Critical Incident
Rapid Response Team
Clayton Foskey
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Executive Summary

On April 28, 2016, the Department received a report regarding the drowning death of 2-year-old Clayton Foskey, which occurred the previous evening. At approximately 7:00 p.m. on April 27, 2016, Clayton got out of the family’s home undetected while his mother, 27-year-old Roxann Potts, was out on the back patio. When Ms. Potts realized that Clayton was missing, she contacted authorities who initiated a multi-agency search. Nearly four hours later, Clayton’s body was found floating in a near-by pond.

Because there was a verified prior report involving Ms. Potts and a previous paramour that occurred within 12 months of the child’s death, a Critical Incident Rapid Response Team (CIRRT) was deployed to the Suncoast Region, Pasco County Sheriff’s Office, to review the past involvement of the Department, Pasco County Sheriff’s Office and the contracted Community Based Care (CBC) Lead Agency, Eckerd Community Alternatives, to assess any potential systemic issues within the local system of care. The review team completed a preliminary review of case records and interviews with child protective investigations staff, stakeholders, and service providers. In Pasco County, the Sheriff’s Office conducts all child abuse and neglect investigations.

Practice Assessment

- The Child Protective Investigator (CPI) demonstrated good engagement skills and was able to gather comprehensive information.
- The totality of information gathered in the prior and current investigations, as well as the prior case management case, failed to give weight to the mother’s long history of engaging in violent relationships and the impact it has.
- Additional information was included in the overall safety assessment; however, additional guidance was not provided by the supervisor or 2nd party reviewer.

Organizational Assessment

- Neither caseload size nor staff turnover were noted to be an issue in this case and had no impact on the CPI’s ability to do their job. Additionally, both the CPI and CPI Supervisor had the experience, education, and training necessary to do their work.
- Continued educational opportunities are available to staff and external stakeholders.
- There are strong relationships among the Department, the Sheriff’s Office, Eckerd Community Alternatives, and other service providers in Pasco County.

Service Array

- Services provided to families in Pasco County are adequate and easily accessible; however, in this case, they were not utilized.
Introduction

On April 28, 2016, the Department received a report regarding the drowning death of 2-year-old Clayton Foskey, which occurred the previous evening. At approximately 7:00 p.m. on April 27, 2016, Clayton got out of the family’s home undetected while his mother, 27-year-old Roxann Potts, was out on the back patio. When Ms. Potts realized that Clayton was missing, she contacted authorities who initiated a multi-agency search. Nearly four hours later, Clayton’s body was found floating in a near-by pond.

In addition to the deceased child, Ms. Potts has two other children, (ages 7 and 9 years, respectively), who were not harmed.

Because there was a verified prior report involving Ms. Potts and a previous paramour that occurred within 12 months of the child’s death, a Critical Incident Rapid Response Team (CIRRT) was deployed to the Pasco County Sheriff’s Office on May 2, 2016.

The review team consisted of representatives from the Department’s Office of Child Welfare from the Central Region and Children’s Legal Services from the Northeast Region, the Child Protection Team Medical Director from the Northwest Region, Central Florida Behavioral Health Network (a substance abuse and mental health provider-Suncoast Region), an independent domestic violence consultant (formerly of Lee Conlee House-Domestic violence service provider-Northeast Region), Devereux (community based care agency-Central Region), and the Hillsborough County Sheriff’s Office (Suncoast Region). In Pasco County, the Sheriff’s Office conducts all child abuse and neglect investigations.

This report presents the CIRRT’s findings, including the child welfare history, the family composition, and a summary of the local child welfare services providers, as well as an analysis of the system-of-care.
**Case Participants**

<table>
<thead>
<tr>
<th>Name</th>
<th>Age at Time of Incident</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clayton Foskey</td>
<td>2 years</td>
<td>Deceased Child</td>
</tr>
<tr>
<td>[redacted]</td>
<td>7 years</td>
<td>Half Sibling</td>
</tr>
<tr>
<td>[redacted]</td>
<td>9 years</td>
<td>Half Sibling</td>
</tr>
<tr>
<td>Roxann Potts (aka Roxann Bracken)</td>
<td>27 years</td>
<td>Mother</td>
</tr>
<tr>
<td>[redacted]</td>
<td>28 years</td>
<td>Father [redacted]</td>
</tr>
<tr>
<td>[redacted]</td>
<td>36 years</td>
<td>Father [redacted]</td>
</tr>
<tr>
<td>Robert Jennings</td>
<td>27 years</td>
<td>Paramour / Father of Clayton</td>
</tr>
</tbody>
</table>

**Child Welfare Summary**

There was one prior report involving Ms. Potts and Mr. Jennings as caregivers.

In June 2015, a report was received following a verbal dispute that occurred between Ms. Potts and her [then] paramour (and Clayton’s reported biological father), Robert Jennings. During the incident, Mr. Jennings threw a chair through a sliding glass door and began making threats to kill himself. He returned to the home sometime later. A second incident of domestic violence occurred in July while the investigation was still open, in which Mr. Jennings reportedly choked Ms. Potts. Mr. Jennings was arrested as a result of the incident and a no-contact order was issued by the court. Ms. Potts was referred for services through the local domestic violence provider and Mr. Jennings was no longer living in the home at the time of report closure.

**Additional Prior History on Family**

Between 2009 and 2012, there were five reports involving Ms. Potts [redacted].

In 2009, three reports were received due to concerns of on-going domestic violence between Ms. Potts and her [then] husband, [redacted], and resulted in Ms. Potts obtaining an injunction against [redacted]. At the conclusion of the third investigation, Ms. Potts was in a domestic violence shelter where she was provided legal assistance, as well as counseling.
In 2012, two reports were received due to concerns of domestic violence between Ms. Potts and her [then] paramour, [redacted], in addition to concerns that [redacted] had been selling drugs from the family’s home. Ms. Potts had obtained an injunction in the first report but had dropped it prior to receipt of the second report. Law enforcement was involved and drugs, as well as paraphernalia, were located in several rooms of the home and were accessible [redacted]. The adults were arrested [redacted].

In April 2013,
System of Care Review

This review is designed to provide an assessment of the child welfare system's interactions with the Foskey/Potts family and to identify issues that may have influenced the system's response and decision making.

In this case, both strengths and opportunities for improvement were identified in the following areas. While opportunities to improve practice were identified, it should be noted that a direct correlation could not be made between the circumstances surrounding Clayton's death and the prior reports involving Ms. Potts.

Practice Assessment

PURPOSE: This practice assessment examines whether the child welfare professionals' actions and decision making regarding the family were consistent with the Department's policies and protocols.

FINDING A: The Child Protective Investigator (CPI) demonstrated good engagement skills with the mother and was able to gather comprehensive information.

The CPI demonstrated skills and abilities in engaging the family and service providers. Although the investigation was not investigated using the new practice model, the CPI had completed training of the new practice and gathered information using the six domains (maltreatment, nature of maltreatment, child functioning, adult functioning, general parenting, and discipline). The amount and level of information provided by Ms. Potts was not only reflective of the CPI's knowledge of the respective domains but also indicative of her level of interviewing skills and rapport building. The level of established rapport was further evident when the mother, herself, contacted the CPI during the course of the investigation regarding the new incident of domestic violence.

FINDING B: The totality of information gathered in the prior and current investigations, as well as the prior case management case, failed to give weight to the mother's long history of engaging in violent relationships.

While the information obtained by the CPI during the course of the open investigation was comprehensive, coupled with the documentation readily available from the prior reports, the relevancy of on-going domestic violence issues and related dynamics were not given the appropriate weight with regards to the family's current level of functioning and on-going service needs.

Ms. Potts has been involved in a series of violent relationships with documented accounts occurring in 2009, 2012 and 2015. While she obtained a domestic violence injunction in all three instances, she failed to follow through on the process in 2009 and 2012 and either subsequently dropped the injunction altogether or allowed her partner to return to the home.

Following Mr. Jennings in 2015, Ms. Potts told the CPI that she was afraid of him and wasn't sure whether she wanted him to come back. However, during a follow up visit to the home two weeks later, Mr. Jennings was observed to be back in the residence. Later that same day, Mr. Jennings reportedly choked Ms. Potts and was arrested as a result of the incident. Although Ms. Potts was referred for counseling services through the local domestic violence provider, documentation did not reflect that any interview occurred with (regarding the new incident) or an assessment of their individual needs was completed.
By the 2015 report, Ms. Potts’ demonstrated that while she may take action to alleviate immediate situations, no true behavioral change had occurred as she continued become involved in violent relationships despite her reported engagement with domestic violence providers. Moreover, she failed to understand the impact that those relationships can continue to have on her physical and emotional well-being.

**FINDING C:** Additional information was included in the overall safety assessment; however, additional guidance was not provided by the supervisor or 2nd party reviewer.

The new incident of domestic violence was reported to the CPI and included in the updated safety assessment. While the supervisor and/or second party reviewer completed updated review, they did not take the opportunity to provide guidance. As a result, the gravity of the situation not taken into consideration in the assessment process as to the possibility of additional service provision or safety considerations.

While there was a recommendation to staff the case for possible judicial intervention, it was only based upon whether or not Ms. Potts followed through with the domestic violence injunction. Although Mr. Jennings was not living in the home at the time of investigative closure, he had been released on bond and, as a result, could have been perceived as a possible threat.

**Organizational Assessment**

**PURPOSE:** This section examines the level of staffing, experience, caseload, training, and performance as potential factors in the management of this case.

**FINDING A:** Neither caseload size nor staff turnover were noted to be an issue in this case and had no impact on the CPI’s ability to do their job. Additionally, both the CPI and CPI supervisor had the experience, education, and training necessary to do their work.

During the period under review, the CPI’s caseload was low with the CPI having anywhere from 12 to 17 open investigations during the period under review (June and July 2015). In addition, the average number of intakes received per month for this CPI for the same period ranged from 14 in June to 9 in July, falling well within the recommended industry standards.

With regards to staff turnover, Pasco County Sheriff’s Office reported that there were two CPIs who separated from their respective positions in June 2015, and one documented separation in July 2015. In calendar year 2015, there were a total of 26 CPI staff separations and with only 50 classified CPI positions, this brings the turnover rate to over 50% in Pasco County, and is consistent with a monthly average of 2 separations per month. It should be noted, however, that
while the overall staff turnover is high, it did not have an impact in this specific case given the length of time the CPI and CPI Supervisor had been working for the agency.

The CPI assigned to the prior investigation began working for the Pasco County Sheriff’s Office in September 2013 and was certified one year later as a Child Welfare Protective Investigator through the Florida Certification Board. The supervisor has been working for the Pasco County Sheriff's Office for over eight years, five of which were in the capacity of a CPI and the past three and a half years as a supervisor. In addition, both had college degrees with the CPI’s major in Criminology and minor in Psychology, and the CPI supervisor’s major in Psychology and minor in Criminology.

**FINDING B: Continued educational opportunities are available to staff and external stakeholders.**

The Pasco County Sheriff’s Office Child Protective Services Division has an annual training calendar which includes regularly scheduled training classes, such as pre-service, Vicarious Trauma, Active Shooter Drill, monthly practice-specific topics, substance abuse, car seat, defensive driving, etc. Pre-service classes are accessible to all of the Sheriff’s Office staff. It is expected that investigation staff attend the scheduled training topics. An email is sent to the investigation staff requesting they sign up for one of the designated times they will be attending. In addition to the annual calendar, if additional training needs regarding a specific topic are identified by supervisors or management, additional training is provided.

Child Protective Services staff were all trained in the new practice model beginning in January 2015. This allowed for full roll out of all investigations to the new practice by fall of 2015.

Notification and invitation of all training classes are sent to external stakeholders via a System of Care distribution list. Various training has been offered to/provided to/trained with the following: guardian ad litem, State Attorney’s Office, case management organizations, hospital social workers, domestic violence advocates, substance abuse mental health providers, child protection team, law enforcement, judges, foster parents, and Department of Juvenile Justice.

Community stakeholders also provide training to the investigation staff for topics such as substance abuse, mental health, and domestic violence during pre-service, as well as any other times as requested by the Sheriff’s Office.

**FINDING C: There are strong relationships among the Department, the Sheriff’s Office, Eckerd Community Alternatives, and other service providers in Pasco County.**

During the CIRRT review and interviews with community stakeholders, individuals consistently reported having a positive relationship and partnership with the Pasco County Sheriff’s Office Child Protective Services Division. There are two assigned domestic violence advocates who work directly with the investigation staff providing support and guidance on cases where domestic violence is identified. In addition, a resource specialist is co-located with investigation staff and processes are in place to refer to diversion services and providers within the community.
**Service Intervention/Array**

**PURPOSE:** This section assesses the inventory of services within the child welfare system of care.

**FINDING A:** Services provided to families in Pasco County are adequate and easily accessible; however, in this case, they were not utilized

There are a multitude of services available in the county as reported through interviews conducted of investigation staff, as well as agency providers.

BayCare Health Systems provides services and programs to families known to the child welfare system for substance abuse and mental health. Family Intervention Services (FIS) / Family Intervention Team (FIT) services are available and being utilized by investigation staff. FIT is an intensive in-home program that has been around for two years and is utilized for cases identified as unsafe, with a child under the age of 10, and substance abuse occurring in the home. FIS works with safe families and provides assessment and referral services for substance abuse, parenting, domestic violence, and anger management. In addition, Eckerd provides diversionary services to include prevention and in-home non-judicial supervision.

There are two domestic violence advocates in the county through the Salvation Army which is co-located with CPI’s in West Pasco County and Sunrise Pasco located in East Pasco County. The co-location of the domestic violence advocates in West Pasco County has been beneficial to the CPIs in that area and has promoted great working relationships between the investigation and management staff and the provider. The advocate works directly with the survivors, contacting them once referred, providing outreach assistance with services, such as shelter, counseling, and obtaining injunctions.

In this case, information was inconsistent with regards to Ms. Potts’ level of interaction with the agency and what, if any, services were identified and provided. While the sheriff’s office reported that Ms. Potts was described as “engaging” with the provider, documentation in the case record noted that Ms. Potts declined to participate with the Salvation Army and, instead, opted to seek services on her own.