



## **FATALITY INVESTIGATION INTO THE HOMICIDE OF ZANIYAH**

### ***OVERVIEW AND MANDATE***

On September 16, 2014, the Committee on Children of the General Assembly requested that the Office of the Child Advocate (OCA) conduct “an in-depth investigation of the August 18<sup>th</sup>, 2014 tragic death of Zaniyah Calloway, a one year old infant who was stabbed to death in Bristol, Connecticut.” Zaniyah’s death was ruled a Homicide by the Office of the Chief Medical Examiner.

The Child Fatality Review Panel (CFRP) is statutorily mandated to review all unexpected and unexplained deaths of children in the state of Connecticut. The Office of the Child Advocate (OCA) takes the lead in investigating these untimely child deaths. According to statute, the OCA may be directed by a number of entities, including the legislature, to conduct an investigation into the unexpected or explained death of a child. The goal for any child fatality review is to outline findings and recommendations to the Governor, the legislature, the general public, and any agency that may have been involved with the child/family.

Given the circumstances surrounding Zaniyah’s tragic death, OCA invited the Connecticut Coalition Against Domestic Violence (CCADV) to participate in the review process. CCADV was a key partner in this review process and is a statutory member of the CFRP.

In January, 2015, the OCA and CCADV met the Co-chairs of the Children’s Committee to provide an overview of the findings of the fatality investigation. A subsequent memorandum of findings and recommendations was developed and transmitted to the Co-Chairs of the Children’s Committee. This formal public report follows for the purpose of making the findings and recommendations of the OCA/CCADV fatality review part of the public record.

### ***METHODOLOGY FOR INVESTIGATION***

The OCA obtained comprehensive records regarding the death of Zaniyah. Records were requested in some instances by exercising the office’s subpoena authority; other records were provided through a formal written request.

The following report is based on information obtained from the Office of the Chief Medical Examiner (OCME), Waterbury Police Department, Connecticut’s Court Support Services Division (CSSD), the Department of Children and Families (DCF), Office of Victim Services (OVS), pediatric medical records, and community provider records. OCA also conducted or attempted to conduct multiple interviews with key state and municipal agencies, and individuals to better understand the case record.

OCA necessarily relied on CSSD and Waterbury Law Enforcement documentation regarding this family and we want to acknowledge these agencies' high level of cooperation and candor regarding this investigation, which included making themselves available for multiple interviews and telephone calls.

As with all OCA child fatality reviews, the focus of this investigation was aimed at quality improvement of state systems that interface with children and families and the prevention of future child maltreatment deaths. The OCA and CCADV's joint investigation also focused on the Waterbury Law Enforcement response to the domestic violence call reported on August 17, 2014, the day prior to the homicide.

### ***OVERVIEW OF FINDINGS***

- Both Zaniyah and the perpetrator AH belonged to families that had extensive and multi-generational involvement with various state systems, including the Department of Correction, Court Support Services Division, the Department of Social Services, the Department of Children and Families, local police, mental health and substance abuse treatment providers.
- Zaniyah was not known to DCF at the time of her death or prior to her death.
- AH had an extensive criminal record and incarceration history, beginning at age 11 (1989). Between 1996 and 2008, AH was arrested and sentenced at least six times for various crimes, including larceny, robbery, drug possession and sale of narcotics.
- AH was convicted in May, 2008 for the Sale of Hallucinogens/Narcotics and sentenced to 10 years, with 4 years to serve. From 1996 to 2013, it does not appear that he ever spent a full year out of prison.
- AH did not complete high school and did not demonstrate significant job or life skills upon discharge from DOC.
- AH was discharged from the DOC on November 27, 2013, initially residing with his mother in Bristol, CT. His conditions of probation required him to refrain from possessing any weapons or drugs and complying with a substance abuse treatment program.
- On December 23, 2013, AH moved in with his wife and children in Waterbury, and his probation case was transferred accordingly to the Waterbury probation office.
- AH was subject to ongoing probation supervision by Court Support Services Division (CSSD). He was assigned to the Prison-to-Probation Unit and monitored regularly. Probation utilizes a system of monitoring and supervision, risk assessment and graduated sanctions for non-compliance with probation requirements. Probation officers often have discretion to use judgment regarding the escalation of sanctions for non-compliance, including decisions to violate an offender for failure to comply with probation requirements. Violations of probation requirements necessarily fall into different categories of determined severity. Violations that do not result in re-arrest

are considered technical violations. For example, evidence of ongoing marijuana use is not typically considered a significant violation of probation conditions. CSSD expects a continuum of compliance and hopes to see an individual make forward progress over time. Latitude may be provided an offender whose incidents of non-compliance are considered minor or exist side-by-side with other indicia of progressive stability (e.g., obtaining housing and employment).

- AH demonstrated signs of ongoing drug use and a failure to comply with mandatory drug treatment. While on probation, he provided 9 urine samples between 12/2013 and 8/6/2014. He tested positive for marijuana on 8 screens, with his last test positive for PCP and marijuana. AH provided a negative urine sample in February, 2014. A review of specific marijuana levels in the positive screens indicates some diminishing use over time, with a test in July 2014 showing less than 100 ng/ml of THC. However the urine screen done on August 6, 2014 again showed escalating marijuana use and PCP use.
- Despite positive urine screens for marijuana, AH also showed signs of increasing stability. According to documents and interviews with CSSD professionals, AH, while continuing to produce periodic urine samples positive for THC (Marijuana), showed other signs of progress: marijuana levels appeared to be diminishing, and he completed a community life-skills program called Reasoning and Rehabilitation. Even with periodic urine screens positive for marijuana, probation supervisors credited AH for finding a stable place to live, moving in with his wife and children, benefitting from a relationship with his mother, obtaining employment (spring of 2014), complying with required office visits, attempting to seek permission from probation when going out of town for a wedding, spending time with his children and, most significantly, not getting arrested again.
- In May, 2014, AH brought his 7 year-old son to his probation appointment, and interactions between father and son were observed to be positive. AH reported that his son was suspended from school for 10 days due to a “misunderstanding” wherein the child brought a wine opener to the school in his backpack. Separate from the probation note, the *police* were called by the school and a report was made indicating that the 7 year-old child brought a knife to school and threatened to kill another child. There is no indication that the school contacted DCF, or that the police contacted probation, or that probation contacted the school. Separate and unrelated reports were made by education, police and probation regarding the same incident.
- Events spiraled very quickly in the immediate weeks prior to Zaniyah’s death, when AH’s purported drug use appeared to escalate and he demonstrated more volatile behavior.
- On July 31, 2014, AH was served with paperwork regarding possible garnishment of wages due to state support enforcement of his child.
- As stated above, on August 6, 2014, twelve days before the death of Zaniyah, AH’s new drug treatment provider and probation officer each conducted drug screens. The community provider’s screen tested for marijuana, but *did not test for PCP*. The

provider's screen results came back to probation on August 13 with a note that AH was again positive for THC. However, the probation officer's screen results *did not return to probation until Saturday, August 16<sup>th</sup>*. Probation's screen tested for both marijuana and PCP and the test eventually came back positive for both drugs. The delay between the administration of the drug screen and the receipt of results was considered by CSSD to be significant and unusual. Investigators learned, however, that even a positive screen for PCP at this point would not necessarily "violate" AH, but would certainly have increased his probation supervision and relevant sanctions, including a likely referral for inpatient treatment.

- On August 17, 2014, a day before the homicide, an incident of domestic violence took place in the home of AH and his wife. 911 was called in by one of the minor children present in the home during the domestic violence incident. Multiple minor children were present. The youth caller stated that AH struck his mother. AH left the home prior to police responding. The responding police officers attempted a lethality assessment<sup>1</sup> for AH's wife, which she refused. Emergency shelter was offered and refused. AH's wife indicated that she had a safe place for herself and her children to stay. AH's wife presented as visibly upset, but she indicated that she did not require medical attention. DCF was not contacted about this incident as the police assessment was that AH's wife was able to keep her children safe and they had no concerns regarding abuse or neglect of the children. Information regarding the Office of Victim Services was provided as well as information regarding obtaining a protective or restraining order. AH's wife initially denied being struck, but then indicated that she was hit in the face and that AH smashed her phone. Police aired a "pick up" for AH. They canvassed the immediate area but did not locate him. There was no indication that law enforcement was aware or determined that AH was on probation.
- While Waterbury Law Enforcement made local attempts to find AH immediately following the domestic violence report, there was no record that police attempted to contact CSSD or *electronically access probation information available to law enforcement*. This information could have provided police with the supervising probation officer information, current address, as well as all past address information, giving Waterbury Law Enforcement additional areas to search for the suspect.
- The next evening (7:00pm), August 18<sup>th</sup>, was the day of Zaniyah's murder. AH's wife reportedly went to AH's mother's home in Bristol to bring him his clothing. AH's wife did not call the police in Waterbury and tell them where AH was staying. There were no restraining or protective orders sought or obtained. At this time baby Zaniyah was at AH's mother's house, as AH's mother was babysitting for her (although she was not in the home at the time of the stabbing). Upon AH's wife's arrival at his mother's home, AH wanted to speak to his wife. After some point in time everyone fled the house due to an alleged change in AH's behavior (apparently family members remained outside

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<sup>1</sup> A lethality assessment helps gauge the risk levels associated with incidents of domestic violence. Its purpose is to help prevent domestic violence homicides and serious injuries. The tool can be administered by law enforcement and other community professionals.

the front door). AH's 11 year old step-daughter was reportedly holding Zaniyah and was not able to get out of the house before the baby was stabbed.

- In the home at the time of the murder were AH's 2 teenage nephews, one younger nephew (8 yo), his step-daughter who was holding Zaniyah, his biological son (7 yo), and AH's wife. Neither Zaniyah's mother or AH's mother were at AH's mother's home when the stabbing occurred.
- Zaniyah was transported to the hospital at which point DCF was notified by the hospital of the incident. Two investigations were opened by DCF, one regarding AH's family and other for Zaniyah's family. DCF made a substantiation of physical neglect against AH for "physical neglect-conditions and circumstances injurious, exposure to family violence, erratic/impaired behaviors, substances abuse w/ adverse impact and inability to provide/maintain safe living environment, emotional neglect- exposure to family violence, conditions and circumstances injurious and substances abuse w/ adverse impact, emotional abuse/maltreatment-exposure to family violence, cruel acts, adversely impacting child, and terrorizing a child." AH was placed on the DCF central registry.

### ***SUMMARY***

OCA and CCADV's investigation focused extensively on the balance between a probationer's progress and non-compliance, and how a probationer's varying behaviors should be weighed in the adult system of risk assessment and response. CSSD documents, internal review and responses emphasize the need to consider the behavior of AH in the context of the overall probation population, to understand where behavior falls in the continuum of risk, and appreciate the relative benefits of graduated sanctions. AH provided multiple positive drug screens for marijuana throughout the duration of his probation. However, for someone with AH's extensive history, he was also seen as demonstrating a modicum of consistency and making some progress in that he moved in with his family, completed a community life-skills program called Reasoning and Rehabilitation, complied with probation officer visits and obtained employment. Probation seeks to give clients the opportunity to change their thinking and make progress over time. Many of these determinations required considered, educated judgment. AH's documented drug use appears to have escalated to PCP in the weeks immediately prior to the homicide of baby Zaniyah. However, the community provider screening AH's urine did not test for PCP, and the results of the probation officer's screen, done in early August, which *did* test for PCP, was unfortunately and uncharacteristically delayed so that results were not received in a timely manner.

### ***RECOMMENDATIONS***

1. Strengthen CSSD processes for detection of a probationer's ongoing or escalating drug use. CSSD-contracted providers and CSSD do not necessarily test for an identical panel of drugs, which allows for inconsistent conclusions about a probationer's drug use. Drug tests are sent to a lab contracted by CSSD and results typically take a couple of days to return. In this case, the last test done by CSSD on August 6 took until the 16<sup>th</sup>, a very unusual delay. CSSD and OCA jointly recommend the need to standardize the panel of drugs that are tested in toxicology screens and whether drug levels will

be documented. CSSD and OCA also jointly recommend the need to implement procedures to ensure consistent and timely receipt of drug toxicology results.

2. CSSD does not “violate” every individual who is non-compliant with aspects of probation requirements, necessarily engaging in an evaluation of the public safety risks presented by a probationer’s activities. For example, even positive toxicology screens may not result in an immediate change in sanctions for a probationer. Specific drug use is relevant and marijuana use has typically raised less concern with probation staff than other drugs such as heroin, cocaine or PCP. Therefore, CSSD should assess its policies regarding the training, supervision and clinical expertise that inform staff’s evaluation of the relative risks presented by probationers’ ongoing substance use and the matching of a probationer’s need for appropriate treatment interventions and sanctions. Continued technical and clinical support from experts in substance addiction and treatment can support CSSD’s risk assessment and use of graduated sanctions.
3. Evaluate the response of CSSD to probationers’ ongoing drug use in the presence or proximity of children.
4. Evaluate and continue to strengthen police protocols for response to domestic violence witnessed by children or where children are on the premises. Policies and protocols should provide clear guidance regarding how to identify children at risk, engage and refer families and children for appropriate community and state agency supports.
5. Evaluate and strengthen protocols for law enforcement’s determination of a suspect’s parole/probation status. Law enforcement has the ability to access a database to determine whether an individual is on probation or parole. This database may not be routinely checked in response to every police call. This database did not appear to be accessed in response to the August 17, 2014 domestic violence call.
6. Consider the opportunities to strengthen cross-system collaboration and the development of model policies as articulated in the “*Improving Outcomes for Children & Youth Impacted by Family Violence*” report ([www.ct.gov/oca](http://www.ct.gov/oca) & [www.ctcadv.org](http://www.ctcadv.org)).
7. Strengthen interagency communication between local school districts and CSSD to improve collaboration and information-sharing that can enhance risk assessment and support for children.
8. Encourage local law enforcement to access probation status of individuals being investigated to determine if a more coordinated effort needs to be facilitated. The state is currently working on construction of a new justice information system that will “take data input from criminal justice databases and make it all searchable.”<sup>2</sup>

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<sup>2</sup> Press Release, Office of the Governor, July 25, 2012 *Connecticut’s Justice Information System Closer to Reality*. Described as a “State of the art public safety system [that] will allow appropriate criminal justice professionals from various agencies and branches of government to seamlessly share comprehensive files and information on offenders,” the system has been under development as part of the state’s criminal justice system improvements. *Id.*

Once the system is complete, a law enforcement officer could obtain all relevant information in the system by just typing a name or address.

9. Additional attempts to locate suspects and a more thorough assessment of incidents involving children should be utilized during a domestic violence investigation. The 911 call on the day prior to Zaniyah's murder was made by a youth indicating that AH had assaulted his mother. Law enforcement attempted a lethality assessment and referral to an emergency shelter—both good practices. However, AH's wife refused both. DCF was not contacted because the Waterbury law enforcement assessed the situation and determined that the she could keep her children safe. Law enforcement inquiries into AH being under the influence of an illegal substance during this incident may have required a DCF referral for the safety of the children.
10. CSSD should consider conducting an internal audit of a sampling of case files to ensure that the testing of PCP is a routine occurrence.
11. CSSD should strengthen their internal review process by adding an inside-outside, multi-disciplinary review process for critical incidents, fatalities, and near fatalities, including a child fatality review process.

### **Final Thoughts**

In 2014, there were 8 infants and toddlers who died by homicide, including Zaniyah. All of these infants and toddlers were allegedly killed by an adult known to the child. Zaniyah's case illustrates the importance of ensuring that our systems are working together, gathering critical information, and making skilled assessments that can be lifesaving. OCA appreciates the ongoing partnerships with systems of care that seek to prevent these tragic and unnecessary deaths of young children.

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*24-hour Statewide, Toll Free Domestic Violence Hotline*  
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