Critical Incident Review Team Final Report

A Critical Incident Review Team is convened by the Department Director when the Department becomes aware of a critical incident resulting in a child fatality that was reasonably believed to be the result of abuse and the child, child's sibling or another child living in the household with the child has had contact with the Department (ODHS). The reviews are called by the Department Director to quickly analyze ODHS actions in relation to the critical incident and to ensure the safety and well-being of all children within the custody of ODHS or during a child protective services assessment. The CIRT must complete a final report which serves to provide an overview of the critical incident, relevant Department history, and may include recommendations regarding actions that should be implemented to increase child safety. Reports must not contain any confidential information or records that may not be disclosed to members of the public. *The CIRT report is created at a specific time as required by statute and does not account for events occurring after the posting of the report*. Versions of all final reports are posted on the ODHS website.

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<tr><td colspan="3">CIRT ID: AMQ6J7N4U9</td></tr>
<tr><td>Date of critical incident:

September 27, 2023</td><td colspan="2">Date Department became aware of the fatality:

September 28, 2023</td></tr>
<tr><td>Date Department caused an investigation to be made:

September 28, 2023</td><td colspan="2">Date of child protective services (CPS) assessment disposition:

January 4, 2024</td></tr>
<tr><td>Date CIRT assigned:

October 3, 2023</td><td colspan="2">Date Final Report submitted:

January 11, 2024</td></tr>
<tr><td>Date of CIRT meetings:

October 30, 2023
December 1, 2023</td><td>Number of participants:
19
21</td><td>Members of the public?
No
No</td></tr>
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Description of the critical incident and Department contacts regarding the critical incident:

Date of report:	**Allegation(s):**	**Disposition(s):**
September 27, 2023 **Assignment decision:** 24 Hours	Neglect by the mother	Founded

On September 27, 2023, ODHS received a report alleging neglect to the 1-year-old child and the child's two siblings, who were ages 1 month and 3 years old, by their mother. Local law enforcement responded to the family home regarding the death of the 1-year-old child. Per the reporter, the mother reported the child had been fussy and congested earlier in the day. She had given the child applesauce and Tylenol, though she did not know if the child was running a fever. She had put the child down on the mother's bed for the night and when she later returned to check on the child, the child was unresponsive. The mother reported she would typically bed share with her children, although specific circumstances around the timeline or sleeping arrangements leading up to the incident were unknown by the reporter. Observations of the sleeping surfaces in the room described a bed with two pillows, a blanket, a flat and fitted sheet, and a Pack n' Play at the foot of the bed. The home was observed to have garbage and cockroaches, and black mold in the bedroom. The mother stated the property management company should know about these concerns. There was plenty of food in the home, and no visible concerns regarding the sibling's health. There was a fentanyl pipe and a broken methamphetamine pipe found in the home, and when questioned about what a urinalysis would indicate, the mother stated it would be "dirty."

On September 28, 2023, the CPS caseworker and permanency caseworker made phone and face-to-face contact with the mother who stated that the day of September 27 was a normal routine. A relative picked up the mother and children to run some errands in the morning. They

dropped the children off with roommates, who were approved safety service providers, so the mother could attend supportive services at 11:30 a.m. After she attended supportive services, she and a relative went shopping for the children and the mother arrived home around 2 p.m.

The child napped on the couch between 2:30 p.m. and 3 p.m., but the 3-year-old sibling woke the child up early. The mother stated the child had been congested and was fussy. She tried to soothe the child with some applesauce, which the child refused. The mother then administered Tylenol. She bathed the child just after 4:45 pm, which helped calm them. Afterwards she gave the child a bottle and laid the child down on the mattress in their bedroom. The 3-year-old sibling kept trying to wake the child, so the mother brought the older sibling out to the living room, where the 1-month-old sibling was sleeping in the swing. She hoped to let the child nap for an hour and half, still allowing for an approximate 10 p.m. bedtime hoping the child would sleep through the night. The mother returned to the room and observed the child with blue lips and the blanket, just below the child's belly. She picked up the child and tried to wake them, but the child remained unresponsive. She attempted to blow air into the child's mouth, but they had spit up, which prevented the air from filling the child's mouth. She began chest compressions and called 911.

The mother stated the child had been sick in the days leading up to the critical incident. About a week prior the child was burning up with a fever and was given Tylenol. The day of the critical incident she had noticed the child was a little warm but not enough for concern. She stated she would have taken the child to the doctor if she thought it was warranted, but she did not feel the symptoms were out of the ordinary. She had recently noticed changes in the child's sleeping pattern such as waking up multiple times at night and appearing uncomfortable. The mother thought this may have been due to growth, teething or exhaustion from high activity during the day. She believed underlying factors within the home may have contributed to their death. The child had a cough which she thought may have been caused by black mold in the home. There were cockroach traps in the home, which she had to kick out of the open at times so the children would not get into them, although they were the type where roaches could crawl in the side.

The mother allowed the siblings to undergo a urinalysis on September 28, 2023, although she expressed confusion about why it was requested. She initially denied she had used drugs within the previous several days before the critical incident, but later admitted she had smoked fentanyl earlier that day around 8 a.m. Her drug of choice was fentanyl, with use of methamphetamine for energy. She stated she never kept substances around the children and only used outside of the home, including the morning of the critical incident. The mother had concern about her roommates potentially using substances. None of her roommates were at the home during the critical incident, and the last one who was home left right before the child took a bath.

On September 28, 2023, a protective action plan was implemented with 24/7 supervision of the siblings by a maternal relative. The CPS caseworker made face-to-face contact with the siblings on September 29, 2023. The CPS caseworker talked about the drug tests on the children and the details about the plan. The mother expressed concern about her housing situation and getting the kids back to her care quickly.

The father was said to be houseless. The mother said she would occasionally see him on public transit, but that she did not maintain any level of contact with him. The CPS caseworker spoke to the paternal grandparents who informed the father about the critical incident. The paternal grandparents reported they had not seen him in over two months.

The allegations of neglect to the child and their siblings by their mother were coded as founded. The children were exposed to an unsafe environment due to drug use in the home by the mother. The mother acknowledged concerns of drug use by her roommates and allowed them to care for the children. Additionally, the siblings tested positive for substances immediately after the critical incident.

Description of relevant prior Department reports under the mother's case:

Date of report:	**Allegation(s):**	**Disposition(s):**
May 24, 2021 **Assignment decision:** 24 Hours	Neglect by the parents	Unfounded

On May 24, 2021, ODHS received a report alleging neglect to the sibling of the deceased child, who was 9 months old at the time, by the parents. According to the reporting party, the family was staying in a shelter where staff observed concerns the parents were using substances. This included observations that the father had been acting erratically for about four days preceding an incident when the mother experienced a near overdose. The 9-month-old child was present for the substance use and was in the room with the mother when she was unresponsive. Emergency services were called, and the mother was taken to the emergency room. The child was left with a paternal relative, who also resided in the shelter. Ultimately, the child went to stay with a maternal relative, who was believed to be a safe caregiver. Due to this incident, the family would be evicted from the shelter.

On May 25, 2021, the assigned CPS caseworker called the shelter staff and learned they had been concerned for substance use by the parents for the last few days. There was marijuana paraphernalia found in the family's room following the incident with the mother. The father initially reported she used "dope" but then stated he purchased marijuana that might have been laced. The staff at the shelter stated the mother had self-reported having mental health concerns but declined supports and services. The staff further reported concerns that the parents didn't have ID or birth certificates and would need services and support. Due to this incident, the family would need to vacate the shelter for at least three days. They would be welcomed back but would be permanently exited if another violation took place. Lastly, they reported the child is often unkempt and left in soiled diapers.

The assigned CPS caseworker contacted the parents at the shelter on May 25, 2021. Regarding the incident, the mother reported the father bought marijuana from someone on the streets. The last thing she remembered before emergency services arrived was smoking the marijuana. The mother reported previous use of methamphetamines until she quit (without treatment or supportive services) when she learned she was pregnant with the child. In 2020, she unknowingly overdosed on fentanyl after smoking laced marijuana.

The father reported he bought marijuana from someone at a nearby homeless camp. He took a shower while the mother smoked the marijuana and discovered her passed out when he was done with the shower. The father reported untreated mental health and reported a history of substance use. Both parents agreed to urinalyses (UA) and completed them before the end of the day.

Contact with the child, who was in the care of a maternal relative, took place on May 25, 2021. The child appeared clean in presentation and the maternal relative had all necessary equipment and supplies for the child's care.

On May 27, 2021, the CPS caseworker provided the parents a gift card for gas and notified the mother that her UA was positive for marijuana. Due to concerns for the mother's health, the unknown information about why she collapsed and was unconscious, and due to the pending UA results for the father, the parents agreed to allow the child to stay with the maternal relative. On June 1, 2021, test results were received from the father's UA and was positive for methamphetamine. When this was discussed with the parents, the mother denied any inclination he was using methamphetamine and did not condone it. The father agreed to participate in supportive services.

Throughout the CPS assessment, the father continued to struggle with substance use and a second referral to services was made. The parents separated during the CPS assessment. Collateral contacts, including shelter staff and family members, reported throughout the CPS assessment the parents were often observed fighting and arguing. At the conclusion of the CPS assessment, the father was having supervised contact with the child.

On June 7, 2021, a new report alleging neglect to the child by the parents was assigned for a CPS assessment with concerns the child was exposed to methamphetamines. These concerns were addressed in this CPS assessment and are summarized below.

On July 11, 2021, a new report alleging physical abuse to the child by the mother was assigned for CPS assessment. These concerns were addressed in this assessment and are summarized below.

At the conclusion of the report, the allegations of neglect to the sibling, who was 9 months old, by the parents were unfounded. There was no evidence to suggest the parents smoked anything other than marijuana on the day of the reported incident. It was not known why the mother lost consciousness. The parents made appropriate plans for the child to be cared for by a relative following this incident. The child appeared safe in the care of the mother and relative.

Date of report:	**Allegation(s):**	**Disposition(s):**
June 7, 2021 **Assignment decision:**	Neglect by the parents	Unable to Determine
24 Hours		

On June 7, 2021, ODHS received a report alleging neglect to the sibling of the deceased child, who was 9 months old, by the parents. It was reported the 9-month-old child's maternal relative had been caring for the child for most of the week, but the child was in the care of the parents the previous day or two. The child was brought to the emergency department by the maternal relative with eye irritation and odd behaviors. The child tested positive for methamphetamine. The reporter also had some concerns for the dynamics between the parents.

On June 7, 2021, the CPS caseworker spoke with the maternal relative who reported they started caring for the child the previous day and noted the child had some abnormal behaviors. The maternal relative took the child to the ER where they tested positive for methamphetamine.

The parents were contacted, both denied knowing how the child was exposed to substances. The mother denied using any substances and the father was not in the home. The CPS caseworker met the parents in person and implemented a protective action plan with the maternal relative as the safety service provider, providing 24/7 supervision of the child. The father reported his last use was four days prior. The father reported he was scheduled to start supportive services in July but would call around to see if this could happen sooner.

Staff at the shelter reported concern for the parents' behavior, including observing them verbally arguing.

On June 8, 2021, the father decided to leave the shelter and given this decision, the protective action plan would be suspended as there was no indication the mother was using substances.

During the remainder of this CPS assessment, the father continued to struggle with substance use. He was referred to supportive services twice and ultimately left the family unit.

At the conclusion of this CPS assessment, the allegations of neglect to the child by the parents was coded as unable to be determine. The child tested positive for methamphetamine; the parents denied knowing how the child was exposed. Neither parent could provide an explanation but there was a concern that the parents allowed houseless friends to sleep in their vehicle and this might have contributed to the child's exposure.

Date of report: July 10, 2021 **Assignment decision:** 24 Hours	**Allegation(s):** Physical Abuse by the mother	**Disposition(s):** Unfounded

On July 10, 2021, ODHS received a report alleging physical abuse to the sibling of the deceased child, who was 10 months old at the time of this report, by the mother. It was reported that law enforcement was called by a

community member indicating the mother was holding and shaking the 10-month-old child aggressively. Law enforcement contacted the mother outside of a community of people who were houseless. The mother did not appear intoxicated or under the influence and she denied shaking the child, who appeared healthy and uninjured.

The CPS caseworker spoke with the staff at the shelter where the mother and child were frequenting. They had not witnessed any physical abuse of the child but noted small bruising to the face. Their concerns were less focused on physical abuse and more centered around the child's hygiene and tired presentation.

The CPS caseworker made face-to-face contact with the mother and child on July 11, 2021. The mother denied shaking or otherwise harming the child, who was observed with a faint bruise on the right cheek. No other bruises were noted while the child's diaper was changed, and hygiene appeared appropriate. The mother believed the bruise was the result of the child falling while attempting to walk. The CPS caseworker observed the child toddling and practicing with a push toy.

On July 12, 2021, the child was medically evaluated, imaging was done but could not be fully completed as the child was inconsolable. There were no concerns noted on the imaging that was completed. The child abuse pediatrician did not believe the child had been shaken.

Shelter staff and relative collaterals were contacted, and no one suspected physical abuse by the mother.

During this CPS assessment, the father was living in a community of people who were houseless. He was struggling with substance use and was referred to supportive services. He and the mother were no longer in a relationship at the closure of the CPS assessment.

It was determined the allegation of physical abuse to the sibling, who was 10 months old, by the mother was unfounded. There was no evidence to suggest the child was shaken, which included observations by a child abuse pediatrician as well as imaging showing no internal injuries. The faint bruise on the child's cheek appeared to be unrelated and likely because the child was learning to walk, resulting in some falls.

Date of report:	Allegation(s):	Disposition(s):
August 5, 2021 **Assignment decision:** Closed at Screening	Threat of Harm by the parents	Not Applicable

On August 5, 2021, ODHS received a report alleging threat of harm to the sibling of the deceased child, who was 11 months old at the time of this report, by the parents. It was reported the 11-month-old child was frequently seen with the mother in a community of people who were houseless. There were concerns for substance use occurring in that community and concern that the child was being exposed to substance use. Law enforcement went to the community but were unable to contact the parents or the child. Law enforcement spoke with a person in the community who knew the family, who stated the mother and child stay in the shelter across the street while the father resides in a tent nearby. Law enforcement observed the tent and did not note any evidence of a baby or small child residing there.

It was determined this report did not meet criteria for a CPS assessment and was closed at screening. Notifications were sent to the supervisor and CPS caseworker as this report was made during an open CPS assessment.

Date of report:	Allegation(s):	Disposition(s):
February 4, 2022 **Assignment decision:** 24 Hours	Threat of Harm by the father	Unfounded

On February 4, 2022, ODHS received a report alleging threat of harm to the sibling of the deceased child, who was 1 year old, by the father. It was

reported the father was domestically violent to the mother in the presence of the 1-year-old child. This violence happened over the course of the night and into the morning. The father did not want the mother to go to her motel room, so he physically assaulted her and kept her phone from her. She had bruising and marks from the physical violence and was noted to be pregnant, likely in her third trimester. The child was present during the entirety of this incident.

On February 5, 2022, the CPS caseworker contacted the mother and a maternal relative at the motel, both residing in their own rooms. The CPS caseworker noted an odor of marijuana in the room but did not document addressing the odor. The mother stated she had a history of methamphetamine use but had not used since becoming a parent. The mother confirmed the information that was reported regarding the physical violence perpetrated by the father; however, she stated the child was in the maternal grandmother's motel room and was not subjected to the incident. The maternal grandmother confirmed this information. The mother was provided DV resources by the CPS caseworker.

The father was reported to be houseless and without a phone.

This CPS assessment was closed using a documentation protocol. At the conclusion of this assessment, the allegation of threat of harm to the 1-year-old sibling by the father was determined to be unfounded on the basis that the child was reported by the mother and the grandmother to be in the motel room of the relative when the physical assault occurred.

Date of report: February 23, 2022 **Assignment decision:** 24 Hours	**Allegation(s):** Threat of Harm by the mother	**Disposition(s):** Unfounded

On February 23, 2022, ODHS received a report alleging threat of harm to the child, who was a newborn, by the mother. The reporting party stated the child was born on February 22, 2022, and the urinalysis was

presumptively positive for amphetamines and THC at birth. The mother reported her last use of methamphetamines was two years previous and admitted to currently using marijuana. The mother appeared to be caring for and nurturing the child appropriately, but the reporter was concerned about the mother's unstable housing. The mother was informed of safe sleep practices. The family intended to discharge to a motel room and be there for about a week before moving into an apartment. It was noted the mother's prenatal care consisted of two appointments.

The assigned CPS caseworker met with the mother in the hospital (documentation is not clear the day this occurred) and in the hotel where she stayed with a maternal relative and two siblings. The CPS caseworker spoke with hospital staff regarding the presumptive positive urinalysis, which was sent for confirmation testing. The results came back negative. The mother was tested a second time, which also came back negative. The mother reported she accessed housing services and moved into subsidized housing before the closure of the CPS assessment.

During this CPS assessment, a new report was reported with concerns the maternal relative was seen driving with the 1-year-old sibling in their lap and an individual in the car was observed snorting a substance in the car. This report was closed at screening and this new information was partially assessed in the open CPS assessment. The CPS caseworker spoke with the relative, who reported while looking for a parking spot, the sibling was crying in the car seat. The relative took the sibling out and held them in their lap while looking for a parking spot. The relative promised not to do this again. Documentation does not reflect that the concerns about the individual using substances in the car were discussed.

The mother was asked about the children's father, and she denied having any contact information or knowledge of his whereabouts. Documentation does not reflect that contact with the father was attempted.

The allegation of threat of harm to the child was coded as unfounded. The child was found to be presumptively positive at birth for methamphetamine and THC; however, confirmation testing showed negative test results. This CPS assessment was closed using the documentation protocol.

Date of report:	Allegation(s):	Disposition(s):
April 2, 2022 **Assignment decision:** Closed at Screening	Threat of Harm by the maternal relative	Not Applicable

On April 2, 2022, ODHS received a report alleging threat of harm by a maternal relative to the sibling of the deceased child, who was 1 year old. It was reported the relative was observed driving through a parking lot with the sibling in their arms. Additionally, it was reported there was an unknown individual in the front seat observed to be snorting substances in the car. Law enforcement was contacted and observed the relative in the vehicle with the sibling in their lap; however, the car was parked and therefore law enforcement could not take any action in the way of a citation. The relative reported they was driving from one part of the parking lot to the other. They reported they knew the individual in the car and owed them some money and was providing them a ride. They denied the individual was using substances in the car.

It was determined this report did not meet criteria for a CPS assessment. At the time of this report, there was an open CPS assessment and information from this report was sent to the CPS caseworker and supervisor for further assessment.

Date of report:	Allegation(s):	Disposition(s):
August 7, 2023 **Assignment decision:** 24 Hours	Threat of Harm by the mother	Founded

On August 7, 2023, ODHS received a report alleging threat of harm to the younger sibling of the child, who was a newborn, by the mother. At birth,

both the newborn sibling and the mother tested positive for fentanyl. The mother disclosed she was struggling with opioid use and used fentanyl during her pregnancy. She reported the children's father was in and out of the home on an inconsistent basis and was also struggling with fentanyl use. The mother reported a maternal relative lived in the home and was acting as a safety service provider for the children. The mother's prenatal care was limited. She reported being involved in supportive services, but still using fentanyl. The newborn sibling was in the NICU and would remain there for at least a week due to concerns of withdrawal.

On August 8, 2023, the CPS caseworker had face-to-face contact with the newborn sibling in the NICU. The hospital social worker said the newborn would remain in the NICU for another two weeks. Contact with the mother was attempted this same day; however, the address provided appeared incorrect and the CPS caseworker was unable to leave a voicemail on the mother's phone. Later that day, the CPS caseworker attempted to call the maternal relative, but was not successful. Attempts to contact additional relatives by phone were made, but contact was not successful due to outdated contact information.

On August 9, 2023, the CPS caseworker spoke with the hospital social worker, who was able to provide an updated phone number for the mother and additionally reported the mother was currently at the hospital. On August 10, 2023, the CPS caseworker contacted the mother by phone and a meeting was scheduled for August 11, 2023.

At this meeting, the mother was forthcoming about her substance use and signed releases of information for service providers. It was learned the hospital social worker would be referring the family for parenting support services, child development resources, and additional supportive services for the family.

Safety threats were identified, and an in-home safety plan was created on August 19, 2023, with in-home services to support the family, including the mother's roommates as safety service providers. Hospital staff voiced concern regarding the mother's presentation in the NICU and cited several examples of the mother struggling to be sufficiently alert, coherent, or safe to hold, feed or respond to the newborn sibling's needs. The mother and her roommates recognized the necessity for close supervision due to the

mother's use and any potential exposure to substances. A discussion about safe sleep occurred, and it was noted the mother had appropriate sleeping arrangements for her children.

Throughout this CPS assessment, contact with the father was attempted by means of his last known phone numbers; however, contact ultimately did not occur. The mother believed he was actively using substances and did not know his whereabouts. She reported her relationship with him to be tumultuous and due to his use, would trigger a relapse for her.

The mother seemed to acknowledge and understand the type of environment needed for her to remain focused on her recovery. The maternal relative was a strong support to the mother and expressed concern for the father's influence on the mother's recovery and violent behavior toward her.

The case met the criteria for an in-home safety plan and a permanency caseworker was assigned to work with the family. The mother's two roommates, the maternal relative, supportive services, and parenting services provided for 24/7 supervision of the children in the home.

The allegation of threat of harm to the newborn sibling by the mother was coded as founded due to a positive test for fentanyl and significant withdrawals along with the mother's continued substance use.

Description of concerns regarding actions taken or not taken by the Department or law enforcement agencies in response to the critical incident or events that led to the critical incident:

The CIRT observed opportunities for improvement in CPS case practice including the following:

The May 24, 2021, and June 7, 2021, CPS assessments had incorrect dispositions that were coded as unfounded and unable to determine, respectively; however, both met definitions for founded allegations under Oregon Administrative Rule.

In the CPS assessment dated May 24, 2021, the mother reported experiencing a recent overdose, the child tested positive for

methamphetamine, and the father was using methamphetamine and experiencing hallucinations. While a protective action plan was implemented during the CPS assessment, it was lifted when the mother reported to have separated from the father. The more appropriate response would have been to continue with the protective action plan to address the present danger or develop an initial safety plan to ensure the children were safe while the safety threats were in operation. In a subsequent CPS assessment, it was learned that the relationship between the mother and the father did not end. Knowledge of this information might have changed the decisions made in the May 24, 2021, assessment.

In the CPS assessment dated August 7, 2023, it was noted the mother and father were not referred to supportive services through the local ART (Addiction & Recovery Team). This resource is often critical in engaging parents in change services early on in a case.

In this same CPS assessment, ODHS identified a safety threat when the younger sibling was born; however, a safety plan was not implemented for the child or older sibling who were residing in the home with the mother, until the younger sibling was out of the hospital, 10 days later. The safety plan included safety service providers who did not appear to be fully assessed for that role and documentation did not indicate how they would monitor the children's safety and interrupt any behavior that caused the unsafe family condition.

Additionally, the local district holds staffings on cases presenting with high-risk factors, and these staffings are most successful when implemented to collaborate with a group of professionals and subject matter experts to assist in case decisions. It would have been beneficial to hold a high-risk staffing in this case.

Lastly, the CIRT noted the parents were young and this detail highlighted the lack of services for young parents, and specific services for young people who struggle with substance use disorder as they transition to adulthood.

Recommendations for improvement in the administration and oversight of the child welfare system that are specific to the critical incident and any historical information reviewed by the team:

The local office was proactive in taking some actions in response to the CPS practice needs in this case. The high-risk staffings mentioned above are reportedly an underutilized tool in the local branch office and leadership reports they are evaluating criteria for the staffings and understand it is important for casework staff to understand the why behind these staffings. A recent safe systems analysis of all CIRTS conducted between 2019 and 2022 in this district was completed by the Child Fatality Prevention and Review Program (CFPRP), and the results should be reviewed and utilized by the local office to lend insight into which case types/criteria should receive a high-risk staffing. The CIRT additionally recommends the local branch evaluate the participant makeup of these staffings and consider including a larger net of professionals such as the local Addiction Recovery Team (ART), housing representative, well-being or community health nurse, mental health provider and ODHS subject matter experts when applicable. The evaluation of the high-risk staffing criteria along with a review of the safe systems analysis and any identified changes for the high-risk staffings should be completed by end of January 2024 with any implementation plan in place no later than March 1, 2024.

The CIRT recommends the local child safety consultant, permanency consultant and branch leadership, which may include Coaching and Training Specialists, arrange for a branch-wide training for key improvement opportunities in this case, including identification of impending or present danger safety threats, in-home safety plan development and monitoring safety plans when active substance use is occurring, and vetting of suitable safety service providers in accordance with OAR 413-015-1200 to 413-015-1230. This training will integrate the ODHS Child Welfare Fentanyl Practice Guide as applicable to safety threat identification and safety planning, and strategies for improving supervision of safety planning during periods of co-case management. This training shall be completed by the end of April 2024.

Additionally, the CIRT recommends representatives from CFPRP, Child Safety Program, Permanency Program will consult with Communications

and Training and Workforce Development to identify strategies for improved messaging to Child Welfare staff for the Fentanyl Practice Guide. These strategies will be identified by end of April 2024, and any action steps identified for staff communication will be completed by May 31, 2024. Any additional actions to further integrate use of the Fentanyl Practice Guide will be outlined, with appropriate timelines, by May 31, 2024.

The CIRT recommends the CFPRP in partnership with CPS, Permanency, Youth Transitions, Treatment Services, and caseworkers from the local office work together to assess current practices and common service referrals for teens and young adults transitioning into adulthood. In addition, this team will determine the feasibility and implementation strategy of creating a referral process to Coordinated Care Organizations and Self Sufficiency Program services with the goal of increasing access and utilization of available supports to youth leaving foster care and/or young parents involved in a CPS assessment. Identified implementation strategies will be initiated no later than September 1, 2024.