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Sierra Hass holds a photo of her brother Kenneth Hass who died in a seclusion room under the care of Oregon State Hospital.
Credit: Isaac Wasserman / Lookout Eugene-Springfield / Catchlight / RFA

LATEST NEWS

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

BY **BEN BOTKIN**
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QuickTake:

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.

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

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Several months before Kenneth Hass died in Oregon State Hospital, an alarmed staffer filed a report about the patient's treatment and living conditions.

While living in a seclusion room littered with feces and trash, Hass received a food container that became mixed with feces and urine. He asked for a new meal.

He did not get one.

"You have food," a staffer responded, according to an internal Oregon State Hospital report about his treatment and the months leading up to his March 18 death at the state-run psychiatric hospital in Salem.

Hass, who was previously homeless in Lane County, went on to eat the soiled food. An employee who witnessed the incident was upset enough to file a complaint about Hass' living conditions with state officials, the report said. But the state's Office of Training, Investigations, and Safety never followed up with the staff member who complained, the report about Hass' death said.

Lookout Eugene-Springfield obtained a copy of the 61-page report from a whistleblower and corroborated the accuracy of its contents with employees at the hospital and other records, including the findings of federal regulators.

The report, called a root cause analysis, is closely guarded within the hospital's executive ranks, with a "not for distribution" label affixed to its cover and throughout its pages. Such reports are compiled by the hospital after major so-called "sentinel" events, such as unexpected patient deaths or serious injuries. The reports generally are intended to allow hospital officials to get honest and candid feedback about issues and solutions.

The report assesses the hospital's treatment of Hass, what went wrong and makes recommendations for changes to prevent future deaths.

On a broader level, the report paints a picture of a troubled institution with systemic failings and a "culture of complacency in which safety issues can be overlooked or ignored."

'Learned helplessness at all levels'

Hospital staff and leaders interviewed for the report "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."

The analysis relied upon interviews with 28 Oregon State Hospital staff members and reviews of more than 1,000 pages of records and security camera footage.

The hospital's main Salem campus is responsible for caring for up to nearly 600 patients at a time, many of them sent there for court-ordered treatment necessary so that they can assist in their defenses against criminal charges in courts throughout Oregon.

Marsha Sills, a spokesperson for the state hospital, would not answer questions about the report, including the systemic problems it identified.

"Oregon State Hospital (OSH) declines to respond to questions based on an improperly disclosed report," Sills wrote in a prepared statement, citing patient privacy laws.

The report does not identify Hass by name. Lookout confirmed his identity through previous interviews with family members, including his sister and legal guardian, Sierra Hass of Springfield. The hospital's report includes details, including the date and time of death, that align with other records about the case.

Sills declined to specifically answer a question about what the hospital can do to change the "culture of complacency," but insisted officials are tackling the issues.

"OSH takes every regulatory finding seriously, and the issues identified in this report are being addressed through ongoing oversight," Sills said.

Oversight continues next week as the Legislature has called Oregon State Hospital officials to appear at 11:30 a.m. Monday before the Senate Interim Committee on Judiciary for a presentation on the prevention of deaths, injuries and other "sentinel events."

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

Culture of complacency

The report identifies systemic and widespread patterns of shortcomings that go beyond the Hass case.

Since November 2023, the hospital has experienced five unexpected patient deaths, including Hass, the report said. In the last two years, federal inspectors with the Centers for Medicare & Medicaid Services repeatedly found violations related to patient care and safety.

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.

The report acknowledged the number of deaths is troubling, especially for a short period of time.

The report also examined other factors that may not have played much of a role in Hass' death at age 25: For example, it said the combination of rapid patient movement throughout the court system and quick but unvetted corrective actions taken in response to patient deaths and other serious events has "made stabilizing the hospital and ensuring safety even more challenging."

> ***This patient's death has resulted in widespread sadness and soul-searching as to why a 25-year-old patient with numerous high-risk factors was not identified and systematically supported.***
>
> — OREGON STATE HOSPITAL CONFIDENTIAL REPORT

The report also found:

1. The hospital's systems are unable to keep pace with the turnover of patients facing serious psychiatric

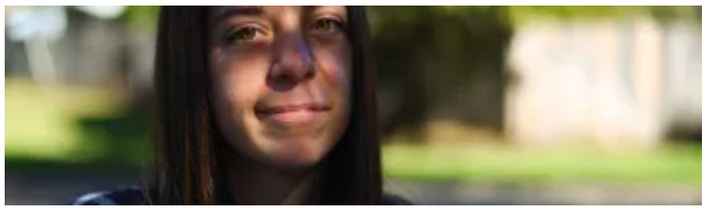
and medical needs.

2. The hospital has a “clumsy” medical record system that impacts the ability to provide efficient care and hinders safe medication administration practices.

3. Reviews of other sentinel events during the past three years have “consistently found that patient risk factors were often not known or understood by the unit team.”

4. Since May 2022, the hospital had a dozen falls with bone fractures or other serious injuries like intracranial bleeding, four incidents with nonconsensual sexual activity and three cases of patient-to-patient assault with serious injuries.

“Staff do not know what to do given the amount of change,” an unnamed senior hospital leader is quoted as saying in the report. “And more change is coming. I don’t know how to get out of this. There is not a level of critical thinking at any level.”



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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‘That won’t work’

Hass first entered the state hospital in March 2022 for court-ordered treatment to face charges in Lane County, which were assaulting a public safety officer, trespassing and attempted assault, common charges when people in mental health crises are arrested.

The charges were dropped after he didn’t show enough improvement within the first year.

Due to a civil commitment order issued in March 2023, Hass continued to live in the Oregon State Hospital.

The final months were among the most challenging: Hass was primarily in seclusion or restraints from July 2024 until his death March 18, 2025, the report said.

Yet during that extended length of time, Oregon State Hospital staff struggled to effectively treat him for a variety of conditions that included schizophrenia and psychosis with delusions, agitation and self-harm, including diving off countertops, the report said.

During that time, staff locked his access to the bathroom due to concerns about him jumping off the sink or toilet and injuring himself on the concrete floor, records show. The seclusion room in which Hass spent the last months of his life included a urinal, bedpan and a mattress on the floor. Hass’ room would quickly become soiled with feces and urine.

Staff became desensitized to the sight of the waste, including on Hass himself, the report said.

The report quoted a staffer who offered to clean Hass once while he was restrained. A nurse responded by saying: “I don’t think anyone has done this (cleaned him) in three months.”

A staffer who washed Hass during that time reported dried feces over his face and body and sores on his testicles, likely from encrusted waste, the report said.

There were efforts to help Hass that met resistance, the report said. A staff member with expertise in patient management and problem-solving started to meet with Hass in May 2024, initially for a three-hour meeting.

The staffer met him every other day when he was in locked seclusion and visited him, playing games and listening to music.

The staff reported Hass “was able to have goal-directed, linear conversations, but was anxious, depressed, and despondent about being in prolonged seclusion,” the report said. “He would exhibit anger at them at times, but most of the time they were able to successfully engage with him and by the end of the session he would be in a better mood.”

When the staff member tried to encourage other workers to use those tools, those efforts did not gain traction.

The staff member “attempted to have staff follow their lead and was mostly met with apathy and resistance,” the report said. “They indicated that it appeared staff had given up on this patient.”

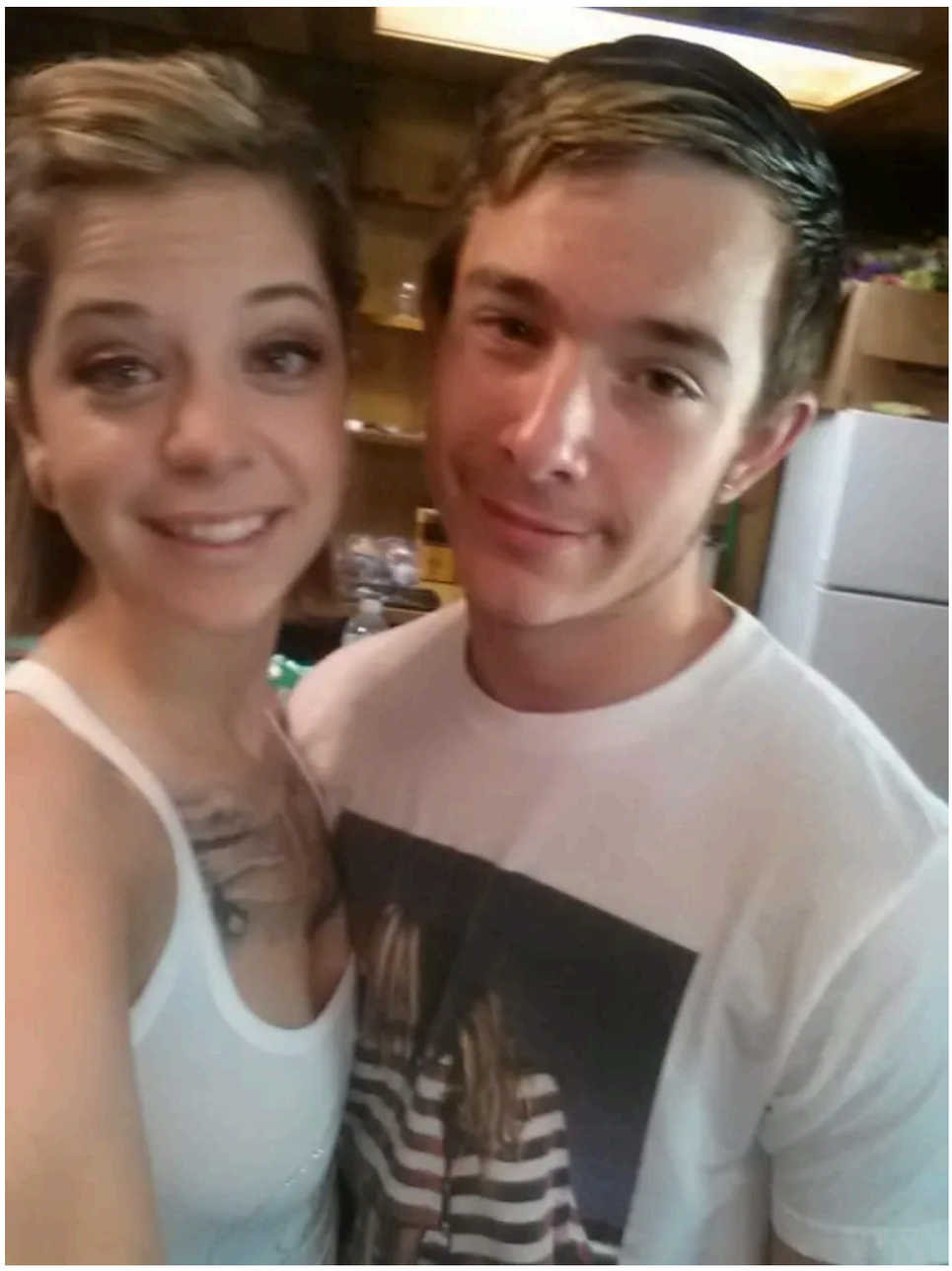
The same staffer repeatedly expressed concerns about Hass’ well-being, the report said, and was told “it’s not safe to enter” his room. Offers to help design ways to allow staff to safely enter and exit the room were rebuffed.

The staffer was told: “That won’t work.”

The report did say Hass could be aggressive, and when the door to his seclusion room was opened, he would typically charge the staff in an attempt to strike them.

But while some staff expressed concerns for their safety, the report said the risk may have been overblown. A safety expert interviewed for the report said Hass didn’t cause serious injuries when he hit people.

The expert said if any staff member was out of work for “more than a couple days” after an encounter with Hass, it “was due to our errors.”



Sierra Hass and her brother, Kenneth Hass, in 2015. Kenneth Hass died at Oregon State Hospital on March 18. He was 25. Credit:

Courtesy photo from Sierra Hass

Accepting the status quo

The report said offers from the hospital's safety experts to "design, develop and carry out the physical interventions" with Hass for room changes "were not listened to and even chastised."

And a staff member reported facing ridicule for bringing up concerns about the room's lack of hygiene.

The review found no evidence that the hospital's infection-control staffers were ever contacted for guidance on how to help the patient or environment.

Rather than clean his room regularly, hospital staff typically moved him to another room at varying intervals, sometimes once every two weeks.

Yet some staff on the unit were under the impression that cleaning happened more frequently — every other day, or once every three days.

Cleanings were chaotic and not uniform when they happened, the report said. Video footage reviewed for the report showed Hass cleaning his own room with towels, or a nurse asking him to move to the far side of his room and quickly removing piled-up garbage.

"It appears that deep cleans of bodily fluids rarely occurred, outside of seclusion room changes," the report said.

Hass stayed for months in that environment.

And at least some staff came to believed their suggestions to improve his conditions would come to naught.

"There are no reliable mechanisms in place to escalate concerns or to track that concerns that have been raised have been considered," the report said. "Staff stated this has resulted in complacency and acceptance of status quo."

The report said complacency had been a "consistent observation" in other root cause analyses conducted during the last two years.

"We don't have a robust accountability mechanism down the chain of command," said one staff member interviewed for the report, echoing what was a lack of accountability for employees.

In this environment, Hass languished.

"He was locked in a room 24-hours a day walking in a circle of human waste," another staff member said.

'Harm and death': Report shows how Oregon State Hospital failed a Lane County patient

Federal inspectors linked repeated failures at Oregon State Hospital to the March 18 death of a patient in a locked seclusion room. When the hospital released the report, it censored those failures from the public's view, an unredacted version obtained by Lookout Eugene-Springfield shows.

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Details of his death

By the time Hass died, he was classified as having a high risk of falling. On the night of March 18, 2025, the hospital made a change: A doctor ordered the bathroom door to be unlocked.

In the span of about an hour, Hass fell three times in the seclusion room's bathroom. In each case, no one entered the room to check on him, this report and other records show.

During the third fall, Hass climbed on top of the toilet, jumped, hit his head and died. Staff saw him fall, gathered outside his room and watched while he lay motionless.

More than four minutes later, they finally entered. Hass had no pulse.

Federal inspectors flagged numerous problems in the response, including the failure to check on the patient during earlier falls and a failure to immediately check on him after he fell the final time.

In the aftermath, Gov. Tina Kotek announced April 11 the replacement of Dr. Sara Walker, the chief medical officer and interim superintendent.

Dave Baden, a deputy director at the Oregon Health Authority, temporarily stepped in as superintendent.

Jim Diegel, a longtime hospital executive in the private sector, became the interim superintendent in late May, shortly after the report's completion.

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

Systemic problems identified before death

Though the root cause analysis report is becoming public only now, its concerns are not new.

In an Aug. 15, 2024, meeting — more than seven months before Hass died — Oregon Health Authority Director Sejal Hathi met with nearly a dozen hospital staff, asking for candid feedback.

A recording of that meeting, reported April 3 by Lookout Eugene-Springfield, showed employees raised concerns about a culture of retaliation, a lack of accountability and a widespread inability to follow existing rules and protocols.

In recent weeks, Oregon State Hospital officials announced improvements they enacted to improve conditions, including teams to review seclusion and restraint cases. Those recommendations came from federal inspectors and accreditation surveyors, a different process than the hospital's internal report.

Sills, the hospital spokesperson, said other changes include "improved treatment care planning to mitigate and prevent future falls," and more training, education and audits of patient care documentation to track staff performance.

The confidential report makes a variety of additional recommendations, including video audits for patients at high risk of falls who are in seclusion; a 60-second rewind feature for video monitoring teams to verify an incident; and drills that include fall responses.

Hospital officials would not answer a question about whether they have enacted those recommendations — and the many others — listed in the report.

But as the report states, questions remain about Hass' death, one that shook the hospital:

"This patient's death has resulted in widespread sadness and soul-searching as to why a 25-year-old patient with numerous high-risk factors was not identified and systematically supported."

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