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Oregon State Hospital, the state's psychiatric hospital, serves nearly 600 patients at its main Salem campus. Credit: Oregon Health Authority

GOVERNMENT & POLITICS

Oregon State Hospital's culture needs to improve, officials tell legislators

BY BEN BOTKIN
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QuickTake: In a legislative hearing Monday, Oregon state health officials stayed mum about a Lane County patient's death at Oregon State Hospital, while touting improvements they made. Dave Baden, a deputy director with the Oregon Health Authority, acknowledged the hospital's culture isn't where it should be.

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Oregon Health Authority officials told a legislative panel Monday they are taking steps to prevent future patient deaths or serious injuries at Oregon State Hospital in Salem. And Dave Baden, the authority's deputy director — who temporarily stepped in as superintendent at the facility — said the culture at the hospital needs to improve.

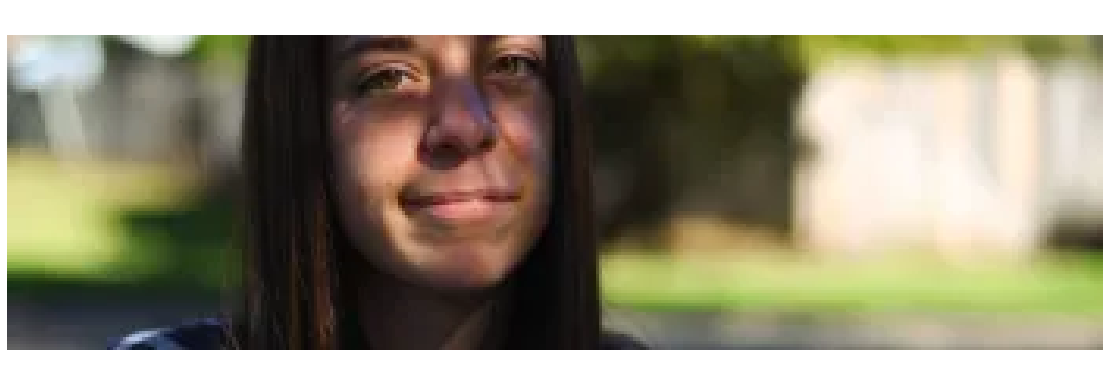
The hearing before the Senate Interim Committee on Judiciary was about the prevention of patient deaths and did not discuss specific cases. The last such unexpected patient death hit the hospital hard: Kenneth Hass died March 18 at Oregon State Hospital, lying motionless on a seclusion room floor for more than four minutes before staffers watching him entered to check his pulse.

By then, he was dead after falling a third and final time within the span of an hour while under staff observation.

The 25-year-old from Lane County, homeless before his entry into the hospital, died at the state-run psychiatric facility under circumstances that Oregon Health Authority officials tried to keep under wraps from the public.

Federal inspectors found violations with the hospital's lack of a timely response the night Hass died and with his care in his final months, during which he lived in a seclusion room filled with feces and urine because access to the room's bathroom had been blocked.

"Would I say that the culture of the Oregon State Hospital is where we all want it to be?" Baden told the Senate panel. "No, but we can continue to make improvements."



A grieving family seeks answers after a patient dies at Oregon State Hospital

Kenneth Hass, who was often homeless in Eugene and throughout Lane County, died in Oregon State Hospital after living for months in seclusion. Nearly eight months later, his family wants accountability and answers.

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Oregon State Hospital has capacity for nearly 600 patients at its main Salem campus, most of them entering for court-ordered treatment needed so they can face criminal charges in courts across the state.

In April, Baden stepped in temporarily as the superintendent after Gov. Tina Kotek replaced Dr. Sara Walker, the interim superintendent and chief medical officer, after learning more details of Hass' death. Jim Diegel became the interim superintendent in late May.

In May, hospital officials drafted a confidential 61-page report, obtained by Lookout Eugene-Springfield, which found the hospital has a "culture of complacency" and "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."

Oregon State Hospital officials have declined to comment on the findings of the report, calling it privileged and confidential.

But Hass' death is the latest of five unexpected deaths at Oregon State Hospital in the last two years, a rate that the hospital's own report said is troubling.

Joined by the hospital's interim chief medical officer, Dr. Amit Bhavan, Baden told lawmakers he could not talk about individual cases, called "sentinel events." Sentinel events include unexpected patient deaths or serious injuries.

Baden said the hospital takes these events, especially deaths, seriously, adding that "every patient deserves to be treated with dignity and respect."

"These are people," he said. "These are patients. These are Oregonians that are in the state hospital."

When the hospital falls short, Baden said, "we have to continue to push to change."

Baden said he's talked to staff who were "closely involved" in recent sentinel events and caregivers are deeply impacted. Each event requires the hospital to look at what went wrong and ask questions, Baden said.

"Are there cultural concerns?" Baden said. "Are there things that we should be putting in place to prevent things from happening in the future?"

Bhavan, the hospital's interim chief medical officer, outlined steps the hospital has taken to reduce the time patients spend in seclusion and restraints.

Bhavan said steps include a team to evaluate cases in which patients are placed in seclusion or mechanical restraints, with the goal of minimizing the time those techniques are used. The hospital also updated criteria for when patients can be released from seclusion or restraints, revised chart logs to track room cleanliness and emergency responses and crafted new medical response protocols for patients in restraints or seclusion.

The hospital's internal report and federal regulators found Hass lived for months in a seclusion room, and often was moved from room to room after a couple of weeks because staffers didn't want to clean his room while he was in it. Hospital staffers also blocked his access to the room's restroom because he was classified as being at high risk of a fall and would jump off the sink or toilet. As a result, his room would become soiled and not get regular cleanings.

The hospital's data comparing October 2024 to October 2025 shows a downward trend in the number of hours patients spend in seclusion or restraints.

In October 2024, the hospital had 156 seclusion events, and it reported 146 seclusion events in October 2025. Average stay in seclusion has decreased from 28.9 hours to 5.4 hours, according to data the hospital presented to lawmakers.

The number of incidents with restraints used has increased, from 50 in October 2024 to 82 incidents last month. But the average time in restraints has dropped, from 344 hours to almost 271 hours.

Sen. Floyd Prozanski, D-Eugene and the committee's chair, asked if there is now a protocol for checking on patients who have fallen.

Bhavan said staffers have that in place now, along with "more robust code-blue training."

In an interview, Prozanski said the hearing was a good opportunity for the committee to hear about the state hospital. He said he doesn't know if any legislation in the next session will address the hospital's issues, adding he's open to suggestions.

"When a person is in the facility we have an obligation — a moral obligation — to ensure those individuals are taken care of and we react to their needs as quickly as possible," Prozanski said. "It appears from some of the media coverage that's not the case. We need to make certain that it is."

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