Critical Incident Review Team
Final Report

A Critical Incident Review Team (CIRT) 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 service 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 posting of the report. Versions of all final reports are posted on the ODHS website.

CIRT information

CIRT ID: 7CL4HS8DC5

Date of critical incident: May 17, 2025

Date Department became aware of fatality: May 17, 2025

Date Department caused an investigation to be made: May 17, 2025

Date of CPS assessment disposition: September 4, 2025

Date CIRT assigned: June 3, 2025

Date Final Report submitted: September 11, 2025

Date(s) of CIRT meeting(s): July 2, 2025; July 30, 2025

Number of participants: 15; 19

Members of the public? No; Yes

Critical incident description

Date of report: May 17, 2025

Assignment decision: 10 Days

Allegation(s): Physical Abuse by an unknown perpetrator; Neglect by the parents

Disposition(s): Unfounded; Founded

ODHS received a report on May 17, 2025, alleging physical abuse to the child, who was 3 years old by an unknown perpetrator. The reporter stated that the local law enforcement agency (LEA) and emergency medical services (EMS) responded to the family home around 12:20 p.m. after a 911 call that stated the child had stopped breathing. EMS and LEA personnel performed CPR until the child was transported to a local hospital where they were pronounced deceased.

Medical providers told the reporter that the child had a history of asthma and was believed to have had a viral infection at the time of the critical incident. The child presented with pinpoint pupils, but the reporter did not believe that an overdose occurred. Narcan was administered to the child as a precaution, but the child was not responsive to the dose.

A previous resource provider to the child met the family at the hospital and told the reporter that they had spent time with the child and the mother on the night of May 16, 2025. The resource provider reported that the child experienced an asthma attack while playing at the playground and that the mother administered a prescribed nebulizer treatment to the child that same night.

The parents told the reporter that the child started feeling unwell around 9 p.m. on May 16, 2025, and woke up a couple of times throughout the night. The mother told LEA officers that the child slept throughout the day on May 17, and she checked on them periodically while allowing them to rest. The mother said that she observed the child breathing about 20 minutes

prior to finding them unresponsive and calling 911. The mother reported that she and the father were taking suboxone but had no further information about substance use by either parent.

LEA reportedly searched the home and found various vape pens throughout the home, but no illicit substances were found.

The Oregon Child Abuse Hotline (ORCAH) received another report about the same incident. The second reporter indicated that on the night of May 16, 2025, the child was being pushed by another child on a merry-go-round when the child injured their nose, causing bleeding. It was unknown how the injury occurred. The reporter expressed some concern for the level of supervision to the children provided by the mother but believed the bruise to be innocuous.

This report was granted an extension by ORCAH to gather further information about the allegations before making an assignment decision for CPS assessment.

The ORCAH screener spoke to a medical collateral on May 18, 2025, to learn more about the drug panel gathered from the child at the time of the critical incident. The medical professional indicated that the initial drug screen was positive for suboxone but was not overly concerned as these drug screens are prone to false positives, possibly due to Narcan administration in this case.

The ORCAH screener followed up with an LEA collateral on May 20, 2025. They indicated that the mother used suboxone but told the reporter that the child was not the type to put things into their mouth.

A CPS assessment was assigned on May 19, 2025.

The CPS caseworker coordinated contact with both parents, a relative and a family friend at the family home on May 28, 2025.

The family friend indicated that they were with the child at the park on May 16, 2025, around 3 p.m., along with their grandchildren. The friend reported that the child came up to them saying that they hit their nose, so the friend comforted them. The child then climbed on the picnic table, jumped down and continued playing for an additional two hours.

The mother reported that the child began to appear sick with symptoms of cough, nasal congestion and a low-grade fever around 9 p.m. on May 16, 2025. She stated that the child had

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a history of asthma, which presented with symptoms of wheezing, and that there were a lot of children from the child's pre-school who had gotten sick recently. The child woke up around 1 a.m. on May 17, and the mother administered children's cold medicine and a nebulizer treatment for their asthma symptoms. The father woke up around 4:30 a.m. and observed the child and the mother on the living room couch. The mother then brought the child back to their bed and they both went back to sleep. The child's bed was in the same room as the parents, close to their bed. The mother stated she got up about an hour later and began cleaning the house. The father's work shift got cancelled due to rainy weather. The parents decided to let the child rest on the day of the critical incident, and the mother checked on the child approximately every 30 minutes.

When the mother went to check on the child around 12:15 p.m., they appeared blue, apneic and unresponsive. The mother said that about 20 minutes prior to finding him unresponsive, the child was breathing independently but was asleep. The medical interventions that followed were in line with the statements made by the reporters.

Both parents met with LEA on the day of the critical incident and submitted drug screens. The mother reported she was prescribed 8 mg of suboxone twice a day, but the father used an injectable buprenorphine (suboxone). The parents reported that they had never seen the child pick something up and put it into their mouth. They cited one example where the child picked up a loose pill of Tylenol and they handed it to an adult.

LEA officers seized several items from the home during their investigation: some tin foil that was near the child's bed and appeared to be candy wrappers, the child's mattress, and the medications that the mother provided to the child during the early morning of the critical incident. LEA took photos of the home, and it was noted that there was a cupboard above the kitchen counter where the parents kept their medications. The mother's prescription of suboxone was located on the bottom shelf of the cabinet, with children's snack items on the shelf above it. Next to the prescription bottle, there was a halved pill of suboxone sitting outside the bottle. The CPS caseworker viewed this cabinet during their contact on May 28 and observed the same prescription bottle and loose halved pill of suboxone.

The CPS caseworker spoke to a medical provider collateral on May 30, 2025. The medical provider believed that the child's death was likely caused by buprenorphine overdose. They

indicated that a 2mg dose of buprenorphine would be a fatal dose to a 3-year-old child. However, an official cause of death was not available at the end of the CPS assessment.

The allegations of physical abuse by an unknown perpetrator were coded as unfounded. During the CPS assessment, there was no evidence that the child was physically abused, and allegations of neglect were better suited to the incident.

The allegations of neglect to the 3-year-old child by their parents were coded as founded. The mother kept their prescribed medication on the bottom shelf of a kitchen cabinet, along with snacks for children. There was a loose, halved pill of buprenorphine observed by LEA and ODHS on the day of the critical incident and in follow up observations of the home. The cause of the child's death was not known during the CPS assessment, but buprenorphine exposure appeared to be a contributing factor. The child was described as being very active, and while the mechanism of ingestion was unknown, it was plausible that the child crawled onto the counter and accidentally ingested the substance.

Relevant case history under the mother's case

Date of report: November 4, 2024

Assignment Decision: 72 Hours

Allegation(s): Neglect by the mother; Threat of Harm by the father

Disposition(s): Founded; Unfounded

ODHS received a report on November 4, 2024, alleging neglect and threat of harm to the child, who was 3 years old, by their mother. The reporter stated that early on the morning of November 3, 2024, the mother inhaled an unknown substance and overdosed in the bathroom of their home. The reporter stated that the father was concerned that the mother was not answering the door; he broke down the bathroom door, observed the mother was unconscious and administered Narcan to her. The reporter learned that the mother became responsive after this was administered but did not know if she sought further medical care. The sibling, who was 13 years old, had been out of their mother's care for years but was visiting the family at this time and witnessed the incident in the home. The child was also said to be present in the home

during the incident, but it was unknown what they observed. The mother reportedly said this was a single relapse, triggered by an argument with the father. The reporter did not have further information about conflict between the parents. The mother was said to be embarrassed about the event, but the reporter did not know about her planning for additional supports around substance use. The father was said to be in recovery and that he takes his sobriety very seriously.

There was a companion assessment involved with this report, listed under the case name of the sibling's relative caregiver with the same report date. The information between the two cases was the same, and the relevant CPS assessment activities are listed here.

The CPS caseworker contacted the 3-year-old child, the 13-year-old sibling and both parents at their home on November 4, 2024.

The father stated that around 7 a.m. on November 3, 2024, he heard the mother in the bathroom, followed by a thud. He went into the bathroom, saw drug paraphernalia nearby and recognized that she had overdosed. She was revived with Narcan. The father indicated that the child was asleep when this occurred, and the sibling was in their bedroom. The sibling heard the father banging on the bathroom door and came out to see what was happening before returning to their room. The father cleared the paraphernalia out of the bathroom. The father could not recall the sibling's response as he was focusing on the mother during the incident. The father was aware of the mother's history with substances but indicated she had been in recovery for one year and believed this to be a single incident of relapse.

The mother said that she had been struggling with mental health symptoms and decided to procure fentanyl. She reported attaining it on November 2 and using it on the morning of November 3, 2024.

The sibling reported that they heard the father yelling and banging on the bathroom door. The sibling left their room to observe but returned to their room. The sibling denied knowing what happened to the mother but believed that they had relapsed. They had no knowledge of the mother using substances in the past year besides this instance. The sibling did not express fear or anxiety around the incident and appeared calm during the interview. The sibling reported that the child was asleep in their bed during the occurrence.

The child was observed to be happy and at ease with the parents. The child was difficult to interview due to their activity level, but they seemed unaware of the incident.

The CPS caseworker spoke to relative collaterals who denied knowledge of the mother using substances outside of this occurrence. The relative provider to the sibling indicated that the mother had made significant progress in maintaining sobriety and they felt it was safe for the sibling to visit the home.

The CPS caseworker spoke to the father's community supervision officer, who had no concerns. The father was said to be maintaining sobriety and doing well.

During the CPS assessment, the mother accessed supportive services, concluded treatment and had shifted to relapse prevention planning.

The allegation of threat of harm to the child by their mother was coded as founded. The mother used fentanyl and overdosed in the bathroom while the children were present. The father administered Narcan, which revived the mother. The sibling reported hearing and observing the incident but appeared unimpacted by the incident. However, there was reasonable cause to believe that there was a threat of severe harm placed on the child due to their developmental level and because of the mother's substance use.

The allegation for neglect was coded as unfounded, as the information gathered through CPS assessment was more in line with concerns for threat of harm.

Date of report: October 7, 2021

Assignment Decision: 24 Hours

Allegation(s): Neglect by the mother; Threat of Harm by the father

Disposition(s): Founded; Unable to Locate

ODHS received a report on October 7, 2021, alleging neglect to the child, who was a newborn, by their mother and their father. The reporter stated that the child was born on this day. The child was having difficulty breathing and experienced symptoms of neonatal abstinence syndrome due to exposure to heroin in utero. The mother reported that she used heroin daily for the previous six years, and her last use was the night prior to the report. The reporter did

not have much information about the father, but reported he was actively using methamphetamine and heroin. The mother had one prenatal appointment, and it appeared that the family did not have items prepared for the child's discharge. The mother had an older child who was out of her care due to safety concerns, primarily substance use.

ODHS had contact with the mother and newborn child on October 8, 2021, at the local hospital where the child was delivered. The mother stated that she was seen once for prenatal care around 7-8 months gestation. At this visit, she was prescribed suboxone, which she did not adhere to. She reported daily use of heroin via IV, methamphetamine use, though it was not a drug of choice, and frequent marijuana use. The mother said she was unable to care for the child at this time due to her struggle with substance use but had decided to engage with supportive services in order to safely parent them in the future.

Medical records indicated that the child was exposed to heroin, methamphetamine and marijuana in utero. The child experienced abstinence symptoms such as shaking, fussing and feeding difficulties. These symptoms were managed at the hospital during the child's first days of life. The father was not present during the child's birth.

The CPS caseworker did not contact the father throughout the CPS assessment, although he was invited to participate in an interview and to attend family meetings. Relative collaterals indicated that the father was not interested in seeking supportive services for substance use concerns or actively parenting the child. The father was believed to be houseless in the local area.

The mother did not have custody of her older child due to ongoing concerns for substance use, which had not been ameliorated. The child was placed in the care of a relative with an out-of-home safety plan.

The allegation of neglect to the newborn child by their mother was coded as founded. The child experienced neonatal abstinence syndrome due to substance exposure in utero. The mother acknowledged she was not in a position to safely parent the child following their birth. The allegation of threat of harm to the child by their father was coded as unable to locate. Despite numerous attempts during the CPS assessment, he did not make himself available to ODHS for assessment or planning.

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Date of report: September 16, 2021

Assignment Decision: Closed at Screening

Allegation(s): Not Applicable

Disposition(s): Not Applicable

ODHS received a report on September 16, 2021, with concerns for the child who was in utero by their mother and father. The reporter stated that the mother had not sought any prenatal care and was actively using heroin throughout her pregnancy. The father was reported to use methamphetamine and heroin.

The report was closed at screening because the child was unborn, and it was not a report of abuse.

Date of report: November 27, 2017

Assignment Decision: 24 Hours

Allegation(s): Neglect by the mother and father

Disposition(s): Founded

ODHS received a report on November 15, 2017, alleging neglect to the sibling, who was 8 years old, by their mother and father. The reporter stated that the sibling experienced frequent urinary tract infections. They were seen by a medical provider on this day because there was blood in their urine. The sibling stated that they saw blood in their urine for about two weeks and no one brought her in until this day. The mother's significant other accompanied them to the appointment. The reporter indicated that they were able to speak with the sibling alone during this visit. The reporter asked the sibling general safety questions. The sibling reported that the family does not have a lot of food, and the sibling experienced hunger frequently. When asked about drugs and alcohol, the sibling stated that she observed people in the home smoking from a pipe, and their eyes would roll up. On one occasion, the sibling came into the bathroom and observed the mother touching her arm – which appeared red – and the mother told them that it was because of medicine.

This report was assessed alongside the report dated November 15, 2017. See the narrative for that report for further information regarding these allegations.

The allegations of neglect to the sibling by their parents and the mother's significant other were coded as founded. See the report dated November 15, 2017, for justification on these dispositions.

Date of report: November 15, 2017

Assignment Decision: 24 hours

Allegation(s): Neglect by the mother and father

Disposition(s): Founded

ODHS received a report on November 15, 2017, alleging neglect to the sibling, who was 8 years old, by their mother and father. The reporter stated that both parents used heroin and methamphetamine. When the sibling was at school, they were observed to be distant and tired. The sibling told the reporter that they didn't get much sleep because there is constant arguing in her home between the parents. The reporter made attempts to meet with the mother, which did not occur. Extended family members told the reporter that the mother would not meet with the reporter because she was often under the influence and did not want to be observed in that state.

The CPS caseworker had unannounced contact with the sibling and both parents at their home on November 16, 2017. The caseworker viewed the home, which smelled of marijuana and cigarettes. The home was cluttered but was not unsafe for children. The caseworker observed a bong by the mother's nightstand, which she reported was a souvenir and was never used. There was sufficient food in the home. The caseworker requested a UA from both parents, and they indicated that they would complete it the following day, which did not occur.

The CPS caseworker and Recovery Support Team lead attempted contact on November 20, 2017. The parents had left a note on the door that indicated they were out of town but would contact the caseworker.

The CPS caseworker attempted unannounced contact with both parents and the sibling on November 28, 2017, following the report dated November 27, 2017. There was no answer at the door.

The CPS caseworker went to the sibling's school on November 28, 2017, and interviewed the sibling. The sibling reported that they did not feel safe in the home with their parents; there were a lot of people that came in and out of the home. The sibling stated that the parents did not feed them, and they were often hungry. When the sibling would ask the mother for food, the mother would tell them that they were tired and to eat whatever was in the home. The sibling reported that the mother used her bong a lot, and the sibling reenacted out how it was used. The sibling disclosed the reported incident; that one time they went into the bathroom and the mother was putting something into her arm, said it was medicine and asked the sibling to leave. The sibling also reported that there were two adults who frequented the home, whom were both known to ODHS as people who used substances and had concerns for safety around children.

After the contact at school, the CPS caseworker attempted to contact both parents several times, via phone and unannounced at their home without response.

On December 6, 2017, the CPS caseworker received a call from a local mental health crisis worker, who indicated that the sibling was experiencing suicidal ideation. The caseworker went to the sibling's school to speak with school staff and the crisis worker. Both parents also responded to the school regarding this.

The crisis worker attempted to safety plan around the sibling's suicidal ideation, and ODHS implemented a protective action plan due to the concerns regarding substance use in the home. Both parents appeared defensive and erratic during their interviews and stated that the concerns were hearsay. The father did not believe that the circumstances in the home were unsafe and stated that the crisis worker had introduced the idea of the sibling feeling unsafe. The caseworker requested UAs for both parents the following day, which were not submitted by either parent. On December 7 and December 8, 2017, the parents were provided referrals for UAs that were not submitted. ODHS implemented the protective action plan, with the sibling placed in the care of their relative.

The CPS caseworker spoke with a relative collateral on December 8, 2017. The relatives reported that the mother was using and dealing substances for about two years. One time, the

father had gone to the mother's home and could not wake her up, presumably due to intoxication from an opiate. The relative indicated that the father sought supportive services in March 2017 but left after a week without completion. The relative stated that both parents would become evasive when they used substances, and that the father's eyes would become dilated. The relative reported that the mother would travel to another city to pick up substances. The relative indicated that they were in recovery from substances and were familiar with the signs of active use. They believed that both parents were actively using, the father both heroin and methamphetamine, and the mother heroin.

The allegations of neglect to the sibling by their parents were coded as founded. Through CPS assessment, it was learned that the parents allowed multiple individuals into the home who were known to use substances. There were numerous concerns that both parents were using substances, though neither parent submitted UAs during the CPS assessment. While there was sufficient food noted in the home during initial contact on the first report of abuse, the caseworker was not able to view the home after the child expressed that they did not get enough food.

Date of report: September 22, 2016

Assignment Decision: 24 hours

Allegation(s): Physical Abuse, Threat of Harm and Neglect by the mother

Disposition(s): Unfounded

ODHS received a report on September 22, 2016, alleging physical abuse, threat of harm and neglect to the sibling, who was 7 years old, by their mother. The reporter stated that the parents were experiencing relationship problems and were in the process of divorce. The father believed that the mother was using heroin, that she had been using marijuana since the previous winter, and that she was in a relationship with another individual who used heroin. The parents argued about this, and the sibling told the reporter that the parents shouted at each other. One time, the parents were arguing, and the mother pushed the father, who fell back and landed on the sibling. Three weeks prior to this report, the reporter observed bruising near the sibling's hip. When the reporter asked the sibling about the bruise, the sibling indicated that they talked back to the mother, and the mother caused the bruise somehow. The

reporter added that a month ago, they had the sibling in their care and the mother came to pick up the sibling. The reporter observed the mother to have dilated pupils, and the mother told the reporter that she had been drinking. The reporter said that the mother did not smell of alcohol, and they allowed the sibling to go with the mother. The reporter was concerned with the sibling's wellbeing; the sibling was experiencing symptoms of decreased self-worth due to the concerns in the mother's home.

The CPS caseworker met with the mother and the sibling separately at school on September 23, 2016, and viewed the family home later on the same day. The sibling did not disclose any physical abuse by the mother or note any concerns while in the mother's care. The sibling did share concerns about the father, but not with the relatives who were present when the sibling spent time with him. The sibling reported that the parents would argue with one another, but only disclosed yelling between them.

The mother declined a UA due to a medical concern that caused bleeding. She reported that she previously struggled with methamphetamine use but had been clean from that substance since 2011. The mother started smoking marijuana within the last year and would drink up to three beers in one sitting. The mother indicated that the father began using methamphetamine about five months earlier, and that this was a contributing factor to their separation.

The CPS caseworker attempted to contact the father numerous times throughout the assessment. Attempts to contact were unsuccessful, and on one occasion the father ignored the caseworker who observed him from the door. On a subsequent attempt on November 7, 2016, the father agreed to meet with the caseworker and Recovery Support Team lead on his front porch. Both workers believed the father was under the influence of a stimulant based on fidgeting and erratic speech, but he did not speak to the allegations. The father declined a request for UA and referrals for supportive services.

The allegations of physical abuse, threat of harm and neglect to the sibling by their mother were coded as unfounded. The mother had begun using marijuana in the previous year, but there was no evidence supporting the mother used heroin or methamphetamine. There were no physical marks on the sibling at the time of the CPS assessment, and the sibling did not disclose any concerns while in the care of the mother.

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Relevant case history under the sibling's resource care provider's case

Date of report: November 4, 2024

Assignment Decision: 72 hours

Allegation(s): Neglect by the mother

Disposition(s): Founded

ODHS received a report on November 4, 2024, alleging neglect to the sibling, who was 13 years old, by their mother. This report reflects the same information that is documented above under the same-date report summarized under the mother's case. Please see that summary for further information.

The allegation of neglect to the sibling by their mother was coded as founded. The mother used fentanyl and overdosed while they had family time in their home with the sibling. The sibling observed the incident and returned to the care of their relative immediately afterwards.

Relevant case history under the daycare provider's case

Date of report: July 7, 2022

Assignment Decision: 24 hours

Allegation(s): Physical Abuse by the daycare provider

Disposition(s): Unfounded

ODHS received a report on July 7, 2022, alleging physical abuse to the child, who was 9 years old, by their daycare provider. When the child returned from daycare, the child's resource care provider observed three separate, half-inch lineal bruises on their left knee.

The OTIS investigator spoke to LEA collaterals and the resource parent via phone on July 8, 2022. The investigator provided photos of the injuries to the local Child Advocacy Center (CAC) and coordinated a forensic medical exam for the child. The resource parent agreed that the child would not return to daycare with that provider until the allegations were assessed.

The resource parent indicated that they observed the bruising when changing the child's clothes on the morning of July 7, 2022. The resource parent observed the bruises to be purplish brown. The resource parent reported that the child recently became mobile. They said that the child used their left leg to push up when starting movement and was the first leg they set down when sitting. The provider indicated that the child did not appear bothered by the bruise; the provider had put light pressure on the area without response from the child. The provider could not attribute a time or occurrence where the child could have been injured.

The provider said that the child was moving all the time now that they were mobile. The provider said that the child had been attending daycare with the daycare provider since they were 3 months old, for 40 hours every week. The resource parent did not have concerns for the child's care with the daycare provider.

The child was seen at the local CAC on July 8, 2022. The report indicated that the bruising may have been caused by fingers grabbing the child's lower leg, though the medical provider had difficulty re-creating how this could have occurred; there was doubt that the child was pulled by the leg. It was noted that the child was newly mobile, and this was the first documented instance of bruising. The daycare provider and resource parent had a history of being reliable caregivers and the CAC recommended no further intervention but to monitor for other bruising or a change in the child's behavior.

The OTIS investigator spoke to the daycare provider on July 27, 2022. The provider said that the child had been in their daycare since January 2022. The provider indicated that they were unaware of any bruising to the child until the resource parent told them about it. The provider reported that on the day of the incident, they could not recall a time where the child experienced pain throughout the day. When the child was at the home on this day, the provider had them in their bed and the child was crawling around and playing. While the child was on the bed, they tumbled over and the provider heard a thump, which they thought was the child's head. The child did not cry after the thump and the provider looked down and saw them lying near the foot of the bed kicking their left leg, which the provider presumed caused the bruising.

The OTIS investigator received results from the skeletal survey that was conducted during the forensic medical exam at the CAC. There was nothing remarkable from the report; no fractures or abnormalities were seen.

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The OTIS investigator spoke to several collaterals about the allegations, none of whom had concerns for the child while in the resource parent or the daycare provider's care.

The allegation of physical abuse to the child by their daycare providers was coded as unfounded. The daycare provider described an incident where the child was playing on the provider's bed, which may have caused the bruising. The child was newly mobile and was described by multiple individuals to have high energy. There was no other information that the bruising had been intentionally inflicted to the child, and it was likely accidentally self-inflicted.

Concerns regarding actions taken or not taken

The CIRT observed an improvement opportunity in this case around staff knowledge of Medication Assisted Treatment (MAT) and the toxic potential of buprenorphine to children if ingested. The CIRT noted that overdoses from buprenorphine are rare but can be fatal to young children. In this case, there was a loose, halved pill from the mother's prescribed dose that was in an area accessible to the child. The halved pill was enough for fatal overdose of a small child. The CIRT observed that there are differences in the degree of oversight and safety precautions offered to patients who access MAT through dedicated Opioid Treatment Programs (OTP) compared to community providers who prescribe the medication (e.g. OTPs may offer lockboxes on site to people accessing treatment, whereas this is not a common practice at pharmacies). However, prescriptions are dispensed in child safe containers from a pharmacy, and patients are counseled by pharmacists and provided documentation about medication.

Per the CIRT, building knowledge among ODHS staff about the potential for child-overdose and differences between providers and was an opportunity for improvement. In the CPS assessment dated November 4, 2024, the mother experienced an overdose from fentanyl. The child welfare practice during this assessment was complimented by the CIRT; the caseworker sought collateral information, made referrals for supportive services and supported the development of a relapse prevention plan by the mother. The mother was apparently not accessing MAT at this time, though it was unclear if discussion took place around MAT specifically. The CIRT believed that the content of internal ODHS trainings could be improved around this nuanced facet of recovery.

Recommendations for improvement

The CIRT recommends that representatives from the Child Fatality Prevention & Review Program and Training and Workforce Development consult with Oregon Health Authority and local Recovery Support Teams and the Child Safety Program to assess current offerings to ODHS staff and strategize for increasing workforce knowledge about the potential dangers of accidental exposure to prescription medications, with particular focus given to buprenorphine and the availability of prevention kits at each ODHS office. Any strategies to improve workforce knowledge will be identified by end of February 2026, with plans for implementation.

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