Domicile Unknown

Review of deaths among people experiencing homelessness in Multnomah County in 2024

December 2025

Multnomah County
Health Department

Table of Contents

Foreword

This report describes the causes of death among 372 community members experiencing homelessness in Multnomah County in 2024, the most recent data available. Each person represented in this report had a meaningful story; their deaths were tragic and most were preventable. These community members were people that our outreach teams connected with and clinicians cared for — we were impacted by their lives, and we keep their stories close to our hearts.

The Multnomah County Health Department compiles this report each year with the goal of understanding the primary contributions to the risks these community members faced. In 2024, federal data showed that at least 7,000 community members experienced homelessness on a given night in Multnomah County.[1] Not having housing is associated with numerous poor health outcomes and ultimately results in a higher likelihood of early mortality compared to having housing.[2] The data presented here reveal not only the number of people who died while experiencing homelessness, but also how they died, underscoring the risks inherent in not having housing.

Although the numbers in this report remain too high, we are encouraged that they are lower than the number of deaths reported for 2023. Currently, there are thousands of people in Multnomah County receiving services to help them on their path to housing and recovery. The data in this report can support positive change by revealing the risks that our unhoused neighbors face, helping us prioritize interventions like increased resources, safe and stable housing options, and access to behavioral and physical healthcare. We are devoted to continuing to support people experiencing homelessness and are hopeful for a continued downward trend in deaths.

Thank you for joining us in recognizing and honoring those we have lost. Together we are creating a safer and more caring Multnomah County.

Richard Bruno, MD, MPH
Health Officer, Multnomah County Health Department

Emily Mosites, PhD, MPH
Epidemiology Manager, Multnomah County Health Department

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1   2024 AHAR: Part 1 - PIT Estimates of Homelessness in the U.S.
2   The health of homeless people in high-income countries: descriptive epidemiology, health consequences, and clinical and policy recommendations - PubMed

Executive summary

In 2024, 372 deaths (51 from Vital Records and 321 from Medical Examiner) occurred among people experiencing homelessness (PEH) in Multnomah County, marking an 18% decrease in yearly total mortality among PEH since a peak of 456 deaths in 2023 (Figure 1). The high-point of deaths in 2023 coincided with the peak of deaths from fentanyl, which affected local jurisdictions across the United States, as well as Multnomah County.[3,4] Three years of data on deaths among PEH from both Medical Examiner (ME) data and Vital Records data are now available since the passage of Senate Bill 850, which as of Jan. 1, 2022, required recording an individual's housing status at death.

Most deaths among PEH fell under the jurisdiction of the ME, with the majority of deaths being accidental in manner (Figure 3). The majority of accidental deaths among PEH were due to drug overdose (N=214) (Figure 6). Synthetic opioids (mainly fentanyl) contributed to a large proportion of overdose deaths (86%), as did psychostimulants (mainly methamphetamine, 82%) (Table 2).

Both an opioid and a psychostimulant were identified in 71% of drug overdose deaths (Table 2). For drug overdose deaths in which only a psychostimulant was identified, decedents were on average six years older at the time of death compared to those with an opioid but no psychostimulant. Compared to the general population of Multnomah County, PEH had a 40-times-increased risk of death from drug overdose (Figure 12).

Transportation deaths continued to be a pressing concern among PEH; there were 19 total transportation deaths in 2024, 16 (84%) of which were among pedestrians or cyclists (Figure 6). Compared to the general population of Multnomah County, PEH had 23 times the risk of death due to any transportation incident, and 54 times the risk for pedestrian or cyclist transportation incident (Figure 12). Pedestrian and cyclist incidents were generally clustered in the darker hours before sunrise and after sunset (Figure 7).

Thirty deaths among people experiencing homelessness were due to assault (N=17) or self-harm (N=13) (Figure 4). Firearms were the most common mechanism of death for assaults (13 of 17, or 76%) (Figure 6). Compared to the general population of Multnomah County, PEH had a 24-times-increased risk of death from assault and seven-times-increased risk from suicide (Figure 12).

The average age at death among PEH in Multnomah County was 48 years — 30 years younger than the current U.S. life expectancy at birth.[5] Nearly half of all deaths among PEH occurred among people 35-54 years of age (Table 1). When limited to drug overdose only, the average age at death among PEH was 44 years (Table 2). A larger proportion of decedents were Black/African American and American Indian/Alaska Native compared to the population in Multnomah County overall. Structural racism and exclusionary policies that constrain access to housing and healthcare are underlying causes of the inequities in mortality among PEH by race.[6]

3   https://multco.us/news/board-declares-90-day-fentanyl-state-emergency-county-city-and-state-coordinate-response
4   http://publichealth.lacounty.gov/chie/reports/Homeless_Mortality_Report_2025.pdf
5   https://www.cdc.gov/nchs/products/databriefs/db521.htm
6   Richard, M. K. Homelessness and race: The impact of structural conditions on Back, White, and Latine homelessness." Social Problems. https://doi.org/10.1093/socpro/spaf044

The most common place of death among PEH was outdoors (Figure 10). Deaths occurred across Multnomah County, generally in higher concentrations in downtown, North/Northeast Portland and inner Southeast Portland. By ZIP code, most incidents occurred in 97209 (Pearl District/Old Town; 35 deaths) and 97266 (Lents/outer Southeast; 25 deaths) (Figure 11).

In 2024, the all-cause mortality among PEH was six times higher compared to the general population of Multnomah County after adjusting for age. The reason for this heightened risk is complex and due to intersecting factors. Multiple causes both lead to homelessness and increase health risks, including lack of affordable housing, racial injustice, lack of social support systems, substance use, mental health challenges, trauma, and a lack of access to physical and behavioral healthcare.

Additionally, homelessness itself contributes to risks that increase the likelihood of death. The Multnomah County Strategic Plan emphasizes decreasing net homelessness and supporting access to stable housing for youth and families.[7] Reducing the risk of death among people experiencing homelessness requires coordinated public health, healthcare and housing interventions.

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7   FY26-FY28 Strategic Plan: Web version | Multnomah County

Tony Jamar Samuel

Born Dec. 26, 1988. Died Dec. 3, 2024. Age 35.

A life of potential lost to substance use

Tony Jamar Samuel was found alone in a hotel room on Southeast 82nd Avenue in Portland on Dec. 3, 2024. He died from an overdose of a fatal combination of fentanyl and methamphetamine. He was 35.

Tony was a quiet child, raised in a working-class family in Columbus, Ohio. He did not have any friends and was often bullied, his family said. His difficult childhood was marked by abuse from his father — toward Tony, his sisters and his mother. Yet, like many other young kids, Tony was happiest when he beat the video game Super Mario Bros. 3 in one try.

The persistent abuse and isolation led Tony to keep to himself, but he always wanted to learn about the world.

"He was a little researcher," said his sister, Valerie. "He was always researching things because all he had was basically himself."

Tony was smart. He was good with computers, and his academic interests kept evolving — from astrology to law to nursing. "It changed every year, but he always wanted to research. He was very intelligent."

Valerie was the closest person in Tony's life.

"I'm nine years older than him, but people used to think I was his mother, because we were just that close," she said.

When Tony was 7 and Valerie was 16, their father went to prison. But the trauma left by his abuse was lasting, contributing to Tony's life-long struggle with depression.

Despite his challenging home life, Tony graduated from high school and studied at Columbus State Community College, Ohio State University, Hocking College in Ohio, and then, eventually, at Mt. Hood Community College in Gresham. Valerie believes he studied either information technology or general research.

Tony identified as gay and found belonging through LGBTQ2S+ football and softball leagues in Columbus.

Tony started smoking marijuana at 17, but did not use harder drugs until he was 30, Valerie said. Substance use, however, was a persistent undercurrent throughout his years in college.

Between 2018 and 2019, after a tumultuous five-year relationship with his boyfriend, Tony endured multiple mental health crises. He stayed twice at a behavioral health hospital in Columbus.

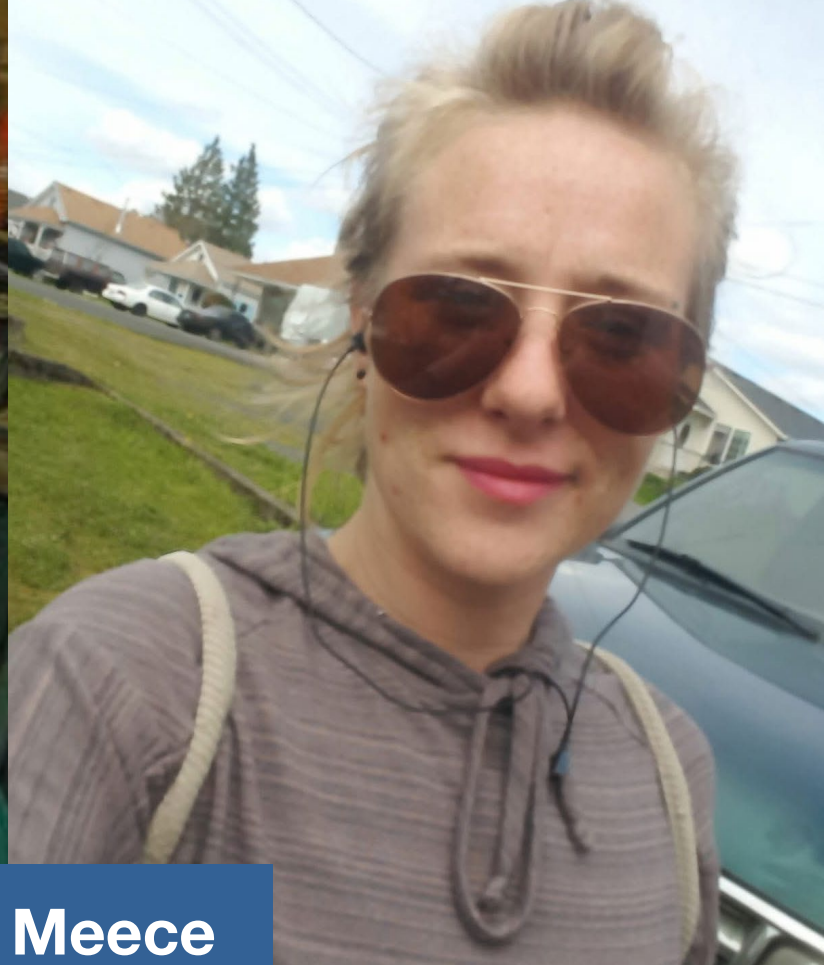"He was suicidal and wanted help," Valerie said.

Around 2020, Tony married. However, his husband died of an overdose just two weeks before Christmas that year, sending Tony into a devastating spiral. His drug use escalated, leading to a terrifying incident on Christmas Day when he became extremely violent toward his sister and mother.

The next day, his birthday, was the last time Valerie saw her brother.

The last four years of Tony's life remain unclear — a patchwork of scattered communications and social media posts. Valerie doesn't know when Tony arrived in Portland, receiving only sporadic text messages and voicemails from him until 2022, when he stopped communicating entirely. She did not even know Tony was in Portland until she received a call saying he had died.

Based on Tony's Facebook page, Valerie now knows he attended Mt. Hood Community College in the fall of 2023. His final post, an image of a mountain, was dated Oct. 20, 2023.

What happened during Tony's last year alive remains unknown. Valerie still struggles with her final memories of her brother. However, Valerie chooses to remember her brother as he was before he struggled with substance use and they lost touch. "He was a very kind soul. He was very caring. He was very sweet. And I was proud to have him as my brother."

Samantha "Sammy" Jo Meece

Born Jan. 21, 1983. Died Jan. 11, 2024. Age 40.

An outgoing, caring old-school hippie at heart

Samantha "Sammy" Jo Meece died Jan. 11, 2024, after taking a fatal combination of fentanyl and methamphetamine in the Pearl District in downtown Portland. She was 40.

Growing up in Sheridan, Wyoming, Sammy was happy and outgoing. She loved playing with her Barbies, listening to music and eating strawberry shortcake.

Her early childhood was challenging — her absent birth mother struggled with alcohol use disorder. But her father, who also struggled with alcohol, remarried when she was 3. That new relationship brought Sammy and her sister, Charlie, into a more stable home environment.

"Besides the first three years of her life, she did well," said her brother, Rick. "She had friends. She grew up with a very supportive, loving family. The only mom she knew was my mom — Sammy's stepmom — taking care of her, getting her to school, making lunches, being a supportive mom."

As a young adult, Sammy always dreamed of "moving to the West," Rick said.

Before she left Wyoming, she gave birth to her daughter, Elise. A few years after Elise was born, Sammy left her in the care of Elise's father, and made the move to St. Helens, Oregon. Sammy would eventually lose contact with her daughter.

Sammy worked in hotels and restaurants. She would tell Rick how much she enjoyed Portland's concert scene and her friends in the music community. She loved to skateboard.

"She was an old-school hippie at heart and started using marijuana recreationally after work and on the weekends once she moved to Oregon," Rick said. "But she did not have a history of mental health problems or drug use."

In 2020, she began working at the Pour House bar in St. Helens after meeting the owner, Shannon.

"When Sammy started working for us, I realized that she had some drug issues," said Shannon. "She was a very sweet girl, heart of gold. Just messed up."

It was only in the last two years of her life, after Sammy lost her job at the end of 2022 and began seeing a new boyfriend, that things took a quick turn, both Rick and Shannon said.

"It went from hearing that she was working and people were helping her, to now she's not going to work, she's homeless and she's with the wrong company," Rick said, noting Sammy's decline happened in a matter of months.

Sammy went to Reno with her boyfriend at the beginning of 2023, where they both ended up getting arrested, and Sammy eventually landed on the street in the city. A month later, Shannon paid for a train ticket back to Portland when Sammy had reached out and said she was sober. But Shannon never would see her again.

"Here's someone who's so positive, and it came out of nowhere," said Rick. "When we found out she had died, it was a surprise. We knew she was doing drugs, and we knew she had probably upped the drugs, but hearing that, wow, she overdosed — it came as a shock to us."

Even while using drugs, Sammy remained a good-hearted person, Rick said. Her family and friends continued to receive messages from her on Facebook saying, "Hey, hope you guys are doing well."

"Sammy could have done anything 'cause she was just the sweetest thing," Shannon said. "She didn't realize what she was worth, and that was very sad. I think that she could have been a great counselor for people who had been through a lot."

Rick described Sammy as a fun-loving person who was outgoing, cared about others, loved to laugh and was a great conversationalist.

"She's got so many people that care about her, so many great memories," he said. "Sammy was the type of person that would talk to you, and you'd like her from the get-go."

Benjamin "Ben" Donald Sizemore

Born April 26, 1983. Died Jan. 15, 2024. Age 40.

Extreme mental illness leads to years on the streets

Benjamin "Ben" Donald Sizemore died Jan. 15, 2024, after an overdose of methamphetamine in the Buckman neighborhood of inner Southeast Portland. He was 40.

Born with multiple diagnosed and undiagnosed neurodevelopmental conditions, including Tourette Syndrome and autism spectrum disorder, life started hard for Ben and never became easier. He grew up in Vancouver, Washington, with his brother and parents.

Ben's brother, who is four years older, described their family as dysfunctional and their childhood as "hellish."

As he got older, Ben displayed symptoms that often accompany bipolar disorder, histrionic personality disorder and schizophrenia. Medical professionals struggled to provide effective help.

Ben's brother, who asked not to be identified, recalled a social worker visiting their home when Ben was very young. But beyond that, he believes whatever systems that might have helped his brother and their family failed to genuinely intervene.

The school system, in particular, "did not do us any justice," his brother said. "Our parents were not mentally, financially or physically prepared to handle Ben's conditions."

Ben's parents separated when he was 10.

"With our parents' inability to comprehend what was going on, and they were more or less fed up with his behavioral issues, it ended their marriage," his brother said.

Ben began smoking marijuana at age 13 and dropped out of school before ninth grade. He struggled to stay on prescribed medication, opting instead to self-medicate with substances.

For the rest of his life, Ben cycled between jail, mental health facilities, low-income housing and the streets.

His last known address was a day center. Records show he had also lived in a low-income, alcohol- and drug-free housing community and other subsidized housing.

The brothers last saw one another 24 years ago. Ben showed up at his brother's apartment in Phoenix out of the blue after he was discharged from a behavioral health facility.

"I hadn't seen or legitimately spoken to him in quite a while," his brother said. "I got up to get ready for work, and he's lying on my couch.

He got from somewhere in the Northwest to Phoenix without them knowing, and he got in without me knowing. He's pretty good at stuff like that."

Ben's brother told him he needed to get his life together and gave him some money, some basic supplies and a bus ticket back to Portland.

Even if he had known that was going to be his final conversation with Ben, without the treatment that eluded Ben throughout his life, his brother isn't sure anything about Ben's life would, or could, have changed.
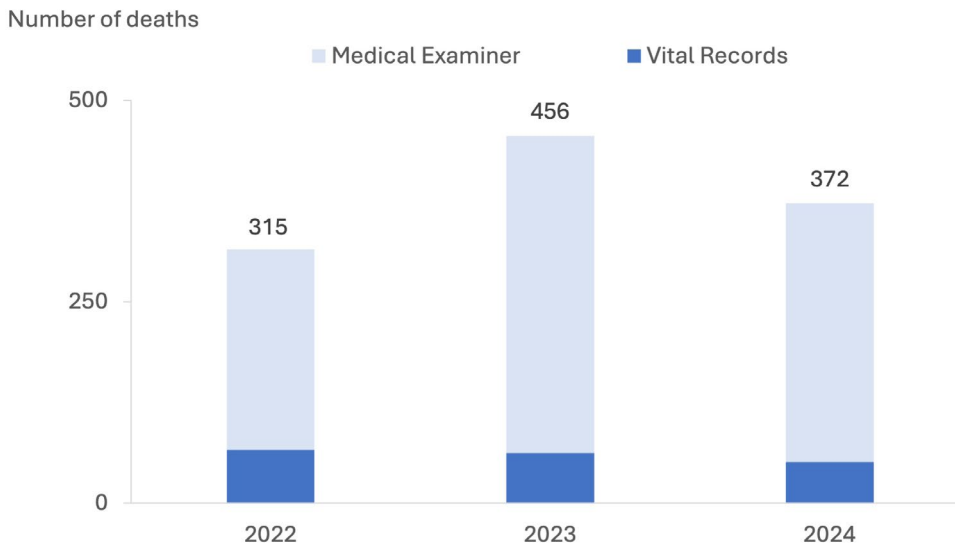
"Is that even possible?"

Findings and takeaways

In 2024, data on 372 deaths among people experiencing homelessness (PEH) were available from Medical Examiner (ME) records and Vital Records (VR).
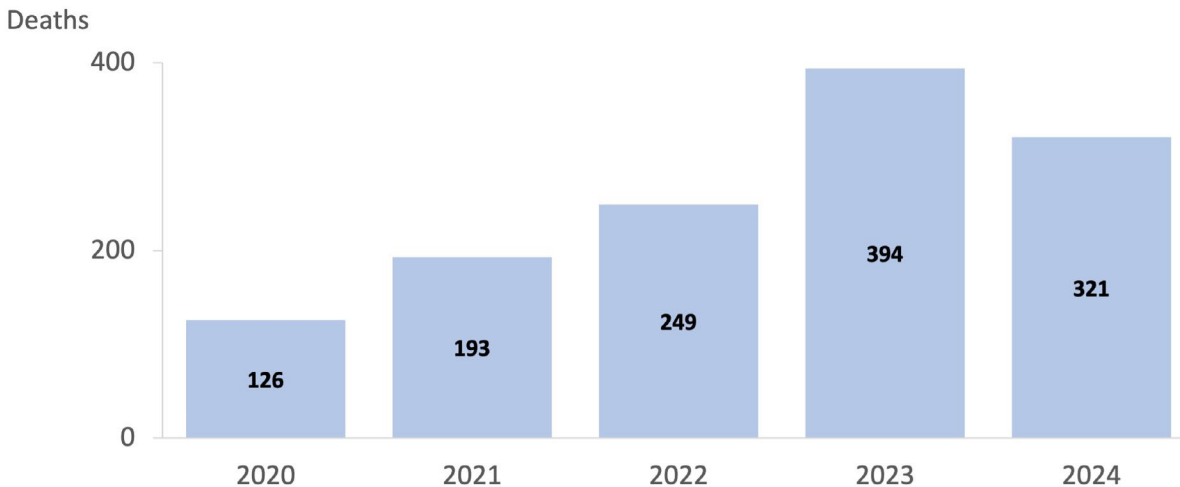
The total number of deaths among PEH, from both ME and VR data, declined by 18% in 2024 from 2023.

Figure 1. Total deaths among people experiencing homelessness in Multnomah County by data source, 2022-2024

In ME data alone, the number of PEH deaths declined 23% between 2023 and 2024, after a sustained rise since 2020.
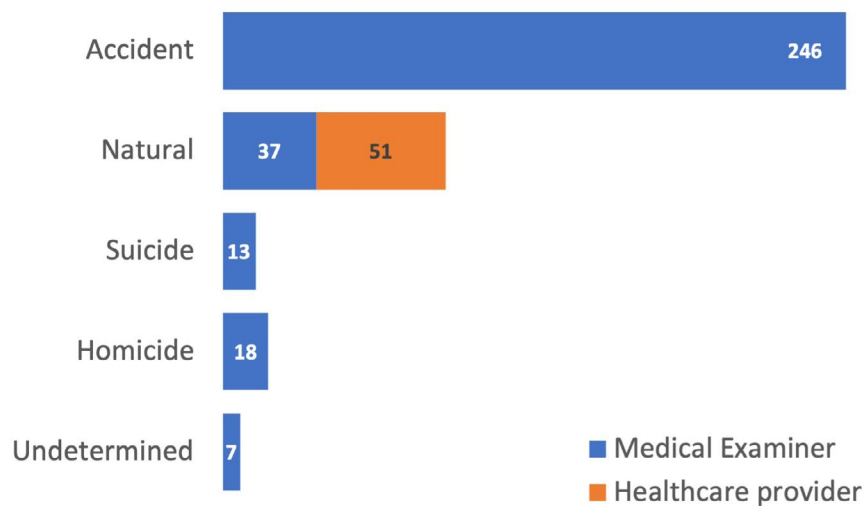
Figure 2. Total ME deaths among PEH by year, Multnomah County, 2020-2024 (N=1,283)*

*Note: This analysis does not include PEH deaths for which a healthcare provider signed the death certificate, since data on those deaths were only available starting 2022 (see methods in the Appendix for more details).

The most common manner of death among PEH was accidental, followed by natural.

Figure 3. Manner of death among PEH in Multnomah County, 2024, by signer of death certificate,* ME and VR data (N=321)

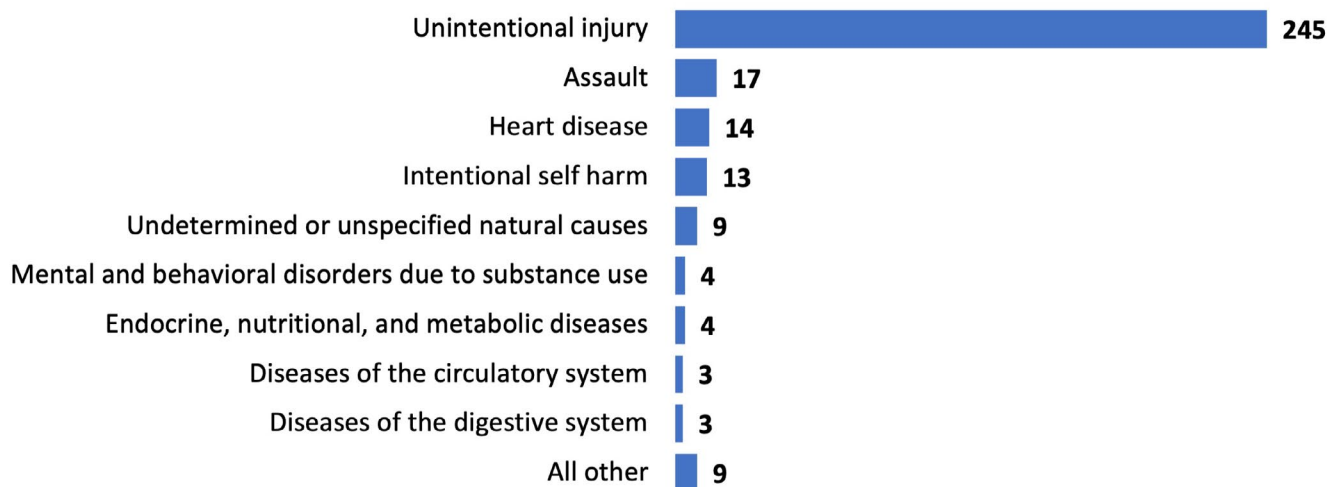*A healthcare provider can be a physician, physician associate or nurse practitioner

"Manner of death" is a medical classification of the circumstances around the death. Manner of death definitions are included in the Appendix; deaths due to drug overdose are included under accidental deaths. The deaths investigated by the ME fell into accidental, natural, suicidal, homicidal and undetermined categories (Oregon Revised Statute chapter 146).[8] All deaths from Vital Records were of natural manner and were certified by a healthcare provider. Among all 88 deaths categorized as natural, healthcare providers certified more than half (58%).

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8   https://www.oregonlegislature.gov/bills_laws/ors/ors146.html

Unintentional injuries, including drug overdose, were the largest contributor to deaths among PEH in the ME data.

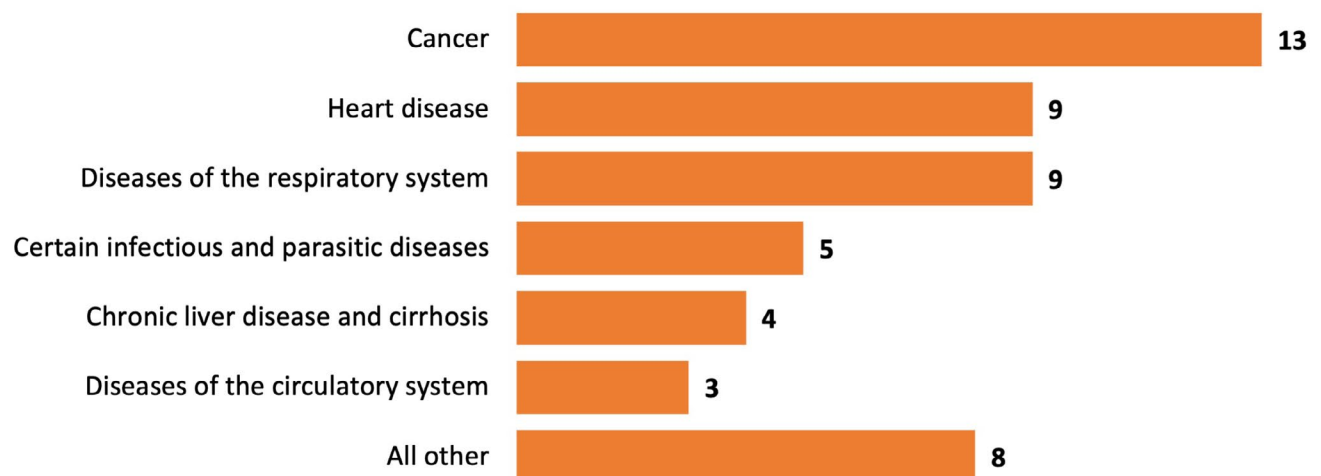**Cancer was the leading cause of death in the VR data.**

Figure 4. Leading causes of death among PEH in Multnomah County, 2024, ME data (N=321)

Cause	Count
Unintentional injury	245
Assault	17
Heart disease	14
Intentional self harm	13
Undetermined or unspecified natural causes	9
Mental and behavioral disorders due to substance use	4
Endocrine, nutritional, and metabolic diseases	4
Diseases of the circulatory system	3
Diseases of the digestive system	3
All other	9

Note: Diseases of the circulatory system exclude heart disease, which is captured separately.

Among ME cases, unintentional injuries made up the largest proportion of deaths (N=245, 76%). Assault was the next largest category (N=17, 5%), followed by heart disease (N=14, 4%). Suicide accounted for 4% of the total (N=13).

Figure 5. Leading causes of death among PEH in Multnomah County, 2024, VR data (N=51)

Cause	Count
Cancer	13
Heart disease	9
Diseases of the respiratory system	9
Certain infectious and parasitic diseases	5
Chronic liver disease and cirrhosis	4
Diseases of the circulatory system	3
All other	8

Among Vital Records cases, the largest proportion of natural deaths were cancer (N=13, 25%), followed by heart disease (N=9, 18%) and diseases of the respiratory system (N=9, 18%). Cancer and heart disease are also the leading causes of death among the entire population of Multnomah County, with 1,251 deaths from cancer and 1,069 deaths from heart disease in 2023.[9]

The highest number of deaths among PEH occurred among males, people aged 35-44 years, and White non-Hispanic people.

However, there were inequities resulting from structural racism: deaths among Black/African American and American Indian/Alaska Native PEH were overrepresented, as were deaths among non-Hispanic people and middle-aged people.

Table 1

Demographic characteristics of deaths among PEH in Multnomah County, ME and VR data, 2024 (N=372)

	Total deaths among PEH (N=372)		Multnomah County Population* (N=803,863)	
Sex	**Count**	**Percent**	**Count**	**Percent**
Female	71	19%	404,718	50%
Male	301	81%	400,239	50%
Age (mean years)	**48**	**n/a**		
Age group (years)	**Count**	**Percent**	**Count**	**Percent**
<25	7	2%	206,335	26%
25-34	63	17%	145,940	18%
35-44	106	28%	137,395	17%
45-54	74	20%	109,343	14%
55-64	65	17%	89,189	11%
65+	43	15%	115,661	14%

9   Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 2018-2023 on CDC WONDER Online Database, released in 2024. Data are from the Multiple Cause of Death Files, 2018-2023, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/ucd-icd10-expanded.html on Dec 3, 2025 4:41:45 PM

Table 1 (continued)

Demographic characteristics of deaths among PEH in Multnomah County, ME and VR data, 2024 (N=372)

Race (alone or in combination)	Total deaths among PEH (N=372)		Total deaths among PEH (N=372)	
	Count	Percent**	Count	Percent
American Indian/Alaska Native	17	5%	24,486	3%
Asian	1-3	<1%	83,286	10%
Black/African American	44	12%	62,474	8%
Native Hawaiian/ Pacific Islander	1-3	<1%	9,691	1%
White	314	84%	650,905	81%
Missing or other	10	3%	n/a	n/a
Ethnicity	Count	Percent	Count	Percent
Hispanic	29	8%	105,204	13%
Non-Hispanic	343	92%	698,659	87%

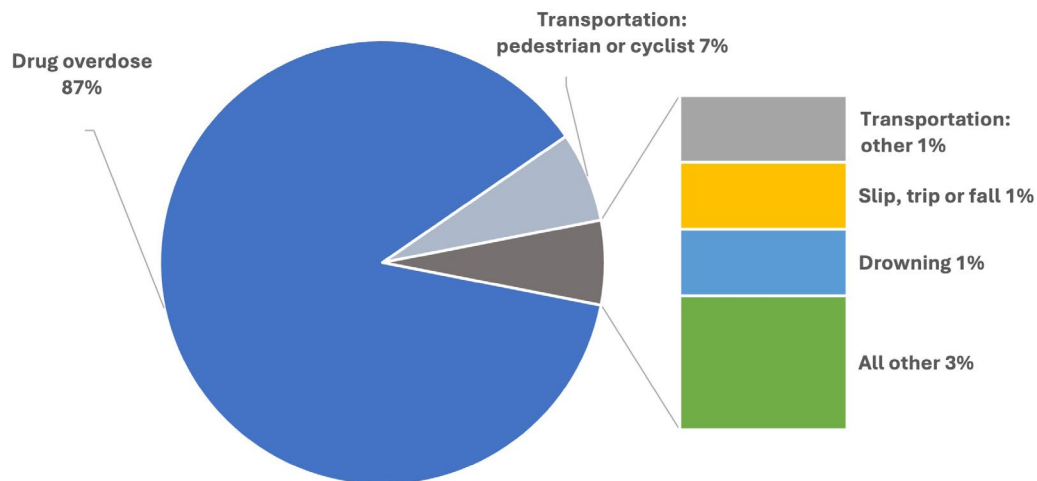*American Community Survey 2023 5-year population estimates

**People can be in more than one group, so the sum of all categories will be greater than 100%.

Structural racism and exclusionary policies that constrain access to housing, education, employment and healthcare infrastructure are likely underlying causes of the inequities in mortality among PEH by race.[6]

The average age at death was 48 years. For deaths certified by a healthcare provider, the average age at death was 64 years (data not shown). Both are younger than the U.S. average life expectancy of 78 years.[5]

Drug overdoses were the cause of most unintentional injury deaths among PEH in Multnomah County. Transportation-related injuries were the second most common contributor.

Figure 6. Distribution of unintentional injuries among PEH in Multnomah County, 2024, ME data (N=245)

The majority of unintentional injury deaths resulted from drug poisoning (overdose) (N=214, 87%), followed by transportation (N=19, 8%), 17 (89%) of which involved a pedestrian or cyclist. There were three deaths due to drowning (1%) and three from falls (1%).

Drug overdose deaths among PEH occurred most often among males, people aged 35-44 years, and among White, non-Hispanic decedents.

However, like all PEH deaths combined, inequities resulting from structural racism were apparent. Black/African American and American Indian/Alaska Native deaths were overrepresented.

71% of all drug deaths among PEH involved both an opioid and a stimulant.

Table 2

Characteristics of drug overdose deaths among PEH, Multnomah County, 2024, ME (N=214)

	Total drug deaths among PEH *(N=214)*	
Sex	**Count**	**Percent**
Female	39	18%
Male	175	82%
Age (mean years)	**44**	**n/a**
Age group (years)	**Count**	**Percent**
<25	4	2%
25-34	43	20%
35-44	76	36%
45-54	45	21%
55-64	36	17%
65+	10	5%
Race (alone or in combination)	**Count**	**Percent****
American Indian/Alaska Native	10	5%
Black/African American	23	11%
White	183	86%
Missing or other*	8	4%
Ethnicity	**Count**	**Percent**
Hispanic	15	7%
Non-Hispanic	199	93%
Drug Type (alone or in combination)	**Count**	**Percent**
Any opioid	185	86%
Synthetic opioids (mainly fentanyl)	183	86%
Psychostimulants (mainly meth)	175	82%
Any opioid + psychostimulant	151	71%
Cocaine	8	4%
Heroin	4	1%

*Due to a small number of deaths, Asian and Pacific Islanders are combined into this category to maintain confidentiality.
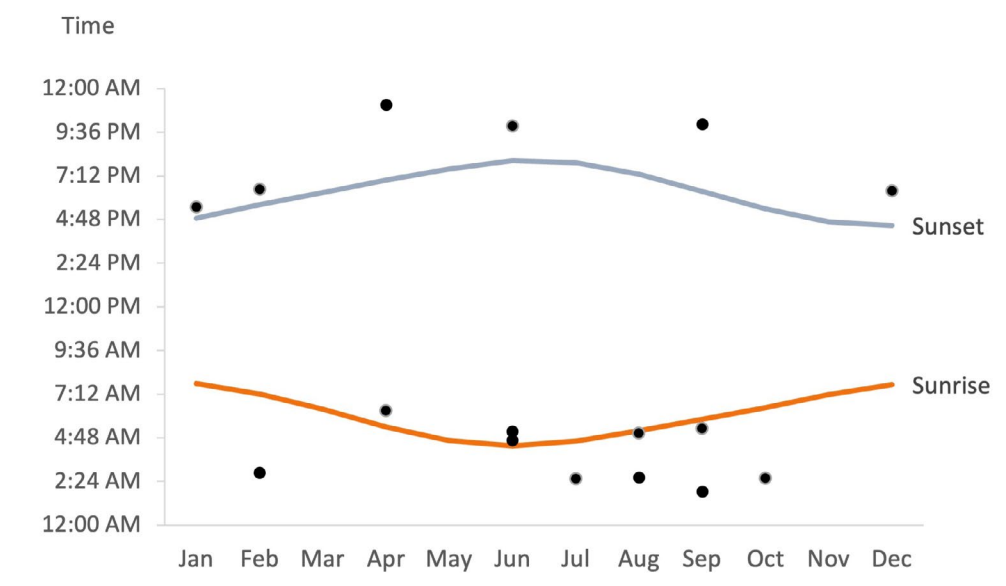**People can be in more than one group, so the sum of all categories will be greater than 100%.

Note: For the specific drug types, each death could have more than one type of drug, so the sum of all drug categories will be more than the total number of deaths. Opioids (mainly fentanyl) and psychostimulants with abuse potential (mainly methamphetamine) were the most commonly listed drugs.

More than half of PEH dying from a drug overdose were between the ages of 35 and 54 (N=121, 57%); the average age at death of this group was 44 years. The mean age at death for PEH who had psychostimulants but no opioids was six years older than PEH who had opioids but no psychostimulants (data not shown). Black/African American and American Indian/Alaska Native persons were overrepresented in PEH overdose deaths, as compared to their respective population proportions in Multnomah County. As with the inequities in overall death, structural racism that constrains access to housing and healthcare is the underlying cause of the inequities in mortality among PEH by race.[7]

Pedestrian and cyclist deaths among PEH primarily occurred before sunrise and after sunset.

Figure 7. Incident time among transportation pedestrian and cyclist deaths among PEH in Multnomah County, 2024, ME and VR data (N=16)

Note: The incident time is on the vertical (Y) axis. Each time of death is a dot on the plot. The solid lines represent the average sunrise and sunset times for each month.[10]
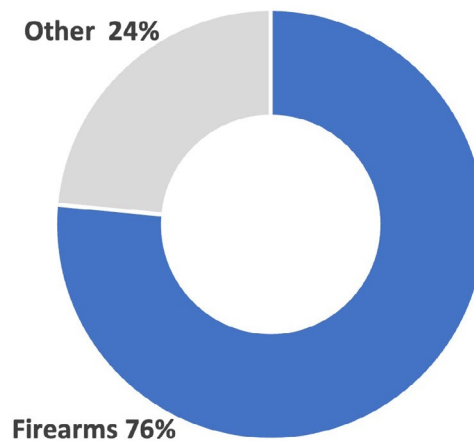
The trend among PEH aligns with overall traffic fatalities in the city of Portland, where 84% of deaths occurred in low-light conditions in 2024.[11]

10 https://gml.noaa.gov/grad/solcalc/sunrise.html
11 Portland 2024 Deadly Traffic Crash Report

Firearms were the most common mechanism in assault deaths.

Figure 8. Most common mechanism of assault deaths in PEH in Multnomah County, 2024, ME data (N=17)

Other 24%

Firearms 76%

On average, 31 PEH died each month in 2024. The highest number occurred in January (53 deaths) and the lowest in July (24 deaths).

Figure 9a. Distribution of deaths in PEH in Multnomah County, 2024, by manner of death and month, ME and VR data (N=372)

	Accident	Undetermined	Homicide	Natural	Suicide	TOTAL
January	36	1	3	11	2	53
February	17	1	3	9	0	30
March	23	0	2	8	1	34
April	26	0	1	2	1	30
May	28	1	1	9	0	39
June	17	1	1	5	1	25
July	8	0	3	10	3	24
August	16	1	2	8	0	27
September	16	1	1	8	3	29
October	16	0	0	7	2	25
November	25	0	0	5	0	30
December	18	1	1	6	0	26
Average	21	1	2	7	1	31

Figure 9b. Distribution of accidental deaths in PEH in Multnomah County, 2024, by month against average (dashed line), ME data (N=246)
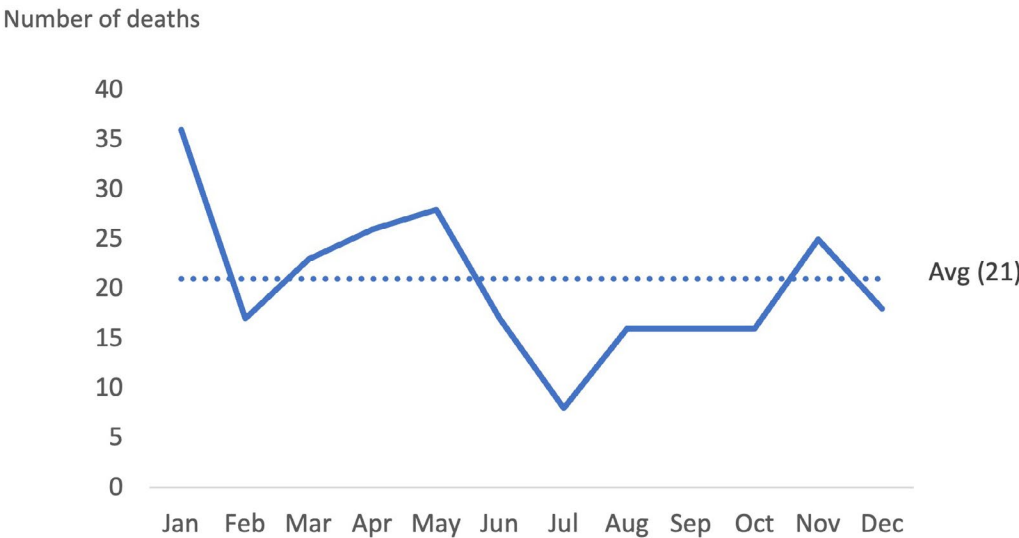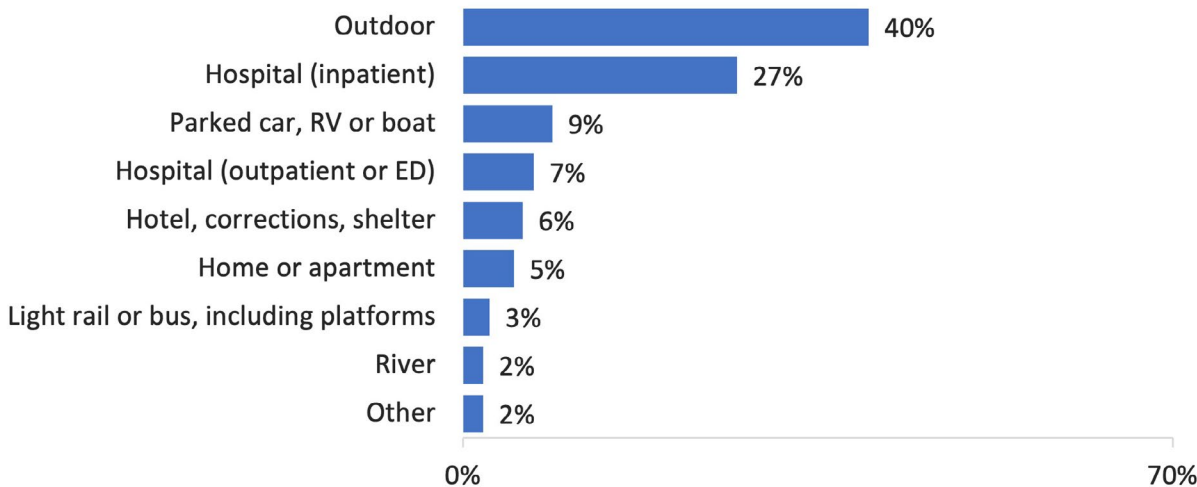
Number of deaths

Figure 9a shows the distribution of deaths among PEH by month and manner of death with shading, where darker shades of blue indicate a higher count. On average, 31 people died each month, with a low of 24 in July and a high of 53 in January. By individual manner, January had the most accidental deaths (N=36). Figure 9b shows only the number of accidental deaths, reflecting three peaks of deaths greater than the average (n=21), in January, May and November. The other manner of death categories had smaller numbers of deaths, without clear trends.

Deaths among PEH most commonly occurred outdoors.

Figure 10. Distribution of deaths in PEH by place of death in Multnomah County, 2024, ME and VR data (N=372)

In 2024, the most common place of death was outdoors (N=149, 40%), followed by inpatient hospital (N=99, 27%). Inpatient hospital deaths were nearly equally distributed among ME cases (N=53, 53%) and non-ME cases (N=47, 47%); however, the outpatient or emergency department hospital deaths were almost always ME cases (N=25, 96%) (data not shown).

Deaths among PEH occurred across Multnomah County, but the Pearl District/Old Town and Lents/outer Southeast areas had the highest numbers.

Figure 11. Deaths among PEH by ZIP code of original injury in Multnomah County, 2024, ME and VR data (N=297)
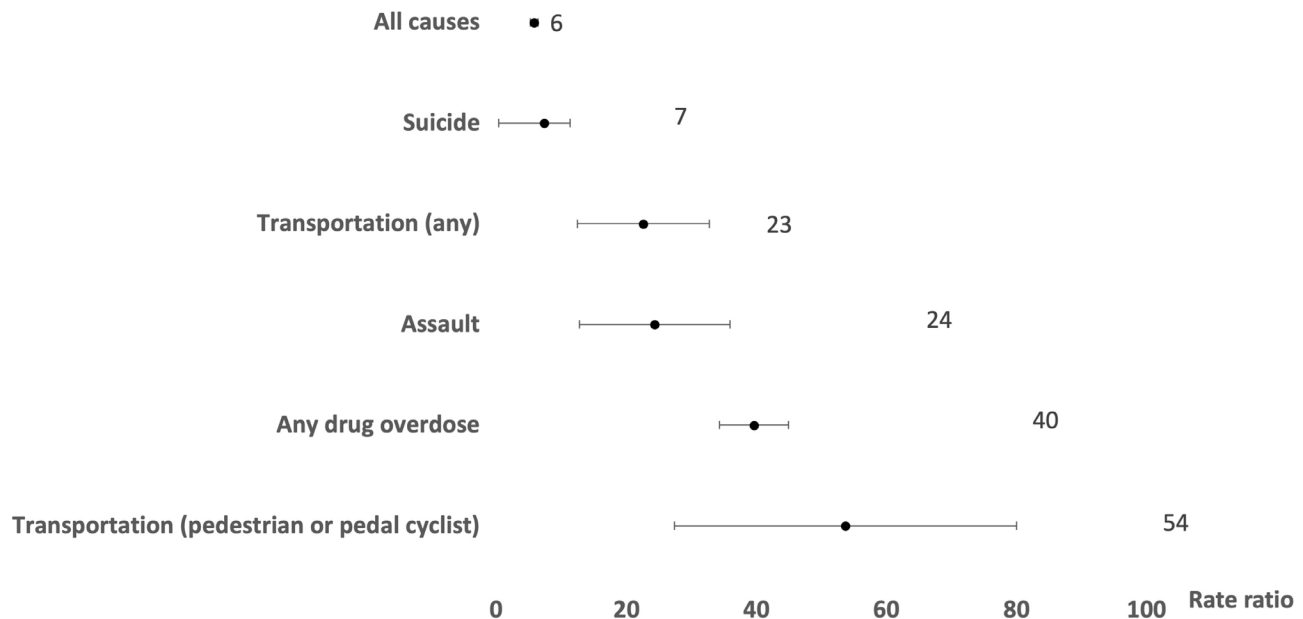

Location data were available only for deaths among PEH that were certified by the ME; 24 of them had missing values for the original location. Those deaths are mapped in Figure 11 by ZIP code, with darker colors indicating a higher number of deaths.

Deaths among PEH had a larger concentration in the downtown Portland core, North/Northeast Portland, inner Southeast Portland, and near the other east-west and north-south arterials of Interstates 84 and 205. For 2024, the ZIP code with the highest total of overall deaths was 97209 (Pearl District/Old Town) with 35 deaths, followed by 97266 (Lents/outer Southeast Portland) with 25 deaths, 97214 (Buckman/Richmond/Sunnyside) with 23 deaths and 97220 (Parkrose) with 21 deaths. When limited to only deaths due to drug overdose, 27 deaths occurred in 97209 (Pearl District/Old Town, 77%) and 20 occurred in 97266 (Lents/outer Southeast, 80%) (data not shown).

The risk of death from any cause was six times higher for PEH compared to the general population of Multnomah County.

Figure 12. Standardized mortality rate ratios (shown as dots) and corresponding 95% confidence intervals (shown as lines) comparing deaths among PEH to deaths among all Multnomah County residents, controlling for age, 2024, ME and VR data

	Rate ratio
All causes	6
Suicide	7
Transportation (any)	23
Assault	24
Any drug overdose	40
Transportation (pedestrian or pedal cyclist)	54

0   20   40   60   80   100   Rate ratio

In 2024, the risk of death for PEH from pedestrian or cyclist transportation-related incidents was 54 times higher than the general population. Compared to the general Multnomah County population, the risk of death for PEH from drug overdose was 40 times higher, the risk from assault was 24 times higher and the risk of dying by suicide was seven times higher, even after controlling for age differences. In 2024, the risk from heart disease and cancer were similar to the general population (rate ratio=1; data not shown). There were no COVID-19 deaths among PEH in 2024.

Discussion

The number of PEH on a single night in 2024 was the highest ever recorded in the United States (771,480 individuals).[12] Multnomah County's Homeless Services Department dashboard shows that between 11,000 and almost 14,000 people experienced homelessness at some point throughout each month in 2024.[13] This report describes the primary causes of death among people experiencing homelessness (PEH) in Multnomah County in 2024. Our analysis shows that at least 372 individuals died while experiencing homelessness in Multnomah County in 2024. Although the number of deaths remains high, we found an 18% decrease in total deaths among PEH in Multnomah County in 2024 compared to 2023.

Despite this encouraging trend, the average age at death among PEH remained low at 48 years, underscoring the premature and preventable nature of these losses. As in prior years, drug overdoses (mainly from synthetic opioids and psychostimulants) remained the leading cause of death among PEH. Notable racial inequities occurred in deaths among PEH as a result of structural racism that influences both the likelihood of homelessness and the likelihood of premature mortality.

Deaths due to drug overdose, mainly fentanyl (alone or in combination with other drugs, especially methamphetamine), accounted for a large proportion of deaths among PEH. Among all Multnomah County residents, deaths attributable to synthetic opioids (including fentanyl) declined 21%, from 483 in 2023 to 379 deaths in 2024.[14] This reflects a decrease in drug overdose deaths seen across the United States.[15] However, PEH were still 40 times more likely to die from any drug overdose compared to the overall county population, controlling for age. This aligns with data from Los Angeles County in 2023, where overdose mortality was nearly 49 times greater among PEH when compared to Los Angeles County residents.[16] Multnomah County's 2024 Overdose Prevention and Response Plan guides efforts at prevention, harm reduction, treatment and recovery support for people struggling with opioid and fentanyl use.[17]

The intersection of homelessness and substance use is complex. Housing is a crucial social determinant of health and is associated with numerous inequities, including mental health concerns, physical health problems, trauma, greater overall mortality and substance use disorders.[18] And while people with substance use disorders may be more likely to face unstable housing situations, the stress and context of homelessness can also worsen substance use. People experiencing homelessness might also be more likely to use drugs alone and face more barriers to accessing treatment.[19]

12 The 2024 Annual Homelessness Assessment Report (AHAR) to Congress (huduser.gov)
13 Homeless Services Department Data Dashboard
14 Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Provisional Mortality on CDC WONDER Online Database. Data are from the final Multiple Cause of Death Files, 2018-2023, and from provisional data for years 2024 and later, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/mcd-icd10-provisional.html on Nov 6, 2025 9:32:19 PM
15 CDC Reports Nearly 24% Decline in U.S. Drug Overdose Deaths
16 Mortality Rates and Causes of Death Among People Experiencing Homelessness in LA County: 2017-2023
17 Multnomah County Overdose Prevention & Response Plan 2024
18 https://nhchc.org/wp-content/uploads/2019/08/nhchc-opioid-fact-sheet-august-2017.pdf
19 https://multco-web7-psh-files-usw2.s3-us-west-2.amazonaws.com/s3fs-public/Substance%20Use%2C%20Fentanyl%20and%20Overdose%20FAQ.pdf

People experiencing homelessness have a high likelihood of transportation-related injuries and deaths from living in near-road environments and from being outside. Multnomah County's analysis of traffic deaths in 2020 and 2021 demonstrated that a quarter of decedents were likely experiencing homelessness at the time of their death.[20]

The current analysis showed 19 deaths from any traffic-related crash, 16 (84%) of which involved pedestrians or cyclists. These deaths accounted for 8% of the total number of unintentional injury deaths among PEH. People experiencing homelessness had a rate of death from transportation-related crashes that was 23 times that of the general Multnomah County population, controlling for age, but when limited to only pedestrians or cyclists, this risk was 54 times the rate of the general population. Los Angeles County's analysis of 2023 data showed a similar risk for all traffic-related deaths, with 20 times the risk compared to their general population.[19]

The data in this report can inform Multnomah County Racial and Ethnic Approaches to Community Health (REACH) program's work to assess racial inequities in traffic incidents and the City of Portland Bureau of Transportation (PBOT) Vision Zero initiative. Incorporating input from PEH could inform community transportation planning and policy interventions to prevent future traffic-related fatalities.

According to 2024 data, structural racism continues to drive notable racial inequities in mortality among PEH in Multnomah County. Black/African American and American Indian/ Alaska Native communities were overrepresented among decedents compared to their respective proportions in the overall Multnomah County population. These inequities arise from laws, policies and systemic practices — like those concerning eviction, debt and discrimination in healthcare, for example — that disproportionately disadvantage racially and ethnically populations experiencing marginalization.[21]

Limitations

Despite the strengths of this analysis, there are some limitations that should be considered. First, the standardized mortality rate ratios we present in Figure 12 should be considered estimates. We estimated the denominator for the rates for PEH from the 2024 Point in Time Count. That report cautions that people enter and leave homelessness continuously throughout the year at potentially differing rates, making a count on one night likely higher or lower than any other date.

Additionally, some of the categories had fairly small sample sizes. For example, there were 13 total suicide deaths and 13 deaths from heart disease. Rates based on smaller numbers often produce large confidence intervals, so caution should be used when interpreting these results. In addition, since we lacked a breakdown by both age and sex, we were only able to adjust the rates for age. Finally, the ascertainment of housing status at death likely includes some incidents of misclassification, particularly in Vital Records data (see Appendix for more details).

20 https://multco-web7-psh-files-usw2.s3-us-west-2.amazonaws.com/s3fs-public/Revised_Final_MultCo%20 traffic%20deaths%202020_2021_0.pdf
21 Kisa A, Kisa S. Structural racism as a fundamental cause of health inequities: a scoping review. Int J Equity Health. 2025 Oct 8;24(1):257. doi: 10.1186/s12939-025-02644-7. PMID: 41063084; PMCID: PMC12506018.

Conclusions

Although we noted a recent decline in the number of deaths in 2024 compared to 2023, the rate of deaths among PEH in Multnomah County remains much higher than the general population. There are multiple intersecting causes that lead to homelessness and lead to the increased risk of death among PEH, including lack of affordable housing, racial injustice, lack of social support systems, substance use, mental health challenges, major trauma and a lack of access to medical and mental healthcare.

Multnomah County's strategic plan emphasizes decreasing net homelessness and supporting access to stable housing for youth and families.[7] Addressing underlying social, economic, environmental and healthcare-related factors, and especially improving access to housing, are necessary to reduce the risk of death among people experiencing homelessness.

Appendix

Methods

Data sources

We used two sources of data to identify deaths among people experiencing homelessness (PEH). The first was the Multnomah County Medical Examiner (ME), which maintains a database of all deaths investigated under its jurisdiction. According to ORS 146.090,[8] the ME investigates and certifies the cause and manner of all human deaths that are:

   a. Apparently homicidal, suicidal, or occurring under suspicious or unknown circumstances;

   b. Resulting from the unlawful use of controlled substances or the use or abuse of chemicals or toxic agents;

   c. Occurring while incarcerated in any jail, in a correctional facility, or in police custody;

   d. Apparently accidental or following an injury;

   e. By disease, injury or toxic agent during or arising from employment;

   f. While not under the care of a physician during the period immediately previous to death;

   g. Related to disease which might constitute a threat to the public health; or

   h. In which a human body apparently has been disposed of in an offensive manner.

In December 2010, the data field "Domicile Unknown" was added to the ME database for Multnomah County so that deaths of people experiencing homelessness, or individuals who may have been homeless at the time of their death, could be more easily extracted. Multnomah County medicolegal death investigators (MDI) make multiple attempts to identify a place of residence for decedents through scene investigation and interviews with relatives and social contacts. MDI are encouraged to classify decedents as "homeless" using this field if they cannot identify a stable residence at the time they complete their report; such cases are later reviewed as described below for final classification.

As of Jan. 1, 2022, Senate Bill (SB) 850[22] established mandatory reporting of housing status at death. This means that reporting is required for all deaths, not just for deaths investigated by the ME. The new requirement creates a way to document homelessness on death certificates by recording "Domicile Unknown" in the residence address. The funeral service practitioner is responsible for listing "Domicile Unknown" in the "Street Name, Rural Route, etc." field for individuals who were homeless at the time of the death.[23] This allowed us to use Vital Records death certificates as a second source of data to include deaths certified by a healthcare practitioner.

We primarily used local Medical Examiner data for the final count of deaths in this report. We supplemented the data with deaths occurring under hospital care through Vital Statistics data. Vital Statistics data also provide deaths certified by the Medical Examiner, but we found that the number of deaths among people experiencing homelessness recorded as Medical Examiner deaths in the Vital Statistics data was lower than the number identified directly through Medical Examiner reports. This may be because of differences in the way data are recorded. For example, a local death investigator may indicate that the decedent was experiencing homelessness at the time of death and leave the residence address blank in Medical Examiner data. However, funeral directors often complete death certificate data, and when they follow up with next of kin, those kin may choose to list their own residence on the death certificate. We found several occurrences of this phenomenon in the course of our data analysis.

Definition of experiencing homelessness

As defined by SB 850, and based on the U.S. Department of Housing and Urban Development's definition, a homeless individual is defined as: an individual who lacks a fixed, regular and adequate nighttime residence; an individual with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground; an individual living in a supervised publicly or privately operated shelter designated to provide temporary living arrangements (including hotels and motels paid for by Federal, State, or local government programs for low-income individuals or by charitable organizations, congregate shelters, and transitional housing); an individual who resided in a shelter or place not meant for human habitation and who is exiting an institution where they temporarily resided.

Review of death data

Data source 1: Medical Examiner (ME) data
We extracted case information for all investigated deaths under Multnomah County jurisdiction during 2024 from the ME database, MDILog (Occupational Research and Assessment Inc., Big Rapids, Michigan). Four hundred sixty-seven deaths were selected for review based on whether they were: 1) flagged as "domicile unknown" or homeless by the medicolegal death investigator; 2) had an indication of homelessness in the address field

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22 https://www.oregon.gov/oha/PH/BIRTHDEATHCERTIFICATES/REGISTERVITALRECORDS/Pages/Senate-Bill-850.aspx

23 https://www.oregon.gov/oha/PH/BIRTHDEATHCERTIFICATES/REGISTERVITALRECORDS/Documents/Death/JobAid%20SB850-FH.pdf

("transient," "homeless," etc.); 3) had no residential address information listed; or 4) a shelter was listed as the place where death occurred. If any of these cases were listed as "domicile unknown" in Vital Records, they were not reviewed, but were designated as likely homeless at death.

For the remaining cases, one reviewer assessed death narrative reports, supplemental information (e.g., law enforcement or emergency medical services reports) and address information for each case to determine which investigations supported the classification of homeless using the established definition. For cases where the narrative was suggestive but inconclusive related to homelessness status, we investigated for more information using both Vital Records (see below) and the Homeless Management Information System (HMIS) database. Two hundred forty-four records were manually reviewed for this analysis.

Data source 2: Vital Records (VR)
Data were obtained electronically from Multnomah County's database of Vital Records, which are updated weekly by the Oregon Health Authority. We selected records for which the place of death was within Multnomah County, the residential street address was listed as "Domicile Unknown," and the signer of the death certificate was a certifying physician, nurse practitioner or physician associate. Deaths certified by a medical examiner were excluded, since they are captured more robustly in data source 1.

Combining data

To facilitate data analysis, we combined data from source 1 into source 2 into one file by using the ME case number. The final number of records in the analytic set was 372.

Race and ethnicity coding

Typically, funeral directors gather information on race and ethnicity from next of kin or close informant interviews. These data are typically more robust than the available Medical Examiner data. Although misclassification of race and ethnicity on death certificates occurs, especially for people of American Indian or Alaska Native ancestry, it is low for White and Black/African American populations, and has decreased over time for the Hispanic and Asian and Pacific Islander populations.[24]

In order to display disaggregated data as much as possible (which is important for resource allocation and culturally specific interventions),[25] we categorized decedents using an "any mention" approach. In this classification, any person can be in multiple groups in the race analysis because they are listed under every racial or ethnic group indicated on the death certificate. For example, if a decedent was marked as both "White" and "Black" on a death certificate, they would be counted in each category. This allows more comprehensive representation for smaller population groups. Therefore, the total can add up to more than 100%. To provide total county population size context, we used race alone or in combination with population proportions from American Community Survey 2023 five-year estimates (these are the most recent estimates available that have detailed race and ethnicity breakdowns). Some death certificates are missing racial and ethnic data and were categorized as unknown.

24 https://www.cdc.gov/nchs/data/series/sr_02/sr02_172.pdf
25 https://vaccineresourcehub.org/sites/default/files/resources/files/AANHPI-Data-Disaggregation-Resource-Guide_Final_508c_6.14.23.pdf

Sex

There are five designations for decedent sex on death certificates in Oregon: "female," "male," "undetermined" (used in cases where the "sex cannot be determined due to a medical condition"), "unknown" (used if sex "cannot be determined after verification with medical records, inspection of the body, or other sources") and "X (non-binary)" (used for individuals whose "gender identity is not exclusively male or female").[26] In this report, the words "female" and "male" are used because all decedents included in the analysis were recorded as "female" or "male" on their death certificates.

Cause and manner of death

A healthcare provider (physician, nurse practitioner or physician associate) or medical examiner completes the cause-of-death section of the death certificate, which also includes the manner of death. "Manner of death" is classified based on the immediate circumstances surrounding a death. Typically, the five manners used are:

- Natural (relating solely to aging or disease process; due to internal processes only)
- Accident (injury or poisoning caused death, no evidence of intent to harm)
- Suicide (injury or poisoning with intent to harm self or cause death)
- Homicide (act committed by another person)
- Undetermined (information pointing to one manner not more compelling than information pointing to another)[27]

Causes of death in Vital Records are coded using the ICD-10 (International Statistical Classification of Diseases) classification.[28] The following coding schemes were used to classify deaths:

- Drug poisoning (overdose): underlying cause of death X40-44 and Y10-14 (accidental and undetermined intents only)

  - Opioid overdose: drug poisoning, plus any multiple cause of death (MCOD) code T40.0-T40.4, T40.6
  - Psychostimulants with abuse potential: drug poisoning, plus MCOD T43.6
  - Synthetic opioid (fentanyl): drug poisoning, plus MCOD T40.4

- Extreme weather (heat or cold): X30-X31
- Pedestrian or cyclist involved in transport crash: V01-V19
- Any transportation crash: V00-V99
- Heart disease: I00-I09, I11, I13, I20-I51
- COVID-19: U07
- Assault: X85-Y09
- Intentional self-harm: X60-X84

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26 Sex Designation on Death Records Quick Reference (oregon.gov)
27 A guide for manner of death classification (NAME.net)
28 International Statistical Classification of Diseases and Related Health Problems (WHO.INT)

Other categories displayed reflect the National Center for Health Statistics (NCHS) 113 leading causes list[29] or ICD-10 category.

Estimating the total population experiencing homelessness

Although the exact number of people experiencing homelessness is unknown, the best estimate we have is based on yearly point-in-time counts that are conducted annually in January by Continuums of Care (CoC; local groups responsible for coordinating homelessness services in a given geographic area) throughout the U.S. As reported in the 2024 Annual Homelessness Assessment Report (AHAR), there were 7,384 people counted as experiencing homelessness in Multnomah County on a single night in 2024 (3,440 sheltered). Detailed age groupings are also available with this data source.[30,31]

Mapping

To create a map of where deaths occurred, we used ZIP code information corresponding to the location of the original incident/injury leading to death. This information was only available for ME-certified deaths. Some fields had an unknown incident location and were excluded from the map. Counts of overdose deaths, rather than rates, were used to represent the absolute burden of deaths among PEH. Maps cannot tell us why incidents occurred where they did or take into account other important details, such as underlying socioeconomic conditions or population size.

Trends over time

To assess the trend in absolute numbers of deaths from 2020 to 2024, we used Joinpoint regression. Joinpoint takes count or rate data and determines where lines are best connected together. For count data, a Poisson regression is run with the year as the independent variable. Joinpoint determines the annual percent change and if this value is statistically significantly different from zero at the $p=0.05$ level. We used Joinpoint 5.4.0 for this regression analysis. Only ME data was used for this analysis because the number of hospital deaths for people experiencing homelessness was not available prior to 2022.

Estimating risk

To compare rates of mortality in people experiencing homelessness against those of Multnomah County residents, we used two denominators:

1. The 2024 Point in Time County estimate for PEH by age group
2. Census estimates by age group for Multnomah County for 2023 from Oregon Public Health Assessment Tool (OPHAT) by age (2024 data were not available at the time of analysis)

To compare these groups to each other while controlling for differences in age, we used a standardized mortality rate (SMR) ratio, with the Multnomah County resident population serving as the standard population. The SMR is especially applicable when two populations have a dissimilar age distribution and/or in cases where the study population may be small.[32]

29 https://www.cdc.gov/nchs/nvss/leading-causes-of-death.htm
30 AHAR Reports HUD Exchange
31 2024 Oregon Statewide Homelessness Estimates (PSU)
32 https://ibis.doh.nm.gov/resource/SMR_ISR.html

Frequencies and means were tabulated using SAS 9.4 (SAS Institute, Cary, North Carolina). PROC STDRate was used to calculate the standardized mortality rate ratios and confidence intervals. Charts and figures were made using Microsoft Excel (2019) and Tableau v. 2024.2.

Data suppression

To protect the privacy of decedents, demographic data were suppressed or combined into subgroups if cell counts were less than three.

Figure A1. Total deaths by ME or non-ME status occurring in Multnomah County by year, 2020-2024

Deaths

Annual average percent increase for ME deaths 2020-2024: 8%

Year	Non-ME deaths	ME deaths
2020	6,383	1,302
2021	6,880	1,552
2022	6,726	1,625
2023	6,310	1,818
2024	6,221	1,777

Non-ME deaths ME deaths

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Authors of Methods and Results

Medical Examiner's Office