

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

BY BEN BOTKIN November 2, 2025

Sierra Hass, whose brother, Kenneth Hass, died at Oregon State Hospital, is advocating for health care reform. "That was my best friend right there," she said. "Nobody deserves to be given up on. These are people that matter. People that shouldn't be brushed aside."

Credit: Isaac Wasserman / Lookout Eugene-Springfield / Catchlight / RFA

QuickTake:

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.



A grieving family seeks answers after a patient d

About 17 Minutes

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Everlit

In the final months of his life, Kenneth Hass lived in a filthy seclusion room at Oregon State Hospital.

His access to the room's bathroom was usually locked, a step staffers took to prevent him from jumping off the sink counter and onto the floor. Garbage, feces and urine often filled his room, according to records and his sister, Sierra Hass of Springfield. After she became his legal guardian in late 2024, she visited her brother in the state-run psychiatric hospital in Salem before he died there March 18, at age 25.

Staffers placed a towel along the bottom of the room's door to keep the odor from drifting into their work area where they observed him, Sierra Hass said. Whenever she visited, she did her best to comfort him, speaking to him through a window, unable to hug him.

"I'd just tell him, 'I love you,'" she said in an interview with Lookout Eugene-Springfield. "'I'm here for you. I'm trying to make this better for you.'"

Hass' death sent shock waves across Oregon State Hospital, which can hold up to 558 patients at its main Salem campus and another 145 patients in Junction City. Courts across Oregon send patients there when they

need mental health treatment to face criminal charges. Less than a month after Hass' death, and after learning more details, Gov. Tina Kotek replaced the hospital's interim superintendent, Dr. Sara Walker.

Yet the Oregon Health Authority, which runs the hospital, also tried to keep those same details under wraps, even after Walker's ouster and after federal officials placed the hospital in immediate jeopardy, which put it at risk of losing funding. Violations included a failure to provide a timely emergency response to Hass when he fell March 18 and was motionless on the floor, a failure to clean his seclusion room and a failure to record reasons for placing him in restraints.

The Oregon State Hospital redacted those details and many others when it released records to the public and Lookout Eugene-Springfield, which obtained an unredacted copy of the federal report.

As with past cases, state hospital officials promised to do better and worked up a corrective plan, as required by the federal Centers for Medicare and Medicaid Services.

The improvements include a team that works with staff directly on a case-by-case basis to reduce the time patients spend in seclusion, a spokesperson for Oregon State Hospital said in a statement to Lookout Eugene-Springfield. The hospital also has updated its assessments to "clearly articulate release criteria" for patients in seclusion and updated logs to track room cleanliness and emergency response, hospital spokesperson Marsha Sills said in an email.

Earlier this year, the hospital redacted the federal report's finding that the hospital failed to develop and implement "policies, procedures and staff training that ensured patient safety and security," citing patient confidentiality.

Kenneth Hass' death is not the only one at the state hospital that cast a spotlight on problems connected to patient care and safety. In the last two years, Oregon State Hospital has faced multiple violations related to care after federal inspectors investigated other patient deaths.



I pray that they will realize that this isn't right, and that they will wake up and that they'll do their job — they'll care.

— SIERRA HASS

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 arrived. And in May 2024, another patient died of a **suspected fentanyl overdose**.

Since her brother's death, Sierra Hass has searched for answers to the questions about his treatment at Oregon State Hospital. But the answers are elusive. And the pain lingers.

Oregon State Hospital officials declined to comment on the violations related to its care of Kenneth Hass.

Sierra Hass knows her brother cannot return, yet she wants to ensure that no Oregonian, anywhere, experiences the same anguish of her family's loss. For this reason, she and Kenneth's father, Sean Oldham, agreed to share Kenneth's story with Lookout Eugene-Springfield.

"My feeling towards the state hospital, obviously, is horrible," Oldham said in an interview at his Cottage Grove home. "I mean, they killed my son. That's how I feel."



Sean Oldham of Cottage Grove holds a picture of himself with his two daughters and infant son, Kenneth Hass. Sierra Hass is on the right. Credit: Ben Botkin / Lookout Eugene-Springfield

A family photo

In Oldham's living room, a family photo lies on a table. In the image, Oldham holds his infant son, with his two daughters on either side.

Oldham has few photos of his son. He lost most of them in a house fire years ago.

Kenneth was born nine weeks prematurely on Aug. 2, 1999. He weighed 4 pounds, 4 ounces. Oldham cut his son's umbilical cord.

He had a mild case of cerebral palsy. But that didn't stop his enthusiasm for running, climbing and hiking.

“He used to worry that he was different because of it, but he was so darn athletic and fast,” Oldham said.

In his early years, Kenneth spent much time with his family in the Creswell area. His father took him fishing.

His oldest sister, Sierra, four years older, became his best friend. The two were inseparable.

On a school playground one day, Kenneth swung off the crossbars and fell to the ground on his chest. His father and sister went to check on him.

“All he could say is, ‘I’m OK. I’m OK,’” Oldham said. “No matter how hard of a hit he took, he just wanted everybody to know he’s OK. He didn’t want anyone worrying about him.”

The last time Kenneth fell, he was a patient in Oregon State Hospital. Hospital staff watched him lie motionless on the floor for more than four minutes before going into the room to check his vitals, records show.

By the time staff entered the room, Hass was no longer breathing.

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

Challenges early in life

Kenneth Hass faced difficulties as a young adult, when symptoms of psychosis emerged, the report said. A few years later, Oregon State Hospital staffers diagnosed him with schizophrenia with paranoia and delusional beliefs, but failed to effectively treat him and wondered if an undiagnosed issue was at the root of the challenges, records show.

In his late teens, Kenneth Hass lived in Texas and graduated from high school, according to a social worker’s report filed in court when his sister filed a petition to be his legal guardian.

He did well in high school, but as a young adult, he became seriously ill and mental health challenges emerged. In Texas, he was arrested in 2019 for assault and spent time in jail before returning to Oregon, the report said.

In Lane County, Kenneth Hass was often homeless on the streets of Eugene. Sierra Hass would take food to her brother.

At times, he'd come and visit with Sierra Hass and her family.

Oldham took his son food and clothes, though it was also difficult to keep track of him.

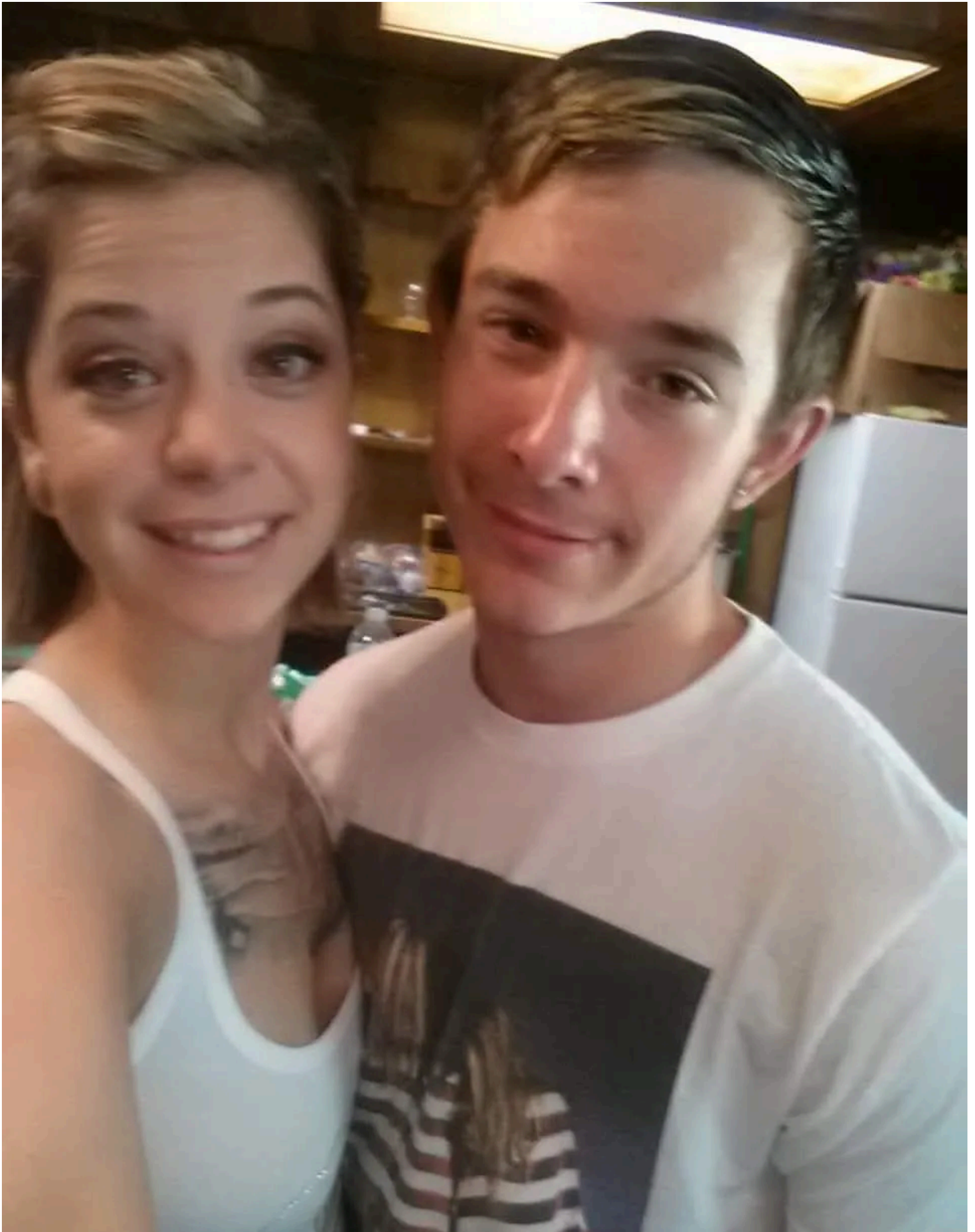
“He would disappear so darn much there at the end,” Oldham said. “Sierra knew where he was, but most of the time I did not.”

Earlier in life, Kenneth Hass looked after his sister.

When she was 16 and he was 12, he stepped between her and a 16-year-old boy who wanted to hit her.

He told her to run and took blows from a bully.

Years later, Sierra Hass looked after him in his darkest hours.





Sierra Hass and her brother, Kenneth Hass, in 2015. (Courtesy photo from Sierra Hass) Credit: Courtesy photo from Sierra Hass

Path to the state hospital

In November 2021, Kenneth Hass was charged in Lane County, accused of assaulting a public safety officer, trespassing and attempted assault, all common charges when people in mental health crises are arrested.

In March 2022, a judge signed an order authorizing Hass' commitment to Oregon State Hospital. The step is necessary for people facing court charges so they can get mental health treatment necessary to assist their attorneys in their defense. Such cases, called "aid and assist," represent the majority of people who enter Oregon State Hospital.

In October, 48 aid-and-assist patients from Lane County were in the state hospital, part of 388 patients statewide, data show.

A year later, according to court records, Hass had not made enough progress to bring charges forward. After reviewing the case, a judge in March 2023 dismissed the charges as Hass could not aid in his defense.

Even though dismissal of the charges often means a patient is released from the hospital, Hass remained there on a civil commitment order issued the same month the charges were dropped.

Hass lived in the state hospital for two more years. And during that time, Sierra Hass worked to get answers about her brother and his treatment. Even now, she's still looking for answers.

In a visit to the hospital in late 2022, Sierra Hass noticed how interaction with others was benefiting Kenneth Hass.

Her brother was playing dominoes with state hospital staffers and, she said, doing well.

"He was in such a better place, physically, mentally, everything," she said. "And so it just really speaks volumes to me that, when he had that human interaction, how much better he did."

But as time wore on — during which she became her brother's legal guardian — she watched his deterioration.

In the months leading up to his death, records show, hospital staff struggled to treat him effectively and blocked his access to the bathroom because he jumped off the sink counter or toilet.

In the months before he died, Hass was shuffled from room to room.

Without bathroom access, Hass' seclusion room became filled with feces and urine. Staff avoided cleaning the room while he was inside, saying it was too difficult with the patient in the room, records show.

When staff decided a room was too filthy, they moved him to another room.



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

'How did this happen?'

Sierra Hass said Kenneth Hass' condition continued to decline as he remained in seclusion for months.

The report into Hass' death compiled by federal inspectors backs up her account and shows that Hass was often in seclusion and staff struggled to interact effectively with him and treat him. They also feared he would assault them, records show. In response, hospital staff often avoided cleaning his room.

“He couldn’t dress himself anymore,” Sierra Hass said. “At times, he couldn’t even lift his head up. His head was just sunk down. So I’m asking them to take him off of these medications and to just see what happens when he gets some human interaction, some love, because he had been in seclusion for months.”

In October 2024, a social worker visited Kenneth Hass because his sister filed court papers to become her brother’s guardian. A report filed by the social worker shows staff at the hospital openly wondered if some other undiagnosed condition hampered efforts to treat his schizophrenia.

“Staff at OSH are speculating that (Hass) may have an undiagnosed brain injury, developmental disability, or other condition that complicates his illness and makes him non responsive to medications usually used for treatment of Schizophrenia,” the social worker’s report said, noting he showed “no signs of improvement.”

That was less than five months before he died.

At times, Sierra Hass struggled to get basic information, even when her brother was alive in the hospital.

“I would drive from Eugene to Salem only to be told that they had canceled our visit, and no reason why,” she said. “Just: ‘Sorry, you’re not going to see him today.’ So it was really impossible to even understand what was going on there. ... How did this happen?”

The experience left her wondering what transpired when she was not present.

“I can only imagine how much worse it was when I was denied my visits,” she said.



Oregon State Hospital in Salem. Credit: Oregon Health Authority

Bound in restraints

Federal inspectors flagged problems after reviewing documentation of the months leading up to Hass' death. On Dec. 21, 2024, Hass was moved to a new seclusion room in restraints and secured to a bed.

An inspector's review found that a registered nurse's progress note said he was "verbally abusive" to staff while placed in restraints, but noted that in and of itself was not enough to continue to keep him in restraints while in his new room.

"It was unclear why (he) remained in 4-point restraints secured to a restraint bed for verbally abusive behaviors after entry into the new seclusion room," the report said.

A couple days later, he was moved again. This time, he was placed in restraints at 3:50 p.m., Dec. 23, 2024, with the restraints attached to his new bed seven minutes later. The door was locked, and Hass remained in

restraints until at least 2:45 a.m. the next day – nearly 11 hours, the report said. Beyond that time frame, inspectors were uncertain due to incomplete records.

Inspectors found a pattern in their review of the case.

“Justification for the ongoing seclusion and additional application of mechanical restraints was not clear,” the report said. “Observation and monitoring of the patient was inconsistent.”



I’d just tell him, ‘I love you. I’m here for you. I’m trying to make this better for you.’

— SIERRA HASS

Singing in seclusion

At about this time, in December 2024, records show that Hass requested and received a Bible. Early in Kenneth’s life, his father said, he took his son to church.

Kenneth Hass drifted away from religion later, but in his seclusion room, he read the Bible.

On Dec. 2, 2024, a nurse wrote that he was “often kneeling and appearing to pray.” Another staffer wrote that he spent time resting on his mattress, pacing and singing in the room, which often had puddles of urine on the concrete floor.

For the father, his son’s interest in faith — even in squalid conditions — brings a measure of comfort. He heard from his daughter that Hass had been reading the Bible.

“In the end, she said that all he did was read the Bible,” Oldham said. “And he was singing the song, ‘Jesus Loves Me.’ I was so happy he realized that.”

Oldham takes comfort in another memory: During one of Sierra’s visits, Kenneth asked her if his father loved him. She told him “yes.”

“Kid, I always want you to know that I always did — no matter how you were,” he said.



Sierra Hass holds a photo of her brother, Kenneth Hass, who died in a seclusion room under the care of Oregon State Hospital. “My daughter keeps asking me, ‘When do I get to see Uncle Kenny?’” Sierra Hass said. Credit: Isaac Wasserman / Lookout Eugene-Springfield / Catchlight / RFA

The night he died

By the time he died, Hass was classified as a high risk for falling. For months prior, staffers had documented his inclination to jump off the bathroom sink and counter onto the floor.

One day in December, Hass fell five times.

Staff usually locked the bathroom door so he wouldn’t jump off the sink and hurt himself. At one point, staff placed a mattress on the bathroom floor to soften potential landings.

On the night of March 18, 2024, the hospital made a change: A doctor ordered the bathroom door to be unlocked. It's unclear why, but the report shows staffers were expected to monitor him continuously — and take action if he was hurt.

In the span of about an hour — from 9:32 p.m. to 10:34 p.m. — Hass fell three times in the seclusion room's bathroom, the report found. In each case, no one entered the room to check on him, inspectors found in their review of video footage.

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. He had no pulse.

'It's broken.' Safety concerns at Oregon State Hospital raised months prior to death of Lane County man

Sierra Hass got a call about the death. Staffers told her little: She found out they tried to keep the bathroom door open for him and didn't expect the fall.

The talk about the door reminded her of a previous conversation involving doors at the hospital: During an earlier visit to her brother, another door — the one needed to enter his room — had stayed closed.

"I had asked the doctors if I could open the door and give him a hug, and they just told me that I couldn't, for safety reasons," Hass said.

Sierra Hass isn't satisfied with that explanation and many of the other ones she's received from the hospital. She has retained an attorney and filed a tort claim notice with the state. At this point, a lawsuit has not been filed.

"What happened was preventable and horrifying," said her attorney, Ben Turner of D'Amore Law Group in Lake Oswego. "And by all accounts, it seems like Kenneth was involuntarily committed. The state forced him to be there, and the promise was they were going to make him better, or try to make him better. From everything I've seen, it seems like they didn't. They just gave up on him."

Beyond the legal process, Sierra Hass hopes for lasting changes.

Her thoughts are still focused on the staffers who failed her brother — and the patients who remain at Oregon State Hospital.

“In any way that I can, I will ensure that this changes and that the hospital has to remember that these are people, these aren’t nuisances,” she said. “Their job is to care for these people. ... I pray for the doctors. I pray that they will realize that this isn’t right, and that they will wake up and that they’ll do their job — they’ll care.”

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