center (San Antonio, Texas) and Desert Hills Psychiatric Center (Tucson, Arizona). In both cases, there's an endemic overreliance on brute force and punitive approaches in order to change behavior, and this ultimately leads to murder. Incidentally, both institutions failed to intervene in ways that could have made a positive impact on the lives of Roshelle Clayborn and Edith Campos (even though these girls were impressionable teenagers looking for positive guidance and good mentorship). Overall, the murders of Roshelle Clayborn and Edith Campos underpin a broader pattern where violence (rooted in coercive practices) replaces therapeutic support in hospitals that claim to provide "*mental health care*."

In my opinion, the facts presented in this request for a fee waiver and expedited processing will also not bolster public confidence in the activities, the engagements and the priorities of the Joint Commission because they were very much complicit in the June 29th 1996 murder of Gloria Huntley at Central State Hospital (Petersburg, Virginia). As previously noted by the Hartford Courant in their October 13th 1998 article, the Joint Commission had visited Central State Hospital in the days leading up to Gloria Huntley's murder. After that visit, the Joint Commission had issued Central State Hospital a "*glowing report card,*" awarding them 92 out of 100 points. By failing to speak up on behalf of Gloria Huntley and giving Central State Hospital such a high score, the Joint Commission (in essence) gave a thumbs up to the hospital's failure to protect patients from fatal harm. Indeed, the Joint Commission's actions – or lack thereof – functioned as a form of encouragement and validation for the hospital's gross negligence and medical malpractice, making their role akin to that of an accessory after-the-fact. The Joint Commission was an accessory after-the-fact in the June 29th 1996 murder of Gloria Huntley because they had knowledge of Gloria Huntley's pain and suffering at Central State Hospital, and (armed with this knowledge,) they actively sought to relieve and comfort Central State Hospital from any responsibility for the harm they caused to Gloria Huntley's physical and mental well-being. In my opinion, the Joint Commission's complicity was not an innocent oversight but a form of assistance in order to prevent apprehension, trial and punishment. It should be noted that the Joint Commission very high rating of Central State Hospital is starkly inconsistent with the findings of the State of Virginia and the Department of Justice (DOJ) which concluded that [1] there was foul-play in the June 29th 1996 death of Gloria Huntley; [2] Central State Hospital does not merit the "*glowing report card*" awarded to them by the Joint Commission.

The core issues presented in this records request are as follows. 1) Have you had conversations about the decision of President Ronald Reagan to recognize on (or around) April 04th 1983 that child abuse and child neglect threaten the lives of children? If yes, will you promptly disclose those records? 2) Have you had conversations about the decision of President Ronald Reagan to recognize on (or around) April 04th 1983 that the prevention of child abuse "*requires that neighborhoods and communities be attentive to the problems of families in their midst and be willing to help when help is needed*?" If yes, will you promptly disclose those records? 3) Have you had conversations about the decision of President Ronald Reagan to recognize on (or around) April 04th 1983 that the prevention of child abuse "*requires the active concern of educational, medical, mental health, law enforcement, and social service professionals, and the efforts of volunteers and private citizens?*" If yes, will you promptly disclose those records? 4) Have you had conversations about the decision of President Ronald Reagan to recognize on (or around) April 04th 1983 that "*the health and well-being of children underlie the future of America?*" If yes, will you promptly disclose those records? 5) Have you had conversations about the decision of President Ronald Reagan to recognize on (or around) April 04th 1983 that there exists (in American society and government) a systemic form of reverse age discrimination? If yes, will you promptly disclose those records? 6) Have you had conversations about the decision of President Ronald Reagan to recognize that Senate Joint Resolution 21 requires civil society and government (at the local, state and federal levels) to bring to the forefront of public attention documented instances of reverse age discrimination? If yes, will you promptly disclose those records? 7) Have you had conversations about the decision of President Ronald Reagan to recognize that Senate Joint Resolution 21 requires civil society and government (at the local, state and federal levels) to bring to the forefront of public attention instances of child abuse in order to prevent the re-occurrence of cruelty targeting children (because of their age groups)? If yes, will you promptly disclose those records? 8) Have you had conversations about the decision of President Ronald Reagan to recognize that Senate Joint Resolution 21 invites "*the Governors of the States; the Commonwealth of Puerto Rico and the Territories; the Mayor of the District of Columbia; the heads of voluntary and private groups; and the offices of local, State and Federal government to*" observe the month of April as "*National Child Abuse Prevention Month?*" If yes, will you promptly disclose those records? 9) Has your local/state government commemorated National Child Abuse Prevention Month in Calendar Year 2026 (or in the years prior to 2026)? If yes, will you promptly disclose those records? 10) Have you had conversations about the circumstances that led to Roshelle Clayborn's August 18th 1997 murder at Laurel Ridge Residential Center (San Antonio, Texas)? If yes, will you promptly disclose those records? 11) Have you had conversations about Roshelle Clayborn being a Black girl who was 16 (sixteen) years of age at the time she was murdered on (or around) August 18th 1997 at Laurel Ridge Residential Center? If yes, will you promptly disclose those records? 12) Have you ever had conversations about the last words uttered by Roshelle Clayborn before her murder: "***I can't breathe?"*** If yes, will you promptly disclose those records? 13) Have you had conversations about the circumstances that led to Edith Campos February 02nd 1998 murder at Desert Hills Psychiatric Center (Tucson, Arizona)? If yes, will you promptly disclose those records? 14) Have you had conversations about Edith Campos being a girl who was 15 (fifteen) years of age at the time she was murdered at Desert Hills Psychiatric Center (Tucson, Arizona)? If yes, will you promptly disclose those records? 15) Have you had conversations about the decision of the Hartford Courant to recognize in October 1998 that the forcible administration of psychotropic drugs is a factor increasing the risk of murder in psychiatric hospital settings? If yes, will you promptly disclose those records? 16) Have you had conversations about the decision of the Hartford Courant to recognize in October 1998 that children below the age of 18 (eighteen) "*disproportionately bear the brunt of the misuse and overuse of restraints?*" If yes, will you promptly disclose those records? 17) Have you had conversations about the decision of the Hartford Courant to recognize in October 1998 that the Joint Commission has been complicit in cases where the forcible administration of psychotropic drugs has led to the murder of a patient? If yes, will you promptly disclose those records? 18) Have you had conversations about the decision of the Hartford Courant to recognize in October 1998 that the Joint Commission was an accessory to the June 29th 1998 murder of Gloria Huntley at Central State Hospital (located in Petersburg, Virginia)? If yes, will you promptly disclose those records? 19) Have you had conversations about the decision of the Hartford Courant to recognize in October 1998 that the Joint Commission comforted Central State Hospital following the June 29th 1996 murder of Gloria Huntley by giving them glowing reviews? If yes, will you promptly disclose those records? 20) Have you had conversations about Cornell University as a post-secondary academic institution that defines the term "*accessory*" as someone who aided or contributed to the commission or concealment of a crime? If yes, will you promptly disclose those records? 21) Have you had conversations about Cornell University as a post-secondary academic institution that defines the term "*accessory before-the-fact*" as someone who did anything to encourage, aid, or assist in any material manner in the commission of crime, thereby participating in the design of a crime? If yes, will you promptly disclose those records? 22) Have you had conversations about Cornell University as a post-secondary academic institution that defines the term "*accessory-after-the-fact*" as someone who, knowing a crime was committed, receives, relieves, comforts, or assists the offender or in any manner aids them to escape arrest or punishment? If yes, will you promptly disclose those records? 23) Have you had conversations about Michael A. Ayele (a.k.a) W as a Black Bachelor of Arts (B.A) Degree graduate of Westminster College (Fulton, Missouri) and a former Missouri healthcare employee (listed on Missouri's Accountability Portal) who has witnessed his written content pertaining to abuse in psychiatric hospital settings subjected to frenzy before it was very inappropriately filtered and distorted on search engines such as AOL, Bing/MSN, Google and Yahoo? If yes, will you promptly disclose those records? 24) Have you had conversations about Michael A. Ayele (a.k.a) W as a Black B.A Degree graduate of Westminster College (Fulton, Missouri) and a former Missouri healthcare employee (listed on Missouri's Accountability Portal) who has never in the past contacted employees/legal representatives of the AOL, Bing/MSN, Google and Yahoo ISE to demand that that they generate cues such as "*Michael Ayele Child Abuse Prevention Month,*" "*Michael Ayele schizophrenia,*" "*Michael Ayele investigation,*" "*Michael Ayele murder?*" If yes, will you promptly disclose those records? 25) Have you had conversations about the decision of ISE such as AOL, Bing/MSN to filter and distort Michael A. Ayele (a.k.a) W's written publications on matters pertaining to abuse in psychiatric hospital settings by generating unwelcome and unapproved prompts such as "*Michael Ayele Child Abuse Prevention Month,*" "*Michael Ayele schizophrenia,*" "*Michael Ayele investigation,*" "*Michael Ayele murder?*"

Under penalty of perjury, I hereby declare all the statements I have made to be true and accurate to the best of my knowledge. Thank you for your attention to this matter.

Be well. Take care. Keep yourselves at arms distance.

Michael A. Ayele (a.k.a) W
Anti-Racist Human Rights Activist
Audio-Visual Media Analyst
Anti-Propaganda Journalist

Work Cited

[i] Child abuse and child neglect continue to threaten the lives and health of over a million of our Nation's children. Their physical suffering and emotional anguish challenge us, as parents, neighbors, and citizens, to increase our attention to their protection and intensify our efforts to prevent their maltreatment.

Children may be endangered by physical battering, denial of the basic necessities for life and health, sexual abuse and exploitation, or emotional cruelty. Public concern can help prevent maltreatment and help protect children. Action taken after cruelty has occurred is often too late. Prevention of abuse requires that neighborhoods and communities be attentive to the problems of families in their midst and be willing to help when help is needed. It requires the active concern of educational, medical, mental health, law enforcement, and social service professionals, and the efforts of volunteers and private citizens.

The health and well-being of our children underlie the future of our Nation. The Congress, by Senate Joint Resolution 21, has recognized the need for public attention to prevention of child abuse and has requested me to proclaim April 1983 as National Child Abuse Prevention Month.

Now, Therefore, I, Ronald Reagan, President of the United States of America, do hereby proclaim the month of April 1983 as "National Child Abuse Prevention Month." I urge

all citizens to renew our Nation's commitment to meet the serious challenge that child abuse and child neglect pose to the welfare of our children and families.

I invite the Governors of the States; the Commonwealth of Puerto Rico and the Territories; the Mayor of the District of Columbia; the heads of voluntary and private groups; and the offices of local, State and Federal government to join in this observance. I also urge them to encourage activities whose purpose is to prevent and treat child abuse and child neglect.

In Witness Whereof I have hereunto set my hand this 4th day of April, in the year of our Lord nineteen hundred and eighty-three, and of the Independence of the United States of America the two hundred and seventh. Proclamation 5039 – National Child Abuse Prevention Month, 1983.

[ii] ***Roshelle Clayborne pleaded for her life.***

Slammed face-down on the floor, Clayborne's arms were yanked across her chest, her wrists gripped from behind by a mental health aide.

*"**I can't breathe," the 16-year-old gasped.***

Her last words were ignored.

A syringe delivered 50 milligrams of Thorazine into her body and, with eight staffers watching, Clayborne became, suddenly, still. Blood trickled from the corner of her mouth as she lost control of her bodily functions.

Her limp body was rolled into a blanket and dumped in an 8-by-10-foot room used to seclude dangerous patients at the Laurel Ridge Residential Treatment Center in San Antonio, Texas.

The door clicked behind her.

No one watched her die.

But Roshelle Clayborne is not alone. Across the country, hundreds of patients have died after being restrained in psychiatric and mental retardation facilities, many of them in strikingly similar circumstances, a Courant investigation has found.

They died pinned down on the floor by hospital aides until the breath of life was crushed from their lungs. They died strapped to beds and chairs with thick leather belts, ignored until they strangled or their hearts gave out.

*Those who died were disproportionately young. They entered our health care system as troubled children. They left in coffins. All of them died at the hands of those who are supposed to protect, in places intended to give sanctuary. (…) "**It's going on all around the country," said Dr. Jack Zusman, a psychiatrist and author of a book on restraint policy. The nationwide trail of death leads from a 6-year-old boy in California to a 45-year-old mother of four in Utah, from a private treatment center in the deserts of Arizona to a public psychiatric hospital in the pastures of Wisconsin. In some cases, patients died in ways and for reasons that defy common sense: a towel wrapped around the mouth of a 16-year-old boy; a 15-year-old girl wrestled to the ground after she wouldn't give up a family photograph. Many of the actions would land a parent in jail, yet staffers and facilities were rarely punished. "I raised my child for 17 years and I never had to restrain her, so I don't know what gave them the right to do it," said Barbara Young, whose daughter Kelly died in the Brisbane Child Treatment Center in New Jersey.***

***The pattern revealed by The Courant has gone either unobserved or willfully ignored by regulators, by health officials, by the legal system.** (…) The facility where Roshelle Clayborne died insists her death had nothing to do with the restraint. Officials there say it was a heart condition that killed the 16-year-old on Aug. 18, 1997. Bexar County Medical Examiner Vincent DiMaio ruled that Clayborne died of natural causes, saying that restraint use was a separate "clinical issue." But that, too, is typical in restraint cases. Medical examiners rarely connect the circumstances of the restraint to the physical cause of death, making these cases impossible to track through death certificates. The explanations don't wash with Clayborne's grandmother. "I'll picture her lying on that floor until the day I die," Charlene Miles said. "Roshelle had her share of problems, but good God, no one deserves to die like that." **With nobody tracking, nobody telling, nobody watching, the same deadly errors are allowed to occur again and again.** (…) "As a nation we get all up in arms reading about human rights issues on the other side of the world, but there are some basic human rights issues that need attention right here at our back door," said Jean Allen, the adoptive mother of Tristan Sovern, a North Carolina teen who died after aides wrapped a towel and bed sheet around his head. (…)*

Few seemed to care much about Roshelle Clayborne at Laurel Ridge, where she was known as a "hell raiser." But Clayborne had made one close friendship — with her roommate, Lisa Allen. Allen remembers showing Clayborne how to throw a football during afternoon recess on that summer afternoon in 1997. "She just couldn't seem to get it right and she was getting more and more frustrated. But I told her it was OK, we'd try again tomorrow," said Allen, who has since rejoined her family in Indiana. Within three hours, Clayborne was dead. She had attacked staff members with pencils. And staffers had a routine for hell raisers. "This is the way we do it with Roshelle," a worker later told state regulators. "Boom, boom, boom: [medications] and restraints and seclusion." After she was restrained, Roshelle Clayborne lay in her own waste and vomit for five minutes before anyone noticed she hadn't moved. Three staffers tried in vain to find a pulse. Two went looking for a ventilation mask and oxygen bag, emergency equipment they never found. During all this time, no one started CPR. "It wouldn't have worked anyway," Vanessa Lewis, the licensed vocational nurse on duty, later declared to state regulators. By the time a registered nurse arrived and began CPR, it was too late. Clayborne never revived.

***In their final report on Clayborne's death, Texas state regulators cited Laurel Ridge for five serious violations and found staff failed to protect her health and safety during the restraint. They recommended Laurel Ridge be closed. Instead, the state placed Laurel Ridge on a one-year probation in February and the center remains open for business. In a prepared statement, Laurel Ridge said it has complied with the state's concerns — and it pointed out the difficulty in treating someone with Clayborne's background. "Roshelle Clayborne, a ward of the state, had a very troubled and extensive psychiatric history, which is why Laurel Ridge was chosen to treat her," the statement said. "Roshelle's death was a tragic event and we empathize with the family." With no criminal prosecution and little regulatory action, the Clayborne family is now suing in civil court. The Austin chapter of the NAACP and the private watchdog group Citizens Human Rights Commission of Texas are asking for a federal civil rights investigation into the death of Clayborne.** Medications and restraint and seclusion. Clayborne's friend, Lisa Allen, knew the routine well, too. For six years, Allen, now 18, lived in mental health facilities in Indiana and Texas, where her explosive personality would often boil over and land her in trouble. By her own estimate, Allen was restrained "thousands" of times and she bears the scars to prove it: a mark on her knee from a rug burn when she was restrained on a carpet; the loss of part of a birthmark on her forehead when she was slammed against a concrete wall. Exactly two weeks after Roshelle Clayborne's death, Lisa Allen found herself in the same position as her friend. The same aide had pinned her arms across her chest. Thorazine was pumped into her system. She was deposited in the seclusion room. "It felt like my lungs were being squished together," Allen said. But Lisa Allen was one of the lucky ones. She survived.* Hartford Courant. October 11th 1998. A Nationwide Pattern of Death.: https://www.courant.com/1998/10/11/hundreds-of-the-nations-most-vulnerable-have-been-killed-by-the-system-intended-to-care-for-them/

[iii] ***She was a 15-year-old patient, alone in a new and frightening place, clutching a comforting picture from home. He was a 200-pound mental health aide bent on enforcing the rules, and the rules said no pictures. She defied him; the dispute escalated. And for that, Edith Campos died. She was crushed face down on the floor in a "therapeutic hold" applied by a man twice her size.***

Shy and well-behaved as a girl growing up in Southern California, Edith had problems as a teen. She ran away, took drugs, hung with the wrong crowd. Her family hoped treatment at the Desert Hills psychiatric center in Tucson, Ariz., would help. But Edith Campos died — as did Andrew McClain and Roshelle Clayborne and countless others — when a trivial transgression spiraled into violence. Too often, it's a reaction built right into our system that cares for people with psychiatric problems and mental retardation. (…)

"I can't understand why patients don't die more often with all the things that happen on a daily basis," said Wesley B. Crenshaw, a psychologist who has conducted one of the few national surveys on restraint use. "You have people who are 'cowboying' it," Crenshaw said, "people who really want to get in there and show they're the boss." (...)

In the Edith Campos case, aide Daniel Thomas Walsh successfully fought negligent homicide charges by arguing he had followed hospital guidelines. And the guidelines didn't say he needed to watch Edith's face for signs of distress, the judge found. "It was a tragedy that this girl died in our care," said Kirke Cooper, director of business development for Desert Hills. "But I don't feel there was any wrongdoing on the part of our staff. They are all well-trained in physical control and seclusion." Hartford Courant. October 12th 1998. Why They Die: Little Training, Poor Staffing Put Lives At Risk.: https://www.courant.com/1998/10/12/why-they-die-little-training-poor-staffing-put-lives-at-risk/

[iv] ***A Courant investigation has found more than 26 percent of restraint-related deaths over the past decade involved patients 17 and under. Yet children make up less than 15 percent of the population in psychiatric and mental retardation facilities, according to federal statistics.***

The death rate should come as no surprise.

"You can't believe how many times a kid gets slammed into restraints because an argument will ensue after calling a staff member a name," said Wanda Mohr, director of psychiatric mental health nursing at the University of Pennsylvania.

She and other analysts say children disproportionately bear the brunt of the misuse and overuse of restraints. A 1995 New York study, for instance, found children almost twice as likely as adults to be restrained.

"It's socially acceptable to spank and punish children," said Mohr, reflecting the responses of other experts who say our culture tolerates a physical response to unruly children.

Yet children are both a vulnerable and challenging population.

Firm diagnoses often cannot be made until late adolescence or early adulthood, so providers are less sure how to treat children. And many troubled children enter the mental health system with histories of physical or sexual abuse — so even the threat of physical force can be traumatizing.

For their part, many patients say improper or frequent use of restraints hurts their recovery and defeats the very reason they were admitted. In interviews with more than a dozen children and adults, The Courant's investigation found these patients were left confused, angry and afraid. They rarely felt better. Researchers are finding the same. In a 1994 New York study, 94 percent of patients restrained or placed in seclusion had at least one complaint about the process. Half complained of unnecessary force, 40 percent cited psychological abuse. In a study published this year, Mohr interviewed children after their hospital stays and found many were further traumatized when they were restrained or secluded — or even watching others undergo the procedure. Usually, she found, children saw such treatment as punishment.

The leader of the nation's psychiatric association acknowledged the problem. "It must be especially frightening for a child," said Dr. Rod Munoz, president of the American Psychiatric Association. "It's a struggle of wills where the most powerful win." And troubled children are the ones who lose. Elaina Huckin, 17, of Granby, Conn., is still so disturbed by a restraint five years ago that she can barely speak about it. She was put in a "body bag," a sort of neck-to-toe straitjacket. "They tie you in it. They pull it tighter and tighter. I couldn't move to breathe," Huckin said. "I was screaming and pleading, 'Somebody, please, somebody take me out.'" "It made you so much more suicidal," she said. Hartford Courant. October 12th 1998. Why They Die: Little Training, Poor Staffing Put Lives At Risk.: https://www.courant.com/1998/10/12/why-they-die-little-training-poor-staffing-put-lives-at-risk/

[v] ***Had Gloria Huntley been able to move, had she not been bound to her bed with leather straps for days on end, perhaps she would have tried to draw the attention of the inspectors who were conducting a three-day tour of Central State Hospital.***

Had she been able to move, had she not been pinned down by the wrists and ankles, she might have held up a sign, as she had done before when a visitor came through Ward 7. Her handwritten plea was simple: "Pray for me. I'm dying."

But the inspection team from the nation's leading accreditation agency never noticed Gloria Huntley before leaving the Petersburg, Va., psychiatric hospital.

The three inspectors from the Joint Commission on the Accreditation of Healthcare Organizations issued Central State a glowing report card — 92 out of 100 points. They also bestowed the commission's highest ranking for patients' rights and care when they concluded their review on June 28, 1996.

The next day, Gloria Huntley died. She was 31. Her heart, fatally weakened by the constant use of restraints, had inflamed to 1 1/2 times its normal size. In her last two months, she'd been restrained 558 hours — the equivalent of 23 full days.

Nine months later, the Joint Commission gave Central State an even better score in a follow-up review — even though Huntley's treatment would ultimately be labeled "inhumane" by the state of Virginia and condemned by the U.S. Justice Department.

"How could JCAHO give Central State the highest rating in human rights when they were killing people?" asked Val Marsh, director of the Virginia Alliance for the Mentally Ill.

The way the country's health care system works, how could it not?

The Courant's nationwide investigation of restraint-related deaths underscores just how faulty — how rife with conflicts of interest, how self-protective, how ultimately ineffective — the system of industry oversight and government regulation really is.

The health care industry is left to police itself, but often doesn't.

Time and again, The Courant found, when it comes to the quality and safety of patient care, the interests of the industry far outweigh the public interest.

"One reason you have overuse and misuse of restraints is because oversight is practically nonexistent," said Dr. E. Fuller Torrey, a nationally prominent psychiatrist and author of several books critical of the nation's mental health system. "And the health industry doesn't want oversight."

The chain of agencies, boards and advocates that is supposed to provide oversight — the kind of oversight that might have prevented Huntley's death and hundreds like it — often breaks down in multiple places.

But the heavy reliance on the Joint Commission — an industry group that acts as the nation's de facto regulator — lies at the core of the problem.

The federal government relies on the private nonprofit agency's seal of approval for a psychiatric hospital's acceptance into Medicare and Medicaid programs. And 43 states, including Connecticut, accept it as meeting most or all of its licensing requirements.

But the Joint Commission doesn't answer to Congress or the public. It answers to the health care industry.

The Joint Commission was founded in 1951 by hospital and medical organizations, whose members still dominate the commission's board of directors. The commission is funded by the same hospitals it inspects.

How tough are its inspections?

Of the more than 5,000 general and psychiatric hospitals that the Joint Commission inspected between 1995 and 1997, none lost its accreditation as a result of the agency's regular inspections.

None.

When extraordinary circumstances arise — a questionable death, for instance — the Joint Commission may conduct additional inspections. Even then, less than 1 percent of facilities overall lost accreditation.

Central State was not among them.

Joint Commission officials are the first to say they are not regulators. Participation is voluntary, and 83 percent of hospitals inspected were found to have shortcomings that needed to be addressed.

"Joint Commission accreditation is intended to say to the patient: This is a place that does things well and is constantly working to improve things," said Dr. Paul M. Schyve, a psychiatrist and senior vice president of the Joint Commission.

If the industry is not adequately watching itself, neither is the government. The nation's top mental health official says he has little latitude when it comes to tougher regulation and oversight.

"Most rules governing health care have been left to the states," said Dr. Bernard S. Arons, director of the U.S. Center for Mental Health Services.

When it comes to mental retardation facilities, in fact, inspection is left largely to the states. But their record is not much better. ***The General Accounting Office, the investigative arm of Congress, has found that state regulators are loath to punish state-run facilities. In a study of state mental retardation centers, the GAO found "instances in which state surveyors were pressured by officials in their own and in other state agencies to overlook problems or downplay the seriousness of deficient care in large state institutions."***

When state regulators do show up, their inspections are scheduled with such predictability that facilities can beef up staff, improve services and even apply fresh coats of paint. Often, only the new paint remains after the inspectors leave. "These visits provide only a snapshot," said William J. Scanlon, director of health care studies for the GAO. "And it may be a doctored snapshot."

It is only when the system utterly collapses, as in the Gloria Huntley case, that the federal government intervenes to set rules for patient care. Justice Department abuse investigators, who have authority to intercede when civil rights violations are suspected in publicly run facilities, often find these same facilities were recently given clean bills of health by licensing agencies or the Joint Commission.

"The use of restraints is clearly a very big problem and a very significant issue in nearly all of the institutions we investigate," said Robinsue Froehboese, the top abuse investigator at the Justice Department. But with a staff of 22 attorneys, Froehboese's office can undertake only a handful of major investigations each year. "Nineteenth-century England had a better oversight system than we have now," said Torrey, describing an English system that used full-time government inspectors to check every psychiatric facility without prior notice.

At Central State, the warning signs should have been apparent. But Joint Commission inspectors review just a sampling of patient records — a sampling that may not include problem cases like Gloria Huntley's. Anyone who did look at Huntley's records would have known her health was failing — and that heavy use of restraints was a primary reason. Two years before Huntley's death, a doctor warned officials at Central State that she would die if they didn't change her restraint plan. "Staff members should watch their conscience, and those in charge must always remember that following physical struggle and emotional strain, the patient may die in restraints," stated the ominously titled "duty to warn" letter.

Even if the Joint Commission inspectors had missed Huntley in particular, there were other cases at Central State that should have raised red flags. One patient was restrained for 1,727 hours over an eight-month period, yet another for 720 hours over a four-month period, according to a U.S. Justice Department report. So, in many respects, the investigation into Huntley's death is most remarkable in that it happened at all. When she died on June 29, 1996, the police were never called. It took a hospital employee's anonymous call to a citizens watchdog group, days after Huntley's death, to tip off the outside world that she died while being restrained — and not in her sleep as hospital officials told family members.

The Courant's investigation found at least six cases in which facilities, wary of lawsuits and negative publicity, tried to cover up or obscure the circumstances of a restraint-related death. "It's sort of a secretive thing," said Dr. Rod Munoz, president of the American Psychiatric Association. "Every hospital tries to protect itself." "The incentive is to settle with the family, fix it internally and move on," said Dr. Thomas Garthwaite, deputy undersecretary of health for the U.S. Department of Veterans Affairs. (…)

With the industry failing to monitor itself, with government regulators unwilling to challenge the industry, uncovering abuse is left to "protection and advocacy" agencies established by Congress in each state. (…) Desperate for help, Gloria Huntley turned to one of these organizations in her last months of life. Not only was her complaint not investigated, but three weeks after her death Huntley was sent a letter saying the advocacy agency was dropping her case because it hadn't heard from her in 90 days. The letter ends: "It was a pleasure working with you to resolve your complaint. I wish you the best of luck in your future endeavors…" Hartford Courant. October 13th 1998. "Pray For Me. I'm Dying." https://www.courant.com/1998/10/13/pray-for-me-im-dying/

[vi] *An accessory is someone who aided or contributed to the commission or concealment of a crime. There are two categories of accessories: accessory before-the-fact and accessory after-the-fact. Unlike an accomplice, an accessory does not need to have been actually or constructively present during the commission or concealment of the crime.*

Accessory before-the-fact

An accessory before-the-fact is someone who did anything to encourage, aid, or assist in any material manner in the commission of a crime, thereby participating in the design of the crime. See Johnson v. State, 290 So. 3d 1232 (Miss. 2020).

The basic elements the government must demonstrate to prove that a defendant was an accessory before-the-fact are: (1) someone committed the underlying crime; (2) the defendant advised and agreed, urged the parties, or in some way aided them to commit the offense; and (3) the defendant was not present when the offense was committed. See Evans v. State, 145 So. 3d 674 (Miss. 2014).

The amount of assistance provided is irrelevant, and may also be provided indirectly through a third party. The aid or counsel may be far removed in time from the commission of the crime, although it must be shown to have retained some relationship by causing, encouraging, or assisting the offense.

An accessory before-the-fact is as liable as a principal actor and may be indicted without regard to whether the principal has been convicted. One can be indicted as an accessory before-the-fact even if the accessory does not have the capability to perform the crime.

The primary distinction between an "accessory before-the-fact" and an "aider and abettor" is the actual or constructive presence of the party. If the defendant was actually or constructively present at the offense because of their participation, they are an "aider and abettor." However, if the defendant was not present, they are an "accessory before-the-fact."

Accessory after-the-fact

An accessory after-the-fact is someone who, knowing a crime was committed, receives, relieves, comforts, or assists the offender or in any manner aids them to escape arrest or punishment. See: U.S. v. Triplett, 92 F.2d 1174 (5th Cir. 1991). The aid provided by the defendant to the principal must be given after the principal completes the crime.

The basic elements the government must demonstrate to prove that a defendant was an accessory after-the-fact are: (1) the commission of an underlying crime against the United States; (2) the defendant's knowledge of that offense; and (3) assistance by the defendant in order to prevent the apprehension, trial, or punishment of the offender. See: Ellis v. U.S., 806 F. Supp. 2d 538 (E.D. N.Y. 2011).

It is not required for the government to prove that the defendant acted willfully and with specific intent to commit the original crime; rather, to convict someone of being an accessory after-the-fact, the government must prove that the defendant had knowledge of the original crime and acted with this knowledge when assisting the principal. If the crime charged is murder and the defendant aided the offender prior to the victim's death and after the victim's wound, the defendant cannot be convicted as an accessory after-the-fact to murder.

A defendant may not be convicted of both a crime and of being an accessory after the fact to the same crime. Except as otherwise expressly provided by a Congressional Act, an accessory after-the-fact cannot be imprisoned for more than one-half the maximum term of imprisonment nor fined more than one-half the maximum fine prescribed for the punishment of the principal. If the principal is punishable by life imprisonment or death, the accessory must not be imprisoned for more than 15 years. See: 18 U.S.C. § 3. Cornell University.: https://www.law.cornell.edu/wex/accessory

[vii] Bing/MSN Unwelcome and Unapproved Query "*Michael Ayele Child Abuse Prevention Month.*" https://www.bing.com/search?q=Michael%20Ayele%20Child%20Abuse%20Prevention%20Month&qs=n&form=QBRE&sp=-1&lq=0&pq=michael%20ayele%20child%20abuse%20prevention%20month&sc=0-42&sk=&cvid=F75EF0E848CD44C58395FAD779D2024E

Bing/MSN Unwelcome and Unapproved Query "*Michael Ayele Schizophrenia.*" *https://www.bing.com/search?q=Michael+Ayele+Schizophrenia*

Bing/MSN Unwelcome and Unapproved Query "*Michael Ayele Investigation.*" *https://www.bing.com/search?q=michael+ayele+investigation*

Bing/MSN Unwelcome and Unapproved Query "*Michael Ayele Murder.*" *https://www.bing.com/search?q=michael+ayele+murder*