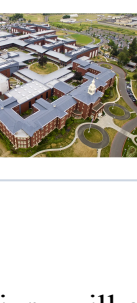
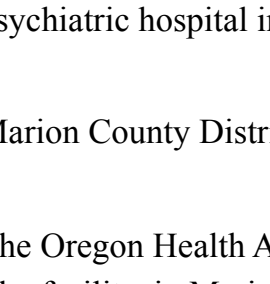


Marion County prosecutor opens grand jury inquiry into Oregon State Hospital

BY BEN BOTKIN
March 13, 2026



The inquiry comes after five unexpected patient deaths at the state psychiatric facility since 2023, including a Lane County man. The hospital also has faced years of challenges related to patient safety and its inability to efficiently move people through treatment and back into their communities.



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A grand jury will examine the management and conditions at Oregon State Hospital, the state-run psychiatric hospital in Salem.

Marion County District Attorney Paige Clarkson announced the grand jury inquiry Friday, March 13.

The Oregon Health Authority oversees the Salem facility, which can serve more than 550 patients at a time. The facility, in Marion County, treats patients from across Oregon’s 36 counties, including Lane County. Most of them arrive through the criminal justice system and need mental health care in order to aid in their legal defense against pending charges.

“Our state’s most crucial facility serving those with mental illness is housed right here in the heart of Salem,” Clarkson said in a statement. “The Oregon State Hospital is statutorily responsible for the majority of our state’s criminal justice response to the behavioral health crisis plaguing our communities.”

The inquiry comes amid a cascade of challenges for Oregon State Hospital. Since 2023, the hospital has experienced five unexpected patient deaths, including 25-year-old Kenneth Hass from Lane County. In those deaths, federal inspectors have found a [repeated pattern of errors in patient care](#) and a failure to follow procedures. In Hass’ case, hospital staff waited to enter the room after watching him fall three times and lie motionless for more than four minutes on the floor after hitting his head, records show.

Separately, the hospital struggles to admit patients who face court-ordered treatment in a timely fashion; the idea is to treat those patients so they’re capable of facing the criminal charges against them. As of March 9, 45 patients from Lane County were in the hospital under such orders, nearly 12% of the 385 patients with pending charges.

A court order requires that patients should be admitted at the hospital no later than seven days after a judge’s ruling. The state hospital, under a federal contempt order to encourage compliance, must pay a \$500 fine per patient for every day that exceeds the seven-day threshold. The state calculated it owes \$558,000 in fines for the period of mid-January to mid-February, court records show.

Clarkson added: “Over the last several years, I have become increasingly concerned that the Oregon State Hospital cannot meet the challenge of the moment: appropriately responding to the growing need for intensive, hospital level of care for individuals whose diagnoses require civil commitment, restoration services, or secure levels of treatment for the safety of themselves and the public. We have an obligation to inquire into what is being done with an eye toward what more is needed.”

Amber Shoebridge, a spokesperson for Oregon State Hospital, said the hospital is committed to “continuous improvement for the safety and dignity of staff and those we serve.”

“OSH will cooperate with the Marion County grand jury and welcomes collaboration and conversation with community and state partners as we all work towards the same goal: a safer, healthier Oregon for patients, providers and communities,” Shoebridge said in an email.

The district attorney’s grand jury inquiry likely will shed more public light on the hospital’s challenges in caring for patients.

The Marion County district attorney in 2025 conducted a grand jury inquiry into conditions at the Oregon Youth Authority’s MacLaren Youth Correctional Facility in Woodburn. The inquiry eventually released a 63-page report to the public, which included details about living conditions, medical care and concluded it is “beyond dispute” that sexual abuse of youth is the most concerning.

With the state hospital, the grand jury will inquire into the “current operations, capacity challenges and public safety implications associated with the Oregon State Hospital,” the district attorney’s release said.

With the myriad problems facing the state hospital, it’s unclear to what extent the grand jury will focus on patient deaths.

The statute used for the grand jury inquiry is broad and allows reviews for the “condition and management” of a facility. The grand jury will determine the scope of the inquiry within what’s allowed in the statute, said Chief Deputy District Attorney Brendan Murphy.

The grand jury’s proceedings are confidential, and the district attorney’s office anticipates a report will be publicly released by the end of the year.

Disability Rights Oregon, a watchdog with a congressional charter to investigate the hospital and other institutions, said the hospital’s problems “are not a mystery.”

“Patients have died, an ongoing leadership vacuum has destabilized care, staff are burned out, and people in crisis are waiting for treatment. None of that requires another investigation, least of all one run by a DA’s office that floods the hospital with criminal referrals, including people charged only with nonviolent misdemeanors,” said Tom Stenson, deputy legal director at Disability Rights Oregon. “Treating the most expensive resource in our behavioral health system as the primary solution is like substituting the ER for primary care. Until Oregon commits to real community-based mental health care, we’ll keep asking the wrong questions and wondering why nothing changes.”

After patient death, confidential Oregon State Hospital report calls out a ‘culture of complacency’

The internal review, obtained by Lookout, found widespread, systemic problems at the state-run psychiatric hospital. Compiled after the March 18 death of a Lane County patient, the inquiry said that staff who advocated to improve conditions for the patient met resistance from their colleagues.

Lookout Eugene-Springfield

Deaths at Oregon State Hospital

Unexpected patient deaths have hit the hospital in different ways.

In November 2023, a patient died in a seclusion room, where staff placed him after he complained of [breathing difficulties](#).

In April 2024, [another patient](#) died the same day he arrived from the Douglas County Jail. Inspectors found medical staff failed to check the patient’s vitals when he was admitted. The hospital’s internal report said the patient was likely already dead upon arrival and that staff didn’t notice this until after taking his photo and transporting him to his unit in a wheelchair. In May 2024, another patient died of a [fentanyl overdose](#). In March 2025, Hass died at the state hospital.

A confidential hospital report into Hass’ death, obtained by Lookout, found staffers were concerned and in interviews with investigators, “spoke of learned helplessness at all levels of the organization with staff no longer asking questions or raising concerns with the assumption that nothing will get done, that their concerns will be dismissed or at times even ridiculed, or that the question must have already been asked.”

After Lookout [published its findings](#), in which staff identified a “culture of complacency,” the hospital launched [an investigation](#) into how the report was disclosed to the public.

Since the patient’s death, the state hospital and health authority have clamped down on the flow of information about patient care violations. The health authority heavily redacted a report, concealing details of its violations of patient care. Lookout obtained a [complete unredacted copy that shed light](#) on the hospital’s failures.

A communications aide for Gov. Tina Kotek also took the unusual step of asking the state hospital to not put out a routine press release when federal regulators placed the hospital in immediate jeopardy, [citing “tough news cycles”](#). The release did not go out.

The state hospital also runs a smaller, separate campus in Junction City.

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