

Grand Jury Inquiry | Marion County 2026



Oregon State Hospital
Salem, Oregon

Table of Contents

Table of Contents	2
Executive Summary	4
Statutory Background	6
Scope of this Report	6
Overview of the Oregon State Hospital	7
Purpose & Function	7
Structure & History	8
Population Served	8
Federal Litigation	13
Time Limits for Hospital Restoration	15
Grand Jury Findings	21
Principal Finding	21
Population	21
Pre-Admission	29
Transportation	30
Admission	30
Medication	32
PSRB	33
Discharge	34
Leadership	35
Patient and Staff Safety	38
Patient Experience	40
Staffing & Services	41
Conflict of Purpose	46
Seclusion	48
Facility Tour	50
Conclusion	51

Grand Jury Findings.....	51
Grand Jury Recommendations.....	53
Acknowledgements.....	55

Executive Summary

On March 13, 2026, Marion County District Attorney Paige Clarkson convened a Grand Jury to inquire into the conditions and management of the Oregon State Hospital, located in Salem Oregon. The investigative Grand Jury was specifically undertaken to examine current operations, capacity challenges, and public safety implications associated with the Oregon State Hospital (OSH).

During the six-month inquiry, the Grand Jury:

- Held 13 sessions where they inquired into the conditions and management of OSH.
- Heard over 47 hours of testimony from approximately 40 witnesses, which included current and former OSH employees, medical providers, OSH management, union representatives, forensic evaluators, a former patient, a patient's mother, witnesses from Marion County Sheriff's Office, a Circuit Court judge, community partners, and other witnesses.
- Considered hundreds of pages of documentary evidence.
- Toured the grounds at the OSH Salem campus.

The inquiry process included over 445 hours of Marion County and Washington County District Attorney's Office time at an approximate cost of \$44,500.

Principal Finding

In summary, the Grand Jury's principal finding is that OSH lacks sufficient bed capacity to simultaneously meet the needs of Oregonians in need of hospitalization at OSH for aid and assist restoration, commitment after being adjudicated guilty except for insanity, or in need of commitment under Oregon's civil commitment laws.

The consequence of this deficit has led to a decrease in patient restoration and/or rehabilitation. This impact is seen in communities across Oregon as patients are discharged into our communities before meaningful treatment is delivered, which directly impacts public safety.

The Grand Jury examined the following aspects of OSH:

- Population
- Pre-Admission
- Transportation
- Admission

- Medication
- Psychiatric Security Review Board
- Discharge
- Leadership
- Patient and Staff Safety
- Patient Experience
- Staffing and Services
- Conflict of Purpose
- Seclusion
- Facility Tour

Overall, the Grand Jury made 19 findings across the categories described above. The findings listed in this report are numbered for organizational purposes and do not reflect the Grand Jury's belief that any single finding is of higher importance than another. These findings relate to the patient's path through the system, such as during admission and their time as a patient, as well as broader concerns at the hospital including patient experience, safety, staffing, and leadership. Additional findings address the population at OSH, an overall conflict of purpose, the use of seclusion, and the Grand Jury's experience during a facility tour. A comprehensive list of all findings can be found at the end of this report.

Statutory Background

Pursuant to Oregon Revised Statute (ORS) 132.440, Marion County District Attorney Paige Clarkson convened a Grand Jury with the goal to understand current operations, capacity challenges, and public safety implications associated with the Oregon State Hospital (OSH). Per ORS 132.250(4), these Grand Jury proceedings were not recorded.

Scope of this Report

The Grand Jury recognizes the limitations of its role in evaluating the operations of OSH. While the Grand Jurors reflect a cross-section of the Marion County community, they may not be mental health or medical professionals, security professionals, or legislative policymakers. This report reflects a community perspective based on snapshot observations, testimony, and evidence presented during the inquiry. It is not intended as an expert audit nor technical analysis. Where appropriate, the Grand Jury highlights potential solutions that arose in discussion but acknowledges complexities exist that may make the recommendations impractical.

The Grand Jury recognizes its statutory role in investigating the conditions and management at OSH, but also acknowledges the role state government plays in the life of a patient. Oregon must ensure humane treatment, accountability, and community safety. If rehabilitation for these patients has not occurred, the issues will continue to be amplified.

While this report is primarily focused on problem areas identified and discussed during the inquiry, OSH has numerous employees focused on the restoration, well-being, and placement of OSH patients.

This report focuses almost exclusively on issue areas in an effort to facilitate sustainable improvements at the facility as quickly as possible. This Grand Jury did not balance areas of concern with areas that were working well.

Finally, this report is intended for general citizens and policymakers without specific mental health, correctional, or criminal justice experience.

Overview of the Oregon State Hospital

Purpose & Function

The Oregon State Hospital (OSH) is a state-operated in-patient psychiatric hospital which operates under the direction of the Oregon Health Authority (OHA) and is accredited by the Joint Commission on the Accreditation of Health Organizations.¹ OSH has campuses in Salem and Junction City, with 558 and 145 beds, respectively.² OSH serves more than 1,500 people per year and employs more than 2,700 staff.³ This inquiry focuses on the OSH Salem campus, located in Marion County.

OSH states it provides “patient-centered, psychiatric treatment for adults from throughout the state who need hospital-level care” and its goal is to “help people recover from their illness and return to the community.”⁴ The hospital provides psychiatric evaluation, diagnosis, and treatment, along with community outreach and peer support.⁵

Hospital level care includes: 24-hour on-site nursing, psychiatric, and other credentialed professional staff, treatment planning, pharmacy, laboratory, food and nutritional services, vocational, and educational services.⁶

Defendant / Patient / AIC

This report uses different terms to refer to an individual, depending on which system or setting is being discussed. "Defendant" is used in the context of court proceedings; "patient" is used in the context of treatment at Oregon State Hospital or another clinical setting; and "AIC" (Adult in Custody) is the term used by correction facilities. These terms are used interchangeably throughout this report and do not indicate a change in the individual's legal status.

A witness told the Grand Jury that the Salem campus has six units. Within the six units there are four programs: two are gender based, one is mixed, and one is geriatric. Total bed capacity at OSH in Salem is 558, which includes 24 beds held for emergency reserve purposes. Each unit

¹ Oregon Health Authority, *Oregon State Hospital – About Us*, available at <https://www.oregon.gov/oha/OSH/Pages/About.aspx> (last accessed July 1, 2026).

² *Id.*

³ *Id.*

⁴ *Id.*

⁵ *Id.*

⁶ *Id.*

has two psychiatric providers. Each doctor has a patient load of 9–10 for high acuity units and 12–13 in medium acuity.

The OSH Salem campus was originally built in 1883 with capacity for 412 patients⁷. A hospital replacement project completed in 2013 increased bed capacity to 620 beds.⁸ The hospital was built with reinforced concrete and the rooms have high ceilings.

Structure & History

In 2006, the U.S. Department of Justice began investigating OSH pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA)⁹ due to overcrowding. At the time, rooms built for two patients housed five to eight. The investigation led to a scathing CRIPA report¹⁰ in January 2008, prompting OSH to immediately address many of the identified issues. Resultingly, the CRIPA investigation did not lead to litigation, there was no settlement, and in 2010 it was dropped and an *Olmstead*¹¹ investigation was begun. The Grand Jury heard testimony related to many of the issues identified in the CRIPA investigation.

During Grand Jury testimony, a former OSH employee said:

“My observation was the Legislature built out the new state hospital but failed [to build out the community resources needed to support that infrastructure] at the EXACT time the community was expected to absorb [patients] and could not tell what the plan was.”

Population Served

OSH is tasked to serve three distinct patient populations: aid and assist (A&A), guilty except for insanity (GEI), and civil commitments (CC).

⁷ Oregon State Archives, *Oregon State Hospital Administrative Overview* (November 2009), p. 2, (last accessed September 27, 2026).

⁸ Rebeka Gipson-King, "Oregon State Hospital Patients Settle into Junction City and Salem Campuses; Portland Campus Closes," *The Lund Report*, March 31, 2015, (last accessed September 27, 2026).

⁹ 42 USC § 1997 (1980).

¹⁰ U.S. Department of Justice, Civil Rights Division, Findings Letter Re: CRIPA Investigation of the Oregon State Hospital, Salem and Portland, Oregon (Jan. 9, 2008), available at https://www.justice.gov/sites/default/files/crt/legacy/2011/04/14/oregon_state_hospital_findlet_01-09-08.pdf (last accessed September 28, 2026).

¹¹ *Olmstead v. L.C.*, 527 US 581 (1999) (the Americans with Disabilities Act requires states to place person with mental disabilities in the community rather than institutions when it has been determined that a community placement is appropriate, a less restrictive setting is not opposed by the individual, and the placement can be accommodated).

Aid & Assist

Under the United States Constitution, a criminal defendant must be able to aid and assist in their own defense.¹²

In Oregon, a court must make two specific findings in order to find a defendant incapacitated (also known as “unable” or “unfit”):

- 1) The defendant has a qualifying mental disorder (a defendant’s mental state due to chemical/drug use or a personality disorder does not qualify), and
- 2) As a result of that mental disorder, the defendant is unable to:
 - Understand the nature of the proceedings against them,
 - Assist and cooperate with counsel of the defendant, or
 - Participate in the defense of the defendant.¹³

Thus, there must be a causal nexus between the defendant’s mental disorder and the impaired ability.

A person’s ability to aid and assist addresses their current mental state and condition (as opposed to mental capacity at the time of the crime, which is discussed below regarding GEI), and therefore their competency to stand trial.

Competency to stand trial is a due process right that may be raised at any time during the criminal proceedings and raised by any party (court, defense counsel, or the prosecutor). When a person’s ability to aid and assist is questioned, the court may call any witness to assist in reaching its decision.¹⁴

Forensic evaluators, either a licensed psychiatrist or psychologist, may perform an examination of the person and review collateral records and information in order to provide an opinion to the court in an evaluation report.

If a court finds that a defendant is unable to aid and assist, the court must:

1. Suspend criminal proceedings against the defendant,¹⁵

¹² *Dusky v. United States*, 362 US 402 (1960).

¹³ ORS 161.360(2).

¹⁴ ORS 161.365(1)(a).

¹⁵ ORS 161.370(2)(a).

2. Receive a recommendation from a community mental health program director whether appropriate community restoration services are present and available in the community, and¹⁶
3. Determine if there is substantial probability that the defendant can be restored to fitness in the foreseeable future.¹⁷

For felonies, Oregon law provides that a defendant may be committed to OSH if “appropriate community restoration services are not present and available in the community” and the defendant requires a “hospital level of care due to public safety concerns if the defendant is not hospitalized or in custody or the acuity of symptoms of the defendant’s qualifying mental disorder[.]”¹⁸. For misdemeanors, Oregon law provides that a defendant may be committed to OSH if: appropriate community restoration services are not present and available in the community, defendant requires hospitalization due to public safety concerns, and the defendant requires hospitalization due the acuity of symptoms to order a defendant to OSH¹⁹.

However, as explained further in this report, federal court orders for the past several years have restricted who may be admitted to OSH and for how long.

¹⁶ ORS 161.355(2) (for Measure 11 offenses, this recommendation is discretionary rather than mandatory).

¹⁷ ORS 161.370(2)(b).

¹⁸ ORS 161.370(3)(a)(A)–(B).

¹⁹ ORS 161.370(4)(a)(A)–(B).

A defendant who is ordered by a court to OSH pursuant to ORS 161.370 is committed for “stabilization and mental health treatment that enables them to understand the criminal charges against them and ‘aid and assist’ in their own defense.”²⁰ Figure 1 below describes a typical patient path from arrest to OSH.

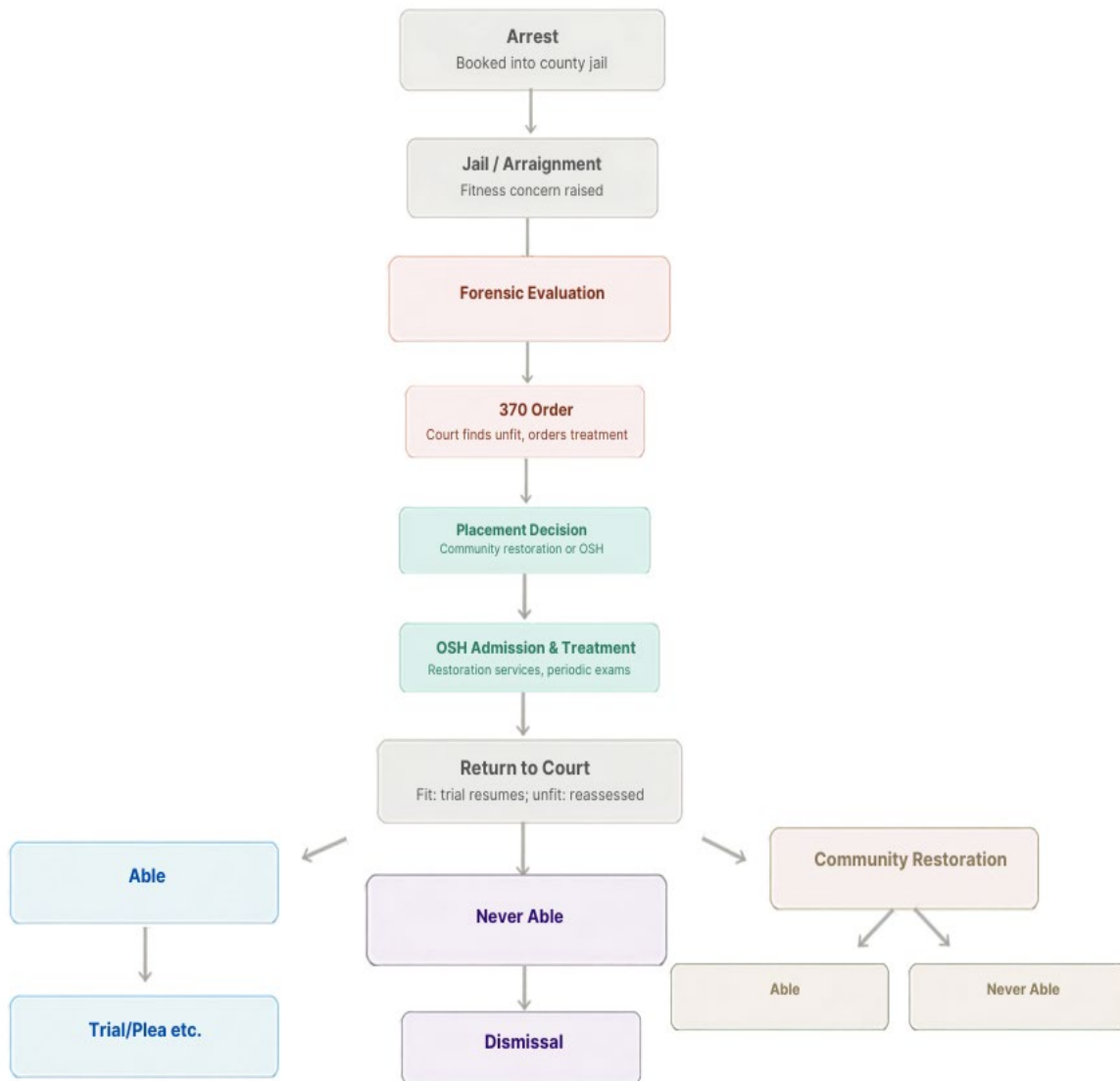


Figure 1 - Arrest to OSH

²⁰ Oregon Health Authority, *Oregon State Hospital – About Us*, available at <https://www.oregon.gov/oha/OSH/Pages/About.aspx> (last accessed July 1, 2026).

Guilty Except for Insanity

Oregon law provides that a person is guilty except for insanity if:

At the time of engaging in criminal conduct, the person lacks substantial capacity either to appreciate the criminality of the conduct or to conform the conduct to the requirements of law; and

(a) But for a qualifying mental disorder, the person would have had such substantial capacity;

(b) A mental disorder other than a qualifying mental disorder is not the primary cause of the lack of substantial capacity; and

(c) The lack of substantial capacity is not the result of voluntary intoxication in combination with a qualifying mental disorder, a mental disorder other than a qualifying mental disorder or both.²¹

GEI is a defense raised by a defendant which requires examination of the defendant's mental state at the time of the criminal conduct.

A qualifying mental disorder does not include "abnormality manifested only by repeated criminal or otherwise antisocial conduct, nor does the term include any abnormality constituting solely a personality disorder."²²

Upon a finding of GEI, the court may order the person to OSH.²³ If the case involves a felony, the person is subject to the jurisdiction of the Psychiatric Security Review Board (PSRB), even after the person is released from OSH.²⁴ If the case involves a misdemeanor, upon the person no longer being affected by a qualifying mental disorder or, if so affected, no longer presents a substantial danger to others that requires commitment, OSH shall discharge the person from custody.²⁵

Civil Commitment

There are two statutory schemes for civil commitment: civil commitment under ORS 426.060 and commitment of extremely dangerous persons under ORS 426.701.

ORS 426.060 commitment is for a person who has a mental illness and needs treatment because the person:

²¹ ORS 161.295(1).

²² ORS 161.295(2).

²³ ORS 161.327 & 161.328.

²⁴ ORS 161.327(1)(a).

²⁵ ORS 161.328(3).

1. Is a danger to self,
2. Is a danger to others,
3. Is unable to provide for basic personal needs, or
4. Has a chronic mental disorder.²⁶

A person under civil commitment is placed under the jurisdiction of OHA for up to 180 days.²⁷

An ORS 426.701 commitment is for when a person:

1. Is extremely dangerous,
2. Suffers from a qualifying mental disorder that is resistant to treatment, and
3. Because of the qualifying mental disorder that is resistant to treatment, the person committed a specific act (*e.g.*, caused or attempt to cause the death of another person, caused or attempted to cause serious physical injury by means of a dangerous weapon, engaged in certain sexual conduct against another, or arson related conduct).²⁸

A person committed under this statute is placed under jurisdiction of the PSRB for up to 24 months.²⁹ Both commitments are subject to renewal upon further order of a court.

Federal Litigation

In 2002, in the case of *Oregon Advocacy Center, et al. v. Mink, et al.* (“*Mink*”), Oregon Federal District Judge Owen Panner entered a federal judgment and injunction against the State of Oregon. This order required that persons found unable to aid and assist by Oregon state courts shall be admitted to OSH “not later than seven days after the issuance of an order determining a criminal defendant to be unfit to proceed to trial because of mental incapacities[...].”³⁰ The court retained jurisdiction to enforce the injunction.³¹

In 2021, *Bowman, et al. v. Matteuci, et al.* (“*Bowman*”), Oregon Federal District Judge Marco Hernandez entered a restraining order after two plaintiffs who were adjudicated as GEI

²⁶ ORS 426.131(1)(a)–(d).

²⁷ ORS 426.130(3).

²⁸ ORS 426.701(3)(a)(A)–(C).

²⁹ ORS 426.701(3)(a).

³⁰ *Oregon Advocacy Center, et al v. Mink*, No. 02-339-PA (D. Or. filed May 15, 2002).

³¹ *Id.*

continued to be confined at the Multnomah County Detention Center for nearly six and eight months, respectively, and alleged their substantive due process rights were violated.³²

Soon thereafter, Oregon Federal District Judge Michael Mosman entered an order consolidating the two cases (now “*Mink/Bowman*”) and appointed Dr. Debra Pinals³³ as a “neutral expert” to make recommendations to address capacity issues at OSH.³⁴ The Grand Jury heard testimony that while Dr. Pinals routinely met with staff to discuss the OSH’s ability to more quickly admit and discharge patients, Dr. Pinals is not an Oregon resident and per testimony only visited the OSH Salem campus once.

In 2022, Judge Mosman entered an order to implement Dr. Pinals’ recommendations following the court’s finding that the State of Oregon was not in compliance with the permanent injunction in *Mink*.³⁵ Specifically, restoration timelines were set to ninety days for a misdemeanor, six months for a felony, and one year for a charge subject to ORS 137.700 (“Measure 11”).³⁶ The purpose of this order was to ensure AICs are admitted to OSH within seven days of being ordered to that facility. This order set timelines different from those under Oregon law (see *Figure 4*).

In 2023, Judge Mosman entered a second amended order. This order restricted admission on misdemeanor cases to those charged with “person misdemeanors”³⁷ and violations of court restraining orders.³⁸ However, at the request of District Attorneys, the court allowed for extensions of the timelines for violent felonies, as well as allowing a thirty-day extension for discharge planning.³⁹

This admissions rubric proceeded until June 2025 when Judge Adrienne Nelson took over *Mink/Bowman* litigation following Judge Mosman’s retirement. On June 6, 2025, Judge Nelson found that “the State [of Oregon] has consistently relied upon the criminal justice system as the State’s default mental and behavioral health system” and “has failed to invest in community behavioral health systems such that for many individuals, the only opportunity to receive

³² *Bowman, et al. v. Matteucci*, No. 3:21-cv-01637-HZ (D. Or. filed Nov. 15, 2021).

³³ Dr. Pinals is “a lecturer at the University of Michigan Law School, and is a clinical adjunct professor at the University of Michigan Law School. She also serves as the director of the Program in Psychiatry, Law, and Ethics and as a clinical professor of psychiatry at the University of Michigan Medical School.” University of Michigan, *Debra A. Pinals*, (last accessed Jul. 1, 2026).

³⁴ *Mink/Bowman*, Nos. 3:02-cv-00339-MO & 3:21-cv-01367 (D. Or. filed Dec. 21, 2021).

³⁵ *Id.* (D. Or. filed Sept. 1, 2022).

³⁶ *Id.*

³⁷ OAR 213-003-0001(15).

³⁸ *Mink/Bowman*, Nos. 3:02-cv-00339-MO & 3:21-cv-01367 (D. Or. filed July 3, 2023).

³⁹ *Id.*

treatment is upon facing criminal charges.”⁴⁰ Additionally, Judge Nelson found that the State of Oregon had been consistently out of compliance with the permanent injunction (from *Mink* in 2002) since 2018, with the average length of detention in January 2025 before admission to OSH as 29 days.⁴¹ Subsequently, Judge Nelson converted Dr. Pinals’ role from a neutral expert to a “court monitor” and empowered Dr. Pinals to hire staff.⁴² Furthermore, Judge Nelson found the State of Oregon in contempt and ordered it pay \$500.00 per patient, per day, that was held beyond the seven-day admission period to OSH as ordered in *Mink* by Judge Panner nearly 23 years prior.⁴³

A year later, on June 1, 2026, Judge Nelson entered an order further restricting which criminal defendants may be admitted to OSH—including many felonies—and eliminated the 30-day extension for discharge planning, significantly limiting the available extensions. Specifically, extensions could only be sought on Measure 11 cases and only one 6-month extension is permitted.⁴⁴ The State of Oregon took no position on the plaintiffs’ motion which led to the order.⁴⁵

On June 9, 2026, Judge Nelson extended these restrictions to June 30, 2027.⁴⁶ Again, the State of Oregon took no position on the plaintiffs’ motion to continue the remedial orders.⁴⁷

Time Limits for Hospital Restoration

Since 2022, federal court orders have limited which defendants may be admitted to OSH and for how long after a 370 order finding that a defendant is unable to aid and assist.

370 order - An order issued under ORS 161.370 directing a defendant found unfit to proceed to receive restoration services, either in the community or at OSH, to become able to "aid and assist" in their own defense. In this report, "370" may also be used to refer to a person subject to such an order.

⁴⁰ *Id.* (D. Or. filed June 6, 2025).

⁴¹ *Id.*

⁴² *Id.*

⁴³ *Id.*

⁴⁴ *Id.* (D. Or. filed June 1, 2026).

⁴⁵ *Id.*

⁴⁶ *Id.*

⁴⁷ *Id.*

Historical Oregon Statutory Timelines for Restoration

Prior to the Mosman timelines discussed below, a defendant found unable to aid and assist would be committed to OSH for restoration treatment for up to three years or a period of time equal to the maximum sentence the court could have imposed if the defendant had been convicted, whichever was shorter as measured from the defendant's initial custody date in jail.⁴⁸

The table⁴⁹ below shows the relevant crime seriousness classifications and maximum hospitalization periods prior to the Mosman order:

Crime Seriousness	Maximum Incarceration	Maximum OSH Restoration
"C" Misdemeanor	30 days	30 days
"B" Misdemeanor	180 days	180 days
"A" Misdemeanor	364 days	364 days
"C" Felony	5 years	3 years
"B" Felony	10 years	3 years
"B" Felony (ORS 137.700)	10 years	3 years (from date 370 order signed)
"A" Felony	20 years	3 years
"A" Felony (ORS 137.700)	20 years	3 years (from date 370 order signed)
Murder	Life with minimum of 25 years	3 years (from date 370 order signed)

Figure 2

Mosman Timelines

Since the Mosman timelines have been in effect, the time limits for restoration of criminal defendants in Oregon have been greatly curtailed, as the table⁵⁰ below from OSH demonstrates:

⁴⁸ ORS 161.371.

⁴⁹ *Id.*

⁵⁰ Source: Oregon Health Authority

Most serious offense	Time limit under federal orders
Violations and Non-Person Misdemeanors	Ineligible
Person Misdemeanors; Contempt with Punitive Sanctions	Maximum sentence for offense or 90 days, whichever is shorter*
Non-Ballot Measure 11 (ORS 137.700(2)) Felonies	6 months*
Ballot Measure 11 (ORS 137.700(s)) Felonies	1 year*

*The federal orders allow the above time limits to be extended for the following reasons:

1. A 30-day extension order for discharge planning, and
2. A 180-day extension order for violent felonies.

Figure 3⁵¹

The table below compares the statutory time limits under Oregon law to the timelines imposed under Mosman:

Crime Seriousness	Oregon Statutory Limit	Mosman Order Limit
"C" Misdemeanor	30 days	Ineligible
"B" Misdemeanor	180 days	Ineligible
"A" Misdemeanor	364 days	90 days (only if a "person misdemeanor" or violation of court protective order)
"C" Felony	3 years	6 months
"B" Felony	3 years	6 months
"B" Felony (ORS 137.700)	3 years (from date of admission to OSH)	1 year
"A" Felony	3 years	6 months
"A" Felony (ORS 137.700)	3 years (from date of admission to OSH)	1 year
Murder	3 years (from date of admission to OSH)	1 year

Figure 4

⁵¹ Oregon Health Authority, *Federal Order Frequently Asked Questions – September 29, 2025*, (last accessed Sept. 18, 2026).

All patients at OSH are eligible for 30-day discharge planning extension. In addition, a 180-day extension for violent felonies is allowable, for a maximum of three-years.

House Bill 2005 Revisions

In 2025, the Oregon State Legislature modified Oregon law to address criminal cases for defendants who are unable to aid and assist, both relating to OSH hospitalization and community restoration through House Bill 2005.

However, while House Bill 2005 created new statutory timelines for hospitalization different than those in ORS 161.371 above, the federal court orders still apply. Provisions regarding the length of community restoration have been fully implemented and are in full effect. Prior to House Bill 2005, there were no time limitations for how long a defendant could be required to be in community restoration.

House Bill 2005 restoration timelines are provided below:

Crime Seriousness	OSH	Community Restoration
Class B or C Misdemeanor or Violation	Ineligible	90 days Ext. 90 days (180 day total)
Non-person Class A misdemeanor	Ineligible	90 days Ext. 90 day increments (365 day total)
Person Class A misdemeanor or Contempt	90 days Ext. 90 days (180 day total)	6 months Ext. in 6 month increments to total (18 month total)
Non-violent Felony	180 days Ext. 6 mos. (12 mo. total)	12 months Ext. in 6 month increments to total of 24 months
Violent felony / Measure 11	12 months Ext. 6 months (18 mo. total)*	18 months Ext. in 6 month increments to total of 24 months

Figure 5⁵²

⁵² Oregon HB 2005, Sec44–45 (2025).

2026 Federal Court Order Revisions

Most recently, in June 2026, federal Oregon District Court Judge Adrienne Nelson issued an order further limiting which defendants may be admitted to the Oregon State Hospital and for how long.

Specifically, Judge Nelson ordered that defendants charged with the following offenses may not be admitted to OSH:

- Criminal Mischief in the First Degree (“C” Felony) [intentional damage to property over \$1,000 in damage],
- Aggravated Harassment (“C” Felony) [spitting on a police officer],
- Unauthorized Use of a Vehicle/ Possession of a Stolen Vehicle/ Criminal Possession of a Rental or Leased Motor Vehicle (“C” Felony) [using or possessing a stolen vehicle, keeping a vehicle past expiration of a rental or lease contract],
- Resisting Arrest (“A” Misdemeanor),
- Burglary in the Second Degree (“C” Felony) [unlawfully entering or remaining in a building with intent to commit a crime therein – commercial buildings],
- Theft in the First Degree/ Theft of Lost or Mislaid Property/ Theft by Extortion or Deception/ Theft of Services (“C” Felony) [theft involving \$1,000 or more in value],
- Identity Theft/ Computer Crime/ Forgery in the First Degree/ Criminal Possession of a Forged Instrument in the First or Second Degree/ Criminal Possession of a Forgery Device/ Fraudulent Use of a Credit Card in the First or Second Degree/ Negotiating a Bad Check (“C” Felony or “A” Misdemeanor) [unlawful use or possession of personal identification, financial documents, and related instruments],
- Mail Theft (“C” Felony) [theft of mail regardless of value],
- Failure to Appear in the First Degree (“C” Felony) [failure of a defendant to appear for court when out of custody by judicial order or release agreement], and
- Disorderly Conduct in the First Degree (“A” Misdemeanor) [bomb or school shooting threat].

Other felony charges could be excluded from admission depending on the defendant’s history.

In addition, Judge Nelson eliminated the 30-day discharge planning extension and limited the violent felony extension to a single 180-day extension and only for charges subject to ORS 137.700 (“Measure 11”).

Judge Nelson stated the following:⁵³

“Based on the evidence before the Court [OSH is] likely to achieve compliance considerably sooner with these remedial measures in effect.”

“Indeed, with them, defendants are projected to achieve compliance this year.”

“Without them, there is no projection for when defendants may achieve compliance.”

Therefore, the court’s only focus was obtaining Oregon’s compliance with the seven-day admission to OSH timeline, irrespective of potential impact on community safety or likelihood of defendant restoration.

Judge Nelson’s order was set to expire on June 30, 2026, but the court issued an extension to June 30, 2027, during a status conference on June 9, 2026.⁵⁴

⁵³ *Id.* (D. Or. filed June 1, 2026).

⁵⁴ *Id.* (June 9, 2026, ECF No. 764).

Grand Jury Findings

Principal Finding

The Grand Jury's principal finding is that OSH lacks sufficient bed capacity to simultaneously meet the needs of Oregonians in need of hospitalization at OSH for aid and assist restoration, commitment after being adjudicated guilty except for insanity, or in need of commitment under Oregon's civil commitment laws.

The consequence of this deficit has led to a decrease in patient restoration and/or rehabilitation. This impact is seen in communities across Oregon; patients are discharged into their communities before meaningful treatment is delivered, directly impacting public safety.

This capacity issue affects the patient and staff experience at OSH and impacts community public safety.

Population

FINDING #1: OSH capacity is insufficient to meet the current treatment needs for the number of Aid and Assist, Civil Commitment, and GEI patients that require services.

OSH Patient Type, History, & Current Status

The Grand Jury heard testimony from many witnesses from OSH how the patient population served by OSH has shifted over the past 15 years. This changed patient population is more violent and more aggressive than prior, which has led to an increase in seclusion practices (discussed below) and a concerning trend of increased assaults on OSH providers—mainly to unit staff such as mental health technicians and nursing staff.

The Grand Jury learned that in 2012, civil commitment patients represented one-third of the overall patient population. However, approximately 35 out of 700 patients are admitted for civil commitment—which is five percent. In 2012, there were 110 aid and assist patients, which was not a concern at the time because GEI patients were the larger concern. However, in 2012, the aid and assist population began to increase and in 2019, due to *Mink*, OSH stopped admitting civil commitment patients altogether.

The two charts that follow demonstrate the rapid and consistent increase in the aid and assist population from 2000–2019:

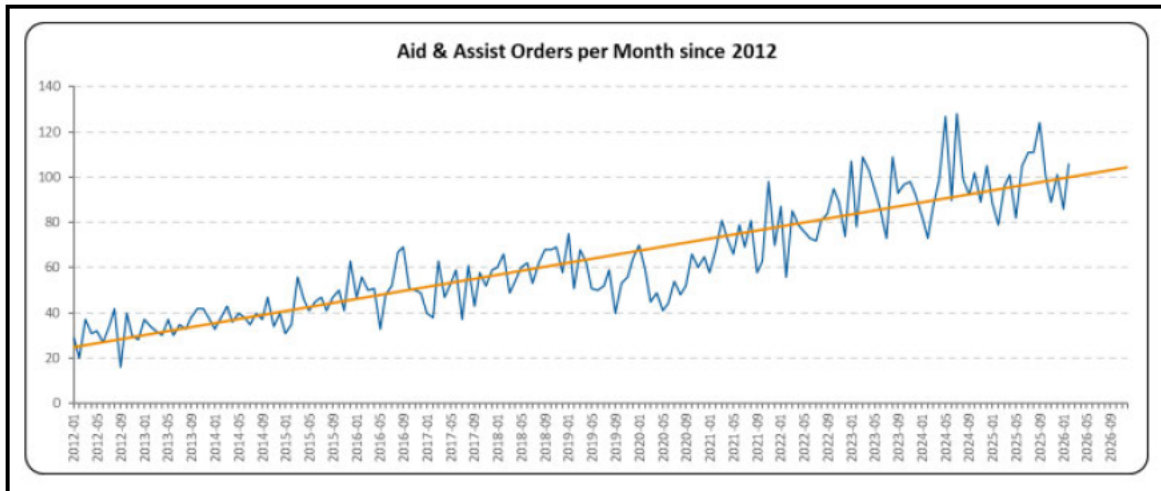


Figure 6⁵⁵

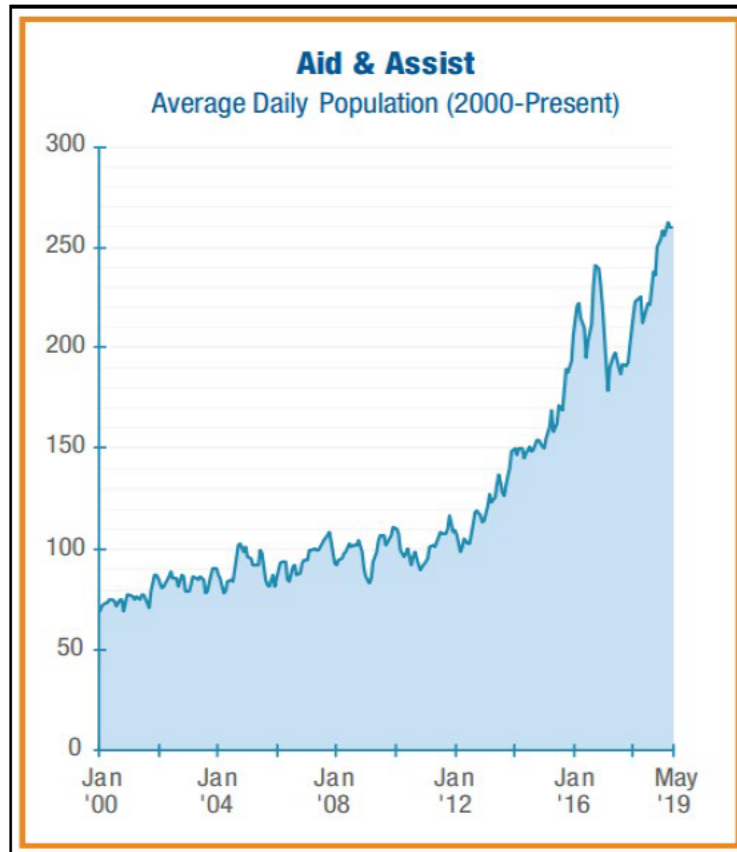


Figure 7⁵⁶

⁵⁵ Oregon Health Authority, *OSH Forensic Admission and Discharge Board – August 2026*, (last accessed Sept. 18, 2026).

⁵⁶ Oregon State Hospital, *Oregon State Hospital – Aid and Assist* (Undated).

Today, there is a distinct change in higher patient acuity (severity), with the result being a population imbalance where now aid and assist patients outnumber civil commitment patients by a wide margin. The Grand Jury heard testimony that the patient population felt stable during 2011 to 2012, but today—due to increased patient acuity and shorter stays (due to federal court orders) —the hospital no longer feels like a safe environment for patients or providers.

Since 2012, OSH has experienced a 252% increase in aid and assist patients.

The Grand Jury is not aware of any study to examine why exactly this shift has occurred, but witnesses testified that factors may include the following:

- Homelessness,
- Drug use,
- Narrowing of civil commitment access,
- Lack of community resources, and
- Mental health stigmatization.

The only patients that OSH can legally turn away from admission are civil commitment patients. In 2019, Senate Bill 24⁵⁷ was passed with the goal of controlling the aid and assist population. The law allowed defendants who were unable to aid and assist to be restored on an out-patient basis (“Community Restoration”). The law also imposed some limits on misdemeanor cases.

Notably, the Grand Jury heard testimony that the rise in the aid and assist population is being seen at a nationwide level and other states can take weeks, months, or even years to have a person admitted to a state hospital (*see Figure 8* for OSH details).

⁵⁷ Oregon State Legislature, 2019 Regular Session, “SB 24 Enrolled,” available at <https://olis.oregonlegislature.gov/liz/2019R1/Measures/Overview/SB24> (last accessed July 5, 2026).

A recent report to the court filed by the Oregon Department of Justice in the Mink/Bowman case included a graph (Figure 8) detailing the Aid and Assist Readmission rate since 2012. The graph depicted a 365-day readmission rate of 8.2% in 2012, and a 365-day readmission rate of 20% in 2026. The number of patients being readmitted for restoration at the Oregon State Hospital combined with the dearth of treatment available for people needing civil commitment resources is concerning to this Grand Jury.⁵⁸

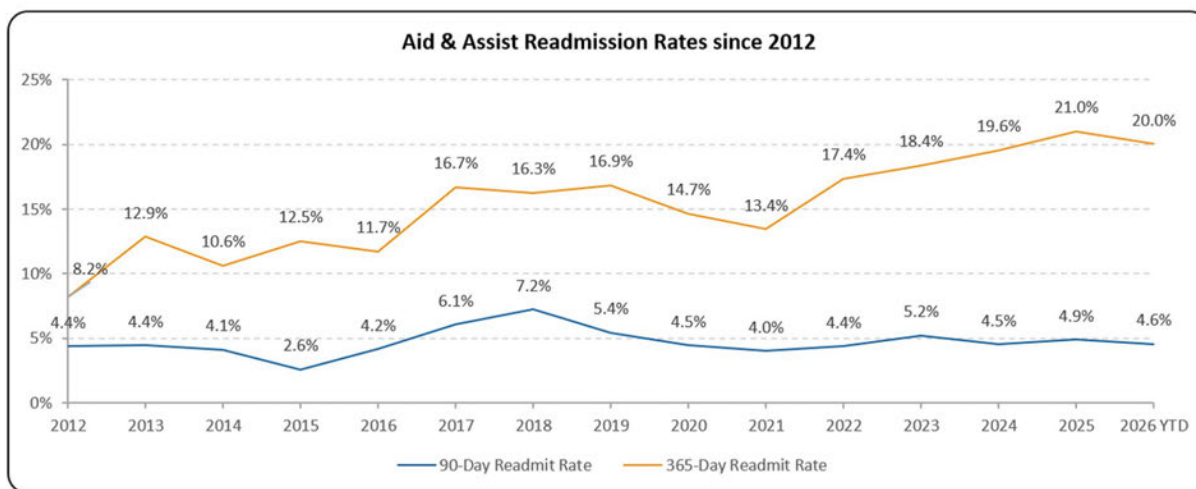


Figure 8

Current OSH Population Status in Oregon

OSH presently is in compliance with the *Mink* order, meaning it is admitting defendants within seven days of being ordered to OSH. On the date of the Grand Jury's facility tour, August 21, 2026, there were 32 patients at OSH under civil commitment.

⁵⁸ *Mink/Bowman*, Nos. 3:02-cv-00339-MO & 3:21-cv-01367 (D. Or. ECF No. 772 Sep. 1, 2026).

Figure 9 below highlights the total number of aid and assist patients at OSH as of September of each year:⁵⁹

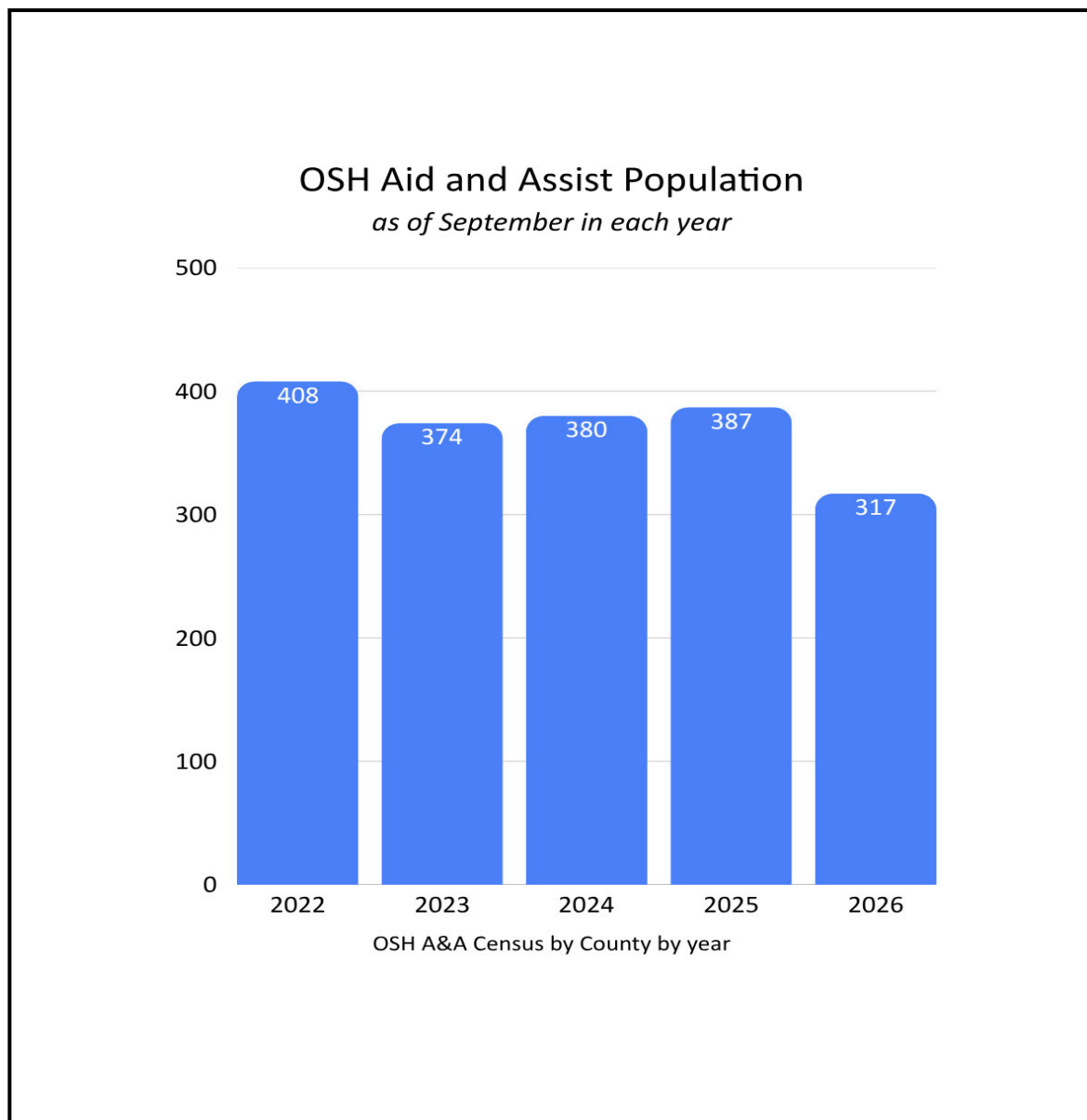


Figure 9

This is three months after the June 1, 2026, order which once again limited admission to OSH.

⁵⁹ Oregon Health Authority, Oregon State Hospital, *Aid and Assist Census by County*: Sept. 6, 2022, Sept. 5, 2023, Sept. 3, 2024, Sept. 2, 2025, Sept. 8, 2026.

How the OSH Aid & Assist Population is Managed

FINDING #2: There are an inadequate number of Forensic Evaluation Services evaluators and staff to meet the patient population demand.

The Forensic Evaluation Services (FES) is a team of psychiatrists and psychologists who are separate and distinct from the treating providers at OSH. FES is tasked with providing an objective and neutral opinion to the court about whether an individual is able to aid and assist. Currently, FES is staffed by 25 full-time psychologists (4 remote), 2 part-time psychiatrists, and 3 part-time psychologists. Most of these staff have one to five years of licensed practice experience.

FES may provide an evaluation at the initial stage of determining a person's ability to aid and assist ("365 exam") or after a period of hospitalization ("370 exam"). The initial question in both examinations is the same:

Does the person have a qualified mental health disorder that impacts their ability to aid and assist in their criminal case?

365 Evaluation

An evaluation ordered by the court under ORS 161.365 to assess whether a defendant has the capacity to understand the proceedings against them and assist in their own defense. Note: A 365 evaluation is conducted *before* a 370 order is issued (see 370 order)—the evaluation's findings inform the court's decision on whether to issue the order. The evaluation does not itself determine fitness to proceed; that determination is a legal decision made by the judge.

FES performs 50 to 60 evaluations per week, or approximately 200 per month, with the majority being for people under aid and assist orders.

Evaluation Process

The Grand Jury heard testimony from present and former FES evaluators at OSH who detailed the process of an evaluation. FES must produce a report for the court whenever the court orders an aid and assist evaluation, even if the defendant refuses to participate in the interview process. Ultimately, the determination of fitness to proceed is a legal decision made by the court, not the examiner.

The process of conducting a forensic evaluation includes five parts:

1. Review of records,
2. Interview with the defendant,
3. Consultation/collateral interviews,
4. Psychological testing, and
5. Report writing.

The interview is an important part of the evaluation. The interview can take, on average, between one and three hours. The interview assesses what the defendant says, doctor's notes, employment history, and prior legal issues. The evaluator assesses what the defendant is telling the evaluator in light of what the evaluator is observing during the interview. This assesses the defendant's response style.

Evaluators may speak with mental health staff at jails, staff and providers at OSH, and both the district attorney and defense attorney. Evaluators are kept separate from treating providers to avoid therapeutic allegiance (the treating provider having a bias for or against the defendant). The length of a defendant's stay at OSH also impacts the quality of the evaluation: longer stays allow more time to gather observational data, while shorter stays limit how much can be observed.

A quarter of evaluations require the aid of an interpreter and FES does not employ any court certified bilingual evaluators. An FES evaluator would need to be *both* a licensed forensic examiner and a court certified interpreter in the defendant's spoken language to do both. Evaluators are trained to consider unique factors for a particular defendant, such as culture. It takes an evaluator between 10 to 12 hours to write a report for an uncomplicated case, while it can take upwards of 80 hours for a complex case. Reports are generally 8 to 15 pages in length, while a complex case report can be 45 pages.

Ultimately, an evaluation report will opine the person is one of the following:

- Able to aid and assist in the defense of their criminal case.
- Unable but can be restored—meaning the defendant is currently not fit but could be restored in the foreseeable future.
- Never able—meaning it is unlikely the defendant could be restored in the foreseeable future.
- Medication never able—meaning a person is unlikely to be restored unless sufficiently medicated (which can lead to a hearing where the court decides whether involuntary medication is warranted).

Evaluation Bottlenecks

A former director of FES told the Grand Jury that in 2022 FES was able to meet the statutory guidelines with a moderate amount of work. However, there was a fear in 2026 that while FES was meeting its statutory deadlines, new requirements in House Bill 2005⁶⁰ would mean FES

⁶⁰ Oregon State Legislature, *2025 Regular Session*, House Bill 2005, available at <https://olis.oregonlegislature.gov/liz/2025R1/Measures/Overview/HB2005> (last accessed July 5, 2026).

would no longer be able to meet the need. Today, some defendants are waiting up to one year for an evaluation.

The Grand Jury heard testimony from a witness currently employed by FES who expressed concern about FES being overwhelmed with the number of evaluations to complete as a result of House Bill 2005. Specifically, 370 evaluations are taking slots that were previously used for 365 evaluations, which is due to the unfunded requirements of the new law.

This witness testified that there has historically been a demand for more evaluations than FES can supply, requiring FES staff to work overtime. The witness stated that while increased funding was requested to address the issue, it was not granted. This witness told the Grand Jury that FES has had a threefold increase in the number of evaluators between 2022 (8 evaluators) and March 2026 (26 evaluators) and yet indicated FES presently needs between 5 and 10 more evaluators to meet the current demand.

The Grand Jury heard testimony from OSH personnel that other states have explored jail adjacent restoration with some degree of success. A significant barrier to looking to a jail to restore a person's capacity to aid and assist in their own defense is that Oregon law does not allow jail staff to forcibly medicate AICs. Additionally, the Grand Jury heard testimony that Oregon jails are ill-suited to provide the level of care and psychiatric treatment needed to restore people residing in Oregon jails. A new system of facilities would need to be created with facilities more suited to restoration services than current jail facilities can provide.

Like the current FES employee, a former director opined FES needs 10 more evaluators, 3 more support staff, and an additional director to meet current evaluation needs.

As one witness stated,

"We don't need a one-million-dollar solution, we need a million one-dollar solutions."

RECOMMENDATIONS:

Explore and implement some form of jail adjacent restoration.

Increase FES staffing (evaluators, support staff, and directors).

Pre-Admission

Individuals ordered to OSH who have pending charges or who have been adjudicated GEI are held in jail while awaiting admission. Per federal court order, all 370 order and GEI admissions must originate from a jail. Every jail in Oregon operates differently, but the Grand Jury heard testimony that the Marion County Jail has a medical unit, mental health staff who can see AICs once a day, and a doctor who visits twice a week. Psychiatric treatment or medications cannot be administered involuntarily in a jail setting.

The Marion County Jail relies on initial screenings and corrections deputies' observations to determine whether a mental health diagnosis may be present for an AIC. Typical behaviors exhibited by AICs awaiting OSH admission include flooding cells, refusing food, nudity, creating biohazardous conditions (feces/urine in cells), shouting or verbal outbursts, and not sleeping.

The number of AICs sent to OSH from the Marion County Jail fluctuates, but during testimony a corrections deputy estimated the average to be approximately 3 to 5 individuals per month.

The Marion County Jail contracts with a psychiatric nurse practitioner (PNP) to assist this population. The PNP sees between 8 and 20 AICs per week. While the PNP does not meet with every individual they can review medications and provide refills for those with a documented diagnosis. The PNP also sees patients directly in jail and prioritizes individuals who are not currently on medications. If a patient refuses to meet with the PNP, they cannot compel the meeting, but will sometimes go to their cell to see if the AIC is willing to engage. Because this is a jail setting, the PNP cannot administer involuntary medication, regardless of how sick the AIC may be.

When an AIC returns from OSH, they are offered continuation of their medications. In the PNPs experience, a significant portion of AICs returning from OSH choose to continue their medications. However, due to the jail's inability to administer involuntary medications, many ultimately stop taking them. The implications of discontinuing psychiatric medications can lead to a resurgence of symptoms, potentially resulting in significant decompensation that necessitates restarting the aid and assist process.

Transportation

Transport from the jail to OSH relies on county law enforcement. A Marion County transport deputy noted that they must enter housing units more often than before due to an increase in the AIC being a biohazard. When law enforcement arrives at OSH, they must wait in line at the sally port to admit the AIC. The wait to be admitted into the hospital averages about 45 minutes from the time they arrive. During this period, the AIC remains in the vehicle with the officer, still in restraints. This wait occurs even though counties are notified by OSH regarding the scheduled time to bring an individual to the facility. The Grand Jury heard from a transport deputy having seen as many as four counties waiting in line for access to the sally port. OSH staff testified to the Grand Jury that it is common to have multiple vehicles lined up to either pick up or drop off a defendant. OSH has only one sally port.

Jails receive a 24-hour notice to transport a defendant to OSH. If a jail cannot complete the transport within that window, the next defendant in line receives the available admission slot. If a defendant loses their slot, they remain in the county jail. Admissions occur only Monday through Friday.

For patients discharged from OSH, the hospital relies on law enforcement for pickup. A transport deputy testified that pickups can take longer and that they have waited up to two hours to return a patient to jail. A transport deputy also observed that AICs typically leave OSH in better condition than when they arrived.

Admission

FINDING #3: The physical layout of the OSH Salem campus receiving area is inadequate for current admissions needs.

FINDING #4: Due to the *Mink* order, admission is based on level of crime rather than severity of mental illness.

Patient Experience

Once the officer arrives at the sally port, they assist the AIC out of the vehicle. At the vehicle, OSH staff take vitals, check restraint sites for injury, ensure that the AIC and staff will be safe without restraints, and conduct a pat-down. Hospital personnel noted this immediate checking of patient vital signs was a recent change made because of a patient being discovered to be

deceased after being received into OSH.⁶¹ The deputy does not go beyond the sally port; OSH staff take custody of the AIC from that point. AICs are checked in one at a time.

At the time of admission, many risk factors are considered. A medical assessment is conducted at the doorway, and nursing and psychiatric staff are present during the admission process. The hospital strives to obtain medical and nursing records prior to admission, but this depends heavily on the facility from which the defendant is arriving.

As needed, OSH staff will see the patient for a physical, will initiate blood draws and may conduct an EKG.

The goal is to start medications as soon as possible. OSH can begin involuntary medications immediately, before the judicial process begins, in instances when an individual poses a danger to themselves or others.

According to an OSH medical provider, patients ideally would be housed based on the type of admission. However, the results of the federal court order prevent OSH from categorizing admissions this way (GEI, civil commitment), a point echoed by other medical professionals who noted that GEI, civil commitment, and aid and assist patients have distinct and unique treatment needs.

RECOMMENDATIONS:

Add additional sallyport(s) to accommodate the volume of admissions and discharges.

Allow patients to be housed based on type of commitment.

Admission Process

OSH has an admissions director and an admissions team of 11 people who coordinate admissions, transports, and discharges from both the Salem and Junction City campuses. The type of OSH commitment determines the admission path. For 370 patients, the admission date is based on the date the court signs the order. OSH typically receives the order from the courts within one judicial day. Because the hospital is at capacity, admissions are driven by available discharges.

⁶¹ Ben Botkin, *A young man's death exposes holes in Oregon's mental health system*, Oregon Capital Chronicle (May 30, 2024), (last accessed September 14, 2026).

The only other admissions OSH may accept are civil commitment patients who meet expedited criteria.⁶² Civil commitment patients are those who are not charged with a crime but have been deemed either a danger to themselves or others or unable to care for themselves. These patients wait in local hospitals for placement.

One psychiatric provider testified to the Grand Jury that jails are generally better equipped to manage physical aggression compared to local hospitals, and the primary concern in jails tends to be suicide risk.

On average, OSH manages approximately 7 discharges and 7 admissions per day. OSH admits and discharges only from Monday through Friday. At the time of testimony, OSH had approximately 1,200 admissions per year.

A 370 patient may “jump the line” if the individual is acutely ill. OSH has created an expedited admission process for these cases. To determine if a defendant meets criteria for expedited admission, OSH relies on records from the jail and the District Attorney’s Office.

OSH uses an internal dashboard to determine how patients can be admitted. To meet federal obligations, OSH may move admitted patients from one unit to another to make room for new admissions. For example, if a bed opens in a geriatric unit but the new patient is not geriatric, OSH may relocate a current patient who meets geriatric criteria into that unit to free up an appropriate bed. The treatment team decides whether a patient can be moved to another unit.

Medication

OSH has what was described to the Grand Jury as a robust pharmacy department. Patients will typically accept the prescribed medications voluntarily. OSH staff will observe patients taking their medications to make sure the patient does not divert what was provided. OSH staff can crush the medications or place in food. While medication diversion does not appear to be a current issue at OSH, staff observes medication administration because medications could later be used as a currency inside the hospital.

Medications are not only encouraged early on, but sustained compliance is also encouraged, as inconsistency can lead to issues. When medication is not consistent, doctors see that the

⁶² Oregon State Hospital, OSH Admissions Office, Expedited Admissions, *(last accessed August 15, 2026)*.

medications are not as effective and the illness becomes more refractory. This was described to the Grand Jury as the “kindling effect”: mental illness becomes difficult to treat when people cycle on and off the medications.

OSH has an independent involuntary medication procedure which can take a week or longer through an administrative process.

According to the Chief of Psychiatry:

“8 out of 10 [patients] will be restored to competency on meds alone.”

PSRB

The population under the jurisdiction of the Psychiatric Security Review Board (PSRB) has grown in recent years. The PSRB is responsible for individuals adjudicated GEI and those found to be civilly committed as extremely dangerous. Individuals under PSRB jurisdiction may live in the community or at OSH.

The mission of the PSRB is “to protect the public by working with partner agencies to ensure persons under its jurisdiction receive the necessary services and support to reduce the risk of future dangerous behavior, using recognized principles of risk assessment, victims' interests, and person-centered care.”⁶³ The PSRB’s values are rooted in its legislative mandate to protect the public, and it achieves maximum levels of public safety through those values.

As of April 2026, the PSRB had 650 individuals under its jurisdiction. Of those, 275 were at OSH and the remainder were on conditional release. The Grand Jury learned that the PSRB does not advocate for specific placements; rather, it determines whether a person can be adequately supervised in the community. Most individuals leaving OSH under PSRB jurisdiction transition to a secure residential treatment facility.⁶⁴ For those on conditional release in the community, the PSRB considers OSH a last resort. In 2025, only 25 individuals were revoked from conditional release and returned to OSH. The PSRB has identified that the threshold for holding someone at a local hospital for stabilization is higher than the threshold for returning them to OSH.

⁶³ Oregon Psychiatric Security Review Board, *Welcome Page*, State of Oregon, (last accessed July 29, 2026).

⁶⁴ OAR 309-035-0105(60) (Secure Residential Treatment Facility (SRTF) means any Residential Treatment Facility that restricts an individual’s exit from the setting).

While the PSRB may attempt to work with their patient outside of OSH, they have identified the high civil commitment threshold as a barrier to keeping the patient in the community. In other words, due to the high bar to be civilly committed, it is easier for the PSRB to revoke the release and readmit to OSH than to civilly commit and keep the patient in a local hospital.

The PSRB functions differently than the aid and assist system. The statutes and mandates differ in that, once an individual meets PSRB jurisdiction, the PSRB cannot simply release them to the community. A significant amount of due diligence is required before the PSRB can approve a release. When community beds are unavailable, the PSRB cannot transition patients from OSH to the community. The PSRB has also identified OSH as “crucial” and “a last resort.”

Multiple witnesses testified that patients under PSRB are more psychiatrically stable when compared to the aid and assist population.

Discharge

FINDING #5: There are an insufficient number of secure and non-secure community placements.

370 patients require a court order or a forensic evaluation to be discharged. A 370 patient may be discharged back to jail if an evaluator determines they are able, will never be able, or have a court order for dismissal or transition into community restoration. GEI discharges are determined by the PSRB (*see Figure 1*).

OSH has a Social Work Department that begins working on discharge planning immediately upon admission. Staff aim to complete a psychosocial assessment within 10 days to begin planning for the patient’s return to the community. Social workers are not responsible for finding placements or knowing what is available across Oregon’s 36 counties, but they assist as much as they can.

The Social Work Department director identified a major issue: patients are required to leave the hospital by circuit court order or federal court order, meaning the decision to release is made by external entities, not OSH staff. The director also noted that the primary barriers to discharge are insufficient community housing and unresolved issues related to violence. Further complicating this, community placements—despite being publicly funded—can refuse to accept a patient.

The pandemic hit this group of staff particularly hard. During that period, the hospital utilized social workers as MHTs. Following the pandemic, the department had a 30% vacancy rate. Although these positions have since been filled, many of the new hires are less experienced.

OSH staff noted,

“We get the work done, but there is a business need for 15 additional social workers.”

OSH has created a complex case discharge process for patients with more complicated needs. Staff go into units and meet directly with these patients.

The burnout rate for professionals working at OSH is high, but due to current conditions, discharge planning cannot pause.

The aid and assist population was identified as particularly challenging due to the lack of available discharge options. Professionals testified that it is traumatic for patients to return to jail, but patients are otherwise unhoused and lack permanent housing. In addition, placement waitlists are weeks to months long. **OSH staff did note that the 30-day extension had been useful.** Another issue with returning patients to jail is that priority is given to those currently at OSH so, once a patient is returned to jail, they lose their priority status for placement.

RECOMMENDATION:

Increase the number of community Residential Treatment Facilities and Secure Residential Treatment Facilities throughout the state.

Leadership

FINDING #6: Instability in OSH leadership has created a culture of fear, uncertainty, and chaos in the organization. Specifically, employees who suggest changes have faced demotion, a change in their position, or termination. This leads to staff being fearful of retaliation for raising concerns or suggesting improvements.

FINDING #7: There are multiple conflicts of interest in regulation and representation of OSH in litigation and human resource management. OHA as the regulatory body for OSH and the body that controls the daily functions of OSH.

FINDING #8: OSH does not have a human resource department outside of what OHA provides. There is no independent human resource unit on OSH site and targeted to OSH needs.

Between 2024 and the present, the Oregon State Hospital has been led by five different people (Dolores “Dolly” Matteucci, Dr. Sara Walker, Dave Baden, Jim Diegel, Sean Murphy, and Jim Diegel again). In March 2018, Dolores “Dolly” Matteucci began serving as the Oregon State Hospital superintendent and ended her tenure as the Superintendent in March of 2024.⁶⁵ After Matteucci’s departure, Dr. Walker began her role as interim Superintendent while a permanent superintendent was sought.⁶⁶ Dr. Walker held the position of Interim Superintendent until she resigned in April 2025, and on April 11, 2025, Dave Baden was appointed Interim Superintendent of the Oregon State Hospital.⁶⁷ After a short time, on May 28, 2025, Jim Diegel was named Interim Superintendent replacing Baden as the search for a permanent Superintendent began.⁶⁸ On June 16, 2026, the Oregon State Hospital announced the hiring of Sean Murphy as the new Superintendent with a set start date of July 13, 2026.⁶⁹ Shortly after the announcement of Murphy’s hiring, on August 12, 2026, Murphy was removed from his position of Superintendent and Jim Diegel was again named the Interim Superintendent.⁷⁰

One employee who works at the Oregon State Hospital noted that each change in leadership has led to a lack of trust in leadership. Additionally, multiple witnesses described an environment where they did not feel they were able to express concerns about staffing levels and patient safety to leadership without fear of retaliation for expressing their concerns. One nurse testified to the Grand Jury that she expressed her concern about what she viewed as inappropriate use of seclusion for one specific patient. About a week after expressing her concern, the patient died in seclusion. Approximately two months after the patient died in seclusion, the nurse was demoted from the position she previously held. In addition to feeling they are unable to bring their concerns about patient safety to leadership, witnesses described not being able to freely express their thoughts about treatment of patients to treating physicians without fear of reprisal or being removed from assignments after sharing an opinion about other options for doing their jobs.

⁶⁵ Ben Botkin, “Oregon State Hospital Superintendent Announces Her Retirement”, *Oregon Capital Chronicle*, March 11, 2024, (last accessed August 26, 2026).

⁶⁶ *Id.*

⁶⁷ “Newsroom - Governor’s Office.” 2019. Oregon.Gov. 2019, (last accessed August 26, 2026).

⁶⁸ “Oregon Health Authority: Oregon Health Authority Hires Interim Oregon State Hospital Superintendent: External Relations Division: State of Oregon” 2025, (last accessed August 26, 2026).

⁶⁹ “Oregon Health Authority: Oregon Health Authority Names New Oregon State Hospital Superintendent: External Relations Division: State of Oregon.” 2026, (last accessed August 26, 2026).

⁷⁰ “Oregon Health Authority: Oregon Health Authority Releases Statement on Oregon State Hospital Change of Leadership : External Relations Division : State of Oregon.” 2026, (last accessed August 26, 2026).

Organizational Structure

Multiple witnesses expressed concern about the Oregon Health Authority (OHA) being responsible for overseeing operations of OSH. One witness noted that OHA is responsible for providing all human resources support OSH and that OSH did not have its own dedicated human resources department. The witness noted that it was unusual for an entity containing over 2,700 employees not to have its own dedicated human resources department. The witness expressed concern that not having a dedicated human resources unit for the OSH leading to less effective strategic recruitment and an inability to effectively discipline when needed.

As heard during witness testimony:

"Remove OSH from the thumb of OHA."

Leadership Presence

Several witnesses were concerned by an apparent lack of presence by leadership on the physical campus of OSH in Salem. Witnesses noted the absence of members of the executive leadership team being present within the secure perimeter of the facility.

A former employee stated,

"Instability has created a culture of fear, people are afraid of speaking up because of [possible] retaliation."

RECOMMENDATIONS:

Establish stable and consistent executive level hospital administration.

Increase the presence of management/administration within the secure perimeter to eliminate the perception of a divide in staff hierarchy.

Provide OSH with independent legal counsel dedicated to representing OSH's interests, separate from the OHA. Establish OSH as a separate entity reporting directly to the Governor of Oregon.

Foster open, non-threatening dialogue between staff and management/administration to create a culture where innovation and change are encouraged rather than penalized.

Patient and Staff Safety

FINDING #9: Inadequate staffing levels create unsafe conditions for both staff and patients. OSH does not have a medical provider present on site 24/7.

FINDING #10: Documentation and reporting of critical incidents lack consistency and completeness.

Many patients admitted to OSH in Salem are admitted for restoration services because of a pending criminal case. Similar to a correctional institution or jail, the institution is responsible for ensuring that people housed in the facility and people who work in the facility remain safe. Additionally, the institution must ensure the community is adequately protected from people held in the facility. The Grand Jury heard testimony from hospital security staff, hospital nurses, doctors, and administrative staff, about the security of the institution and about their feelings of safety inside the institution. This section examines the security and safety measures put in place to protect patients, staff, and the community by looking at the security systems in place, training received, compliance methods used, and incident response plans.

Security Systems

The OSH Salem campus is a closed secure facility with limited entrance and exit from the facility allowed. All people entering the facility are screened before entering the facility. All visitors and employees must walk through a metal detector and are subject to additional searches of their person. When patients are admitted into the OSH Salem campus they are limited as to what they can bring with them into the secure area of the facility. Approximately 1,400 cameras are stationed throughout the OSH Salem campus and the camera feeds are monitored from a central location. A security person monitors these cameras in real time, as well as monitoring calls for acuity events and dispatching Mental Health Security Technicians (MHSTs) to the scene of an acuity event when one occurs. Recordings are maintained for 28 days, and after 28 days have elapsed, the recordings are overwritten. The OSH Salem campus employs 220 MHSTs who are responsible for providing the security needs of the hospital by responding to acuity events, maintaining physical security of the institution, monitoring people and things which enter the hospital, and providing transport for patients within the hospital and to locations outside the hospital.

Whenever a patient must be moved outside of the hospital, two MHST's must accompany the patient to the destination. Some MHST staff are regularly on ground patrol at OSH, but the role of MHSTs is largely reactive and security employees testifying at Grand Jury noted the need for additional security employees due to the high call out rate of employees. Documents provided

to the Grand Jury for call out rates for 2025 indicated a call out rate of 24.37% for Licensed Practical Nurses, a call out rate of 18.91% for Mental Health Registered Nurses, and a call out rate of 26.59% for Mental Health Security Technicians. This call out rate includes both scheduled and non-scheduled leave.

The Grand Jury heard testimony on OSH's heavy reliance on temporary employees (contract and temporary) to staff everyday positions. Additionally, one person testified that the ratio of caregiver to patients has declined (previously 2:1, now 1:1 based on inadequate staffing).

RECOMMENDATIONS:

Ensure a medical doctor is available on site 24/7.

Increase the level of staffing to maintain a 2:1 staff-to-patient ratio.

Add additional security personnel.

Formalize a system for ensuring all critical incidents are properly documented by all necessary staff.

Patient Experience

Contraband

Because of the population served at the OSH Salem campus, items which people are allowed to possess are limited. Patients at the OSH Salem campus are allowed to come into the hospital with four equally sized boxes of personal items. Patients are allowed to possess books and magazines from outside the facility if they have been approved by the interdisciplinary team (IDT). Prohibited items include cell phones, controlled substances, and items which can be used as a weapon. Mail and packages coming into the hospital are screened for drugs by running the items through specialized equipment which detect the presence of controlled substances.

One OSH employee testified to the Grand Jury that the contraband screening process was an over-correction, stating that now an employee must go through a formal process and seek an ADA (Americans with Disabilities Act) accommodation in order to bring their own medications to work such as heart medications or an epiPen.

In addition to searching people coming into the OSH Salem campus, security staff conduct environmental searches (searches to document the conditions of the room) once per week, and full hospital wide searches once per year. For patients in OSH, in person visits are allowed, but no physical contact between the visitor and the patient is allowed to occur, and the visitor must be screened prior to entry into the facility. Patients are allowed to contact whomever they want via phone, and there is no approved call out list for patients in the facility. The only limitation placed is outgoing calls to 911 are not allowed. Phone calls to and from patients at the OSH Salem campus are not monitored or recorded (unlike at a jail or prison where social calls are monitored).

Escape

A wall surrounds the entirety of the OSH Salem campus, but this has not completely stopped patients from escaping from the facility. One security staff member noted the physical structure of the hospital was designed for a population that was less dangerous than the population currently housed at the facility. Security staff testified about one incident where an individual was able to climb up onto the roof of the facility and wander freely on the roof since there were no barriers to prevent movement on the rooftop. The same staff member noted the ability to move freely on the roof has since been remedied by the erection of barriers on the roof to prevent movement.

Although multiple people testified to the remedial measures taken to prevent escape from the facility, the Grand Jury noted there was no opportunity for patients to access the courtyard area because the remedies had not fully been implemented.

Staffing & Services

Security Training

FINDING #11: MHT hiring requirements do not align with job demands. They focus on customer service and lack requirements for relevant experience or physical capability.

FINDING #12: There are an insufficient number of forensic evaluators to keep up with the volume of evaluations.

FINDING #13: Overall staffing levels are too low, which contribute to poor staff morale, high call-out rates, and increased burnout among employees.

OSH employs dedicated staff to maintain security of the institution. When security staff are onboarding, they go through a three-week training course with modules and additional on-the-job training. The training does not train employees in defensive tactics but rather focuses on containment and diffusive tactics and the use of increased number of staff to respond to an incident, rather than traditional use of force. The training program used for security staff and for all employees is an in-house program called "Safe Together." The Safe Together training includes a hands-on component which requires a trainer to sign-off on the employee's competency before the training is completed. The Grand Jury heard testimony from employees who were concerned about the number of employees injured during the physical component of the "Safe Together" training. Documents provided to the Grand Jury in September 2026 indicated that there were 74 staff injuries during this training in 2025, and 41 injuries in 2026.

Compliance Methods

Deescalation

Verbal deescalation techniques and "sheer numbers" are the primary compliance measures OSH employees use when responding to a patient experiencing an acuity event. The primary response to an acuity event is to deescalate the incident by responding to the event with overwhelming numbers, drawing staff from security and other areas of the hospital to the location of the event. Because the hospital operates with a limited number of staff on duty at any given time, this movement necessarily leaves the areas those staff had previously been

attending unattended for the duration of the response. Staff are not trained in defensive tactics and rely on the number of people to deescalate an event rather than respond with force.

Restraints

There are two types of physical restraints utilized at the OSH Salem campus: soft restraints and secure transport restraints (STRs: a metal chain securing the patients wrists to a waist band). Soft restraints are used when patients are moved from one location to another within the hospital and STRs are used any time patients are moved outside of the hospital grounds. Only security staff are authorized to use STRs. MHSTs can use a hard shield when responding to an acuity event which involves the use of a weapon by the patient.

Incident Response

All employees at OSH wear a personal transponder described as a "panic button" that can be activated when an acuity event occurs. When activated, a signal is sent to the control room, and the location of the event is conveyed to security personnel. Different colors are attributed to the event to establish the type of event occurring and the level of response required. The location of the event is determined by the proximity of the personal transponder to the location of the node closest to where the signal originated from. Security staff noted that the fact that this system can lead to a delayed response by security staff or staff going to the incorrect location because a pin-point location is not able to be determined at the outset.

According to testimony by security staff, when an acuity event occurs, all staff involved are supposed to write an incident report and forward the report to security personnel responsible for organizing and collecting incident reports. Security personnel estimated they receive anywhere between 200 to 1,000 incident reports in a week since a single incident will have multiple reports. Although staff are required to write incident reports, witnesses testified there is no formal process in place to ensure reports are written and forwarded to the appropriate personnel.

RECOMMENDATIONS:

Increase the overall number of staff at OSH.

Implement hiring requirements that include mental health or medical training or experience.

Explore how other state hospitals respond to staffing shortages and high call out rates.

General Recruiting, Training and Retaining

FINDING #14: The quality, frequency, and duration of training have declined through the years and jeopardizes the ability to adequately address specific needs of patients at OSH.

FINDING #15: Training is conducted primarily online, lacks any mechanism to track and ensure completion, and onboarding has been reduced from a one-time 20-day process to 5 days.

FINDING #16: OSH's unique needs require customized training rather than standardized "off-the-shelf" programs.

FINDING #17: Deescalation training has decreased and been replaced by training in physical takedowns.

As stated earlier in this report, OSH employs over 2,700 employees. Not all employees have need for access into the secure perimeter of OSH, and this section of the report will focus on the training individuals receive who need to enter the secure perimeter and interact with patients.

From testimony, those on the secure perimeter include the following: mental health technicians (MHTs), licensed practical nurse (LPN), registered nurses (RNs), medical doctors, social workers, psychiatrists, and security personnel. Training for hospital employees varies depending on the level of interaction with patients.

In January 2026, OSH brought on a Director of Training and Education, who was hired to direct and manage a policy team that was to manage training which had previously been consolidated under nursing. The role was expanded to offer first time training and education to all departments. By May 2026, this role was terminated.

Training provided to employees has fluctuated since COVID. As of July 2026, employees are required to do 5 days of new employee orientation and then 3 days of patient facing onboarding. From there, the nursing and security teams have additional training.

In contrast, in 2019 OSH included two-day mandatory training in addition to new employee training. The first day of the two-day training was about mindset and rapport building, and the second day focused on physical restraints and containment. The Grand Jury heard that the first day of training was deemed important because it helped employees better understand the population they were serving. Specifically, the training focused on coping skills, trauma responses, managing one's own emotions, reflective listening, and perspective. In 2020, all in-

person training stopped. In 2022, training resumed, but only the second day content, which included physical restraints and containment. The training includes evasion, manual containment techniques, how to apply mechanical restraints, and how to get a patient into a seclusion room. OSH employees raised concerns to leadership that first-day content was being excluded, but full training did not resume until 2025.

Further complicating the matter of training is the recruitment for new Mental Health Technicians (MHTs). MHTs are the individuals working most closely with patients. Unlike other practice areas (social work, psychiatry, psychology) these employees cannot work from home. They are in the units with their patients the entire shift. The largest staffing category is the MHTs who engage with patients day to day.

In early 2026, discussions about training for MHTs were occurring. MHTs do not require any prior specific training or experience to be hired. Currently, the only qualification to be hired is six months of customer service experience. The Grand Jury heard testimony that most of the MHTs being hired are coming from Kohls, Target, and other large department stores. Training directors shared concerns that the job description was not accurate, and that the job description should include the safety training required.

Most significantly, staff expressed concern that the training required to work with patients has been substantially reduced. For example, prior to 2020, MHTs were required to have a CNA certificate (or be eligible to obtain one during employment) and to meet certain physical standards. This reduction in training is particularly troubling given the evolving needs of the patient population. Before COVID, new employee onboarding lasted 10 days, followed by up to 30 additional days of training for MHTs. Now, MHTs receive only 7 to 10 days of total onboarding and training, which OSH employees report is insufficient for developing competence in the required skills. Staff have emphasized that OSH is not adequately teaching new employees how to interact with patients—arguably the most dangerous and demanding aspect of the work.

Although the hospital lost a significant number of employees in 2020–2021 due to COVID, there is a growing concern that leadership is focused on increasing staffing numbers rather than ensuring that employees are properly trained to work safely and effectively with this population. A current OSH employee expressed concern about the MHT training program under consideration, describing it as an "off the shelf" 16-month program that is believed to be inadequate to properly train this category of staff.

Another significant issue is the absence of a reliable tracking mechanism for required training. While some training is mandatory, each discipline (nursing, psychiatry, social work, security,

etc.) is responsible for its own attendance monitoring. Employees expressed concern that, because of the limited tracking system, individuals may miss portions of required training without being required to make them up. More concerning, for monthly trainings, not all directors consistently follow up with staff who fail to attend, resulting in inconsistent compliance across departments.

One witness stated,

"Leadership ego is superseding patient care decisions."

Another example of insufficient training involves the implementation of the new restraint chair for use during patient acuity events. Staff have long advocated for this tool because it allows patients to be secured in a chair rather than a bed, reducing both physical strain and safety risks for employees. OSH has now developed a pilot program for the restraint chair that includes two two-hour training sessions. According to OSH staff, this level of training is inadequate for safe and effective use of the device, and they have recommended a total of 16 hours of training for all staff involved.

RECOMMENDATIONS:

Establish a proper tracking mechanism to ensure mandatory training is completed in a reasonable timeframe.

Ensure training is specific to OSH and decrease reliance on a "one size fits all" approach to training.

Reinstate a mentorship program when onboarding employees.

Explore ways of establishing residencies in OSH for mental health professionals.

Conflict of Purpose

FINDING #18: OSH’s stated purpose, goals, and mission are incongruent with its current operation.

The Oregon State Hospital (OSH) describes itself as a hospital that “provides patient-centered, psychiatric treatment for adults from throughout the state who need hospital-level care” whose “primary goal is to help people recover from their illness and return to the community.”⁷¹ Further, OSH describes itself as having two campuses that serve three patient populations: 1) civil commitments, 2) guilty except for insanity, and 3) aid and assist.⁷² Finally, OSH’s stated mission is:

Our mission is to provide therapeutic, evidence-based, patient-centered treatment focusing on recovery and community reintegration all in a safe environment.⁷³

Testimony heard by this Grand Jury leads it to conclude that OSH’s stated purpose, goal, and mission are incongruent with its current operation and is not in alignment with the purpose, goal, and mission that OSH is presently tasked with.

For instance, in July 2026, the Grand Jury heard testimony from staff of a local area hospital that from 2013 to 2019 their facility saw 169 persons admitted to OSH through civil commitment. Stated differently, one community hospital in Oregon was able to admit roughly 24 people per year or 2 per month to OSH. In contrast, from 2020 to the present, this same hospital has only been able to admit 7 people, or just 1 per year to OSH.

This represents a year-over-year drop of **95%** from just one community hospital in Oregon. A provider from this hospital described how difficult it is to tell families of patients that they cannot get their loved one to OSH because “we don’t have access to it and it’s virtually closed.” In the past three years this local hospital has only been able to transfer 2 or 3 people to OSH based on expedited criteria.

The Grand Jury heard testimony that this local area hospital has 26 short-term/acute in-patient psychiatric beds available. Since OSH stopped admitting civilly committed people, a person who is civilly committed will remain where they are at the time of commitment. However, once the person no longer requires acute in-patient psychiatric care and rather needs rehabilitative

⁷¹ Oregon State Hospital, *About Us*, available at <https://www.oregon.gov/oha/OSH/Pages/About.aspx> (last visited Aug. 24, 2026).

⁷² *Id.*

⁷³ *Id.*

services, there is nowhere to place these people because OSH has “commandeered” placements for forensic patients (aid and assist).

The Grand Jury also heard from a civil commitment investigator for Marion County who opined that civil commitment was working prior to Mosman and that historically, if a person needed a bed for more than two weeks of care, they could go to OSH. However, due to the number of aid and assist patients, there is no longer room at OSH and civilly committed people are not admitted because OSH can only take a civil commitment if based on expedited criteria or as an Extremely Dangerous Person.

This witness concluded:

“The issue isn’t [people] not being committed but rather they have no place to go.”

As a county judge stated,

“The reality is someone has to commit a crime to go to OSH.”

This reality is evident in light of testimony the Grand Jury heard from the mother of a former patient at OSH. This mother testified that her son had been taken to OSH as a result of being unable to aid and assist. Her son was able to conclude his criminal case, but later she tried twice to have her son committed, and neither time was successful. In fact, the mother had been told on one occasion by a hospital not to pick up her son. The mother told the Grand Jury she could not do that, as she would not release a dangerous citizen into the community.

OSH states that they serve three distinct patient populations, however, this Grand Jury learned that in effect only aid and assist and GEI are presently being served while the civil commitment population is being entirely neglected.

This neglect results in many Oregonians being left without access to necessary and needed medical care. While OSH states it’s “primary goal is to help people recover from their illness and return to the community,” this is not reality. The Grand Jury toured OSH in August and were told that OSH was built for a different population of patients—namely civil commitments and GEI—versus the aid and assist population that it primarily currently serves. The Grand Jury was shown multiple physical modifications to the hospital that are necessary due to this different type of patient. Like the physical building of OSH, the institution’s primary goal is not aligned with the actual operation of OSH.

The goal for a patient admitted to OSH via aid and assist is not to recover from illness and return to and integrate into the community. Rather, it is to restore trial competency so that a person may resolve their criminal charges after returning to jail after OSH treatment.

RECOMMENDATIONS:

Develop regional treatment facilities to serve patients in their community.

Avoid mixing Populations (A&A, GEI, Civil Commitment) within the same hospital location as differing security needs compromise therapeutic environments. Assign distinct populations to separate units.

Increase capacity of OSH to allow for treatment of more patients.

Seclusion

FINDING #19: Seclusion is used too frequently and for too long of duration.

The Grand Jury expressed their concern about the way in which seclusion has been utilized at OSH.

Under OSH Policy 6.003, seclusion is only to be used when less restrictive means are insufficient to protect staff or other patients, and it is used to manage behavior “that presents an immediate risk of harm to the patient or others.”⁷⁴ Witnesses described seclusion as being used when a patient becomes dysregulated. Several witnesses expressed concern with the frequency with which seclusion was being used at OSH and the lack of objective criteria with which to decide when a person should be placed into seclusion.

The seclusion room was described by witnesses as an L-shaped room with a bathroom connected to the room. A seclusion room is barren, with soft floors, hard walls, and a mattress on the floor on which patients can rest. The bathroom has a door which could be locked to prevent patient access into the room. Inside the bathroom is a toilet unit which contains a sink and counter space.

⁷⁴ Oregon State Hospital Policy 6.003 (January 15, 2026).

The Grand Jury heard testimony that while a patient is in seclusion, a staff member (a MHT) is required to continually observe the patient from a room adjacent to the seclusion room and make observations every 15 minutes. Additional checks on the patient are required to occur every hour by a RN, LPN, or CNA, every four hours by a RN, and every 8 hours by a Psychiatrist.

The Grand Jury heard testimony and reviewed documents related to an individual, Kenneth Hass, who spent an extraordinarily long time in seclusion. On March 18, 2025, Kenneth Hass died while in seclusion at the OSH Salem campus.⁷⁵ At the time of his death, Mr. Hass had been in seclusion for about seven months.⁷⁶ Mr. Hass had been committed to the OSH under Oregon's Civil Commitment laws. Because Mr. Hass died while he was in a closed custody facility, the Oregon State Police investigated the circumstances behind his death. The Grand Jury heard testimony from the detective who investigated the death of Mr. Hass as well as testimony from people familiar with Mr. Hass's time in seclusion at OSH. According to testimony from multiple witnesses, Mr. Hass spent approximately 7 months in seclusion, during which time he would be moved from one seclusion room to another every few days because the room he had been staying in would become too filthy and unsanitary for him to remain in.

It was reported that Mr. Hass would defecate and urinate on the floor of the seclusion room, necessitating a move to a clean room. Multiple witnesses testified they were concerned about the amount of time Mr. Hass was placed into seclusion. One witness described filing a complaint about the way Mr. Hass was being treated just one week before Mr. Hass's death. The witness described being demoted from her leadership position approximately two months after Mr. Hass died. The investigation into Mr. Hass's death determined the cause of death was excessive water consumption. Over the course of approximately 3.5 hours, based on the number of times Mr. Hass was seen drinking water from the cup he was provided with and the size of the cup, Mr. Hass was estimated to have consumed approximately 5 gallons of water.

To address high acuity needs, the hospital implemented what was referred to as a Psychiatric Intensive Care Unit (PICU) in April 2025. The idea behind the PICU was to create a team approach to treatment of patients experiencing acuity events to decrease the reliance on long-term seclusion. The Grand Jury heard testimony from OSH staff that they were hoping Mr. Hass would be the first patient to use the PICU model. The PICU model was retired because of a stated lack of sufficient number of patients needing this level of case.

⁷⁵ "Locked up and Alone: Sharp rise in Oregon State Hospital's seclusion of patients pushed state to worst-in-nation status," June 9, 2026, (*last accessed September 14, 2026*).

⁷⁶ *Id.*

Despite the death of Mr. Hass, multiple witnesses expressed ongoing concern about the length of time patients are remaining in seclusion. One witness testified that in May of 2026 3–4 patients were in long-term seclusion. Documents provided to the Grand Jury indicated a total of 1,538 seclusion events in 2025 at OSH Salem campus.

RECOMMENDATIONS:

Reconstitute the PICU directed at decreasing the frequency and length of seclusion events.

Improve the tracking and reporting of seclusion events.

Facility Tour

On August 21, 2026, the Grand Jury was provided with a tour of the OSH Salem campus facility. The tour was conducted by the Deputy Superintendent and the Chief Medical Officer of OSH. Prior to scheduling the Grand Jury tour, a representative from OSH inquired about which areas the Grand Jury would like to see on it's tour. The Grand Jury requested to view the areas where patients were treated (the treatment mall), the rooms where patients were housed, the facilities available for medical treatment in the hospital, the admissions/intake area including the sallyport where patients were received into the hospital, and seclusion rooms. Citing group size, the Grand Jury was divided into two groups to conduct the tour of the facility. The same Deputy District Attorney accompanied each group to ensure the same information was being provided, and the two tours covered the same locations for each.

The Grand Jury was escorted into the secure perimeter of the facility, viewed the law library through a closed door, went into the area where new patients were received, saw the sallyport area through a closed door, viewed the gym, were escorted to the location where the medical facility was located, viewed the hallway in the harbors unit, and viewed the area where vocational rehabilitation activities took place. Citing security and confidentiality concerns, the Grand Jury was not provided access into areas where patients were being treated (the treatment mall) and were unable to see seclusion rooms or examples of restraints used at OSH.

The Grand Jury did see a large open area with green grass and basketball court. Historically, this was an area that patients could access for time outside. On the tour, the Grand Jury learned that the open area has been closed since October 2025 after an escape attempt. Currently the hospital has all the materials to retrofit the area in order to make it safe, but almost a year later,

the area has not been made safe for patients. The Grand Jury noted it did not view areas where patients could access fresh air or areas where physical movement may occur.

Conclusion

Throughout the course of the process, this Grand Jury received evidence that substantiated the need for District Attorney Clarkson's detailed inquiry. As stated, the focus of this inquiry was on identifying areas of improvement which include current operations, capacity challenges, and public safety implications associated with the OSH. These findings, which impact public safety, and the safety and well-being of OSH patients and staff, all point to the need for additional patient bed capacity, improved staff recruitment and training, and leadership that is consistent and strong.

Grand Jury Findings

The Grand Jury's principal finding is that OSH lacks sufficient bed capacity to simultaneously meet the needs of Oregonians in need of hospitalization at OSH for aid and assist restoration, commitment after being adjudicated guilty except for insanity, or in need of commitment under Oregon's civil commitment laws. Additional findings, in the order they appear in the report:

1. OSH capacity is insufficient to meet the current treatment needs for the number of Aid and Assist, Civil Commitment, and GEI patients that require services.
2. There are an inadequate number of FES evaluators and staff to meet the patient population demand.
3. The physical layout of the OSH Salem campus receiving area is inadequate for current admissions needs.
4. Due to the *Mink* order, admission is based on level of crime rather than severity of mental illness.
5. There are an insufficient number of secure and non-secure community placements.
6. Instability in OSH leadership has created a culture of fear, uncertainty, and chaos in the organization. Specifically, employees who suggest changes have faced demotion, a

change in their position, or termination. This leads to staff being fearful of retaliation for raising concerns or suggesting improvements.

7. There are multiple conflicts of interest in regulation and representation of OSH in litigation and human resource management. OHA as the regulatory body for OSH and the body that controls the daily functions of OSH.
8. OSH does not have a human resource department outside of what OHA provides. There is no independent human resource unit on OSH site and targeted to OSH needs.
9. Inadequate staffing levels create unsafe conditions for both staff and patients. OSH does not have a medical provider present on site 24/7.
10. Documentation and reporting of critical incidents lack consistency and completeness.
11. MHT hiring requirements do not align with job demands. They focus on customer service and lack requirements for relevant experience or physical capability.
12. There are an insufficient number of forensic evaluators to keep up with the volume of evaluation needed.
13. Overall staffing levels are too low, which contribute to poor staff morale, high call-out rates, and increased burnout among employees.
14. The quality, frequency, and duration of training have declined through the years and jeopardizes the ability to adequately address specific needs of patients at OSH.
15. Training is conducted primarily online, lacks any mechanism to track and ensure completion, and onboarding has been reduced from a one-time 20-day process to 5 days.
16. OSH's unique needs require customized training rather than standardized "off-the-shelf" programs.
17. De-escalation training has decreased and been replaced by training in physical takedowns.
18. OSH's stated purpose, goals, and mission are incongruent with its current operation.

19. Seclusion is used too frequently and for too long of duration.

Grand Jury Recommendations

1. Explore and implement some form of jail adjacent restoration.
2. Increase Forensic Evaluation Services staffing (evaluators, support staff, and directors).
3. Add additional sallyport(s) to accommodate the volume of admissions and discharges.
4. Allow patients to be housed based on type of commitment.
5. Increase the number of community Residential Treatment Facilities and Secure Residential Treatment Facilities throughout the state.
6. Establish stable and consistent executive hospital administration.
7. Increase the presence of management/administration within the secure perimeter to eliminate the perception of a divide in staff hierarchy.
8. Provide OSH with independent legal counsel dedicated to representing OSH's interests, separate from the OHA. Establish OSH as a separate entity reporting directly to the Governor of Oregon.
9. Foster open, non-threatening dialogue between staff and management/administration to create a culture where innovation and change are encouraged rather than penalized.
10. Ensure a medical doctor is available on site 24/7.
11. Increase the level of staffing to maintain a 2:1 staff-to-patient ratio.
12. Add additional security personnel.
13. Formalize a system for ensuring all critical incidents are properly documented by all necessary staff.
14. Increase the overall number of staff at OSH.

15. Implement hiring requirements that includes mental health or medical training or experience.
16. Explore how other state hospitals respond to staffing shortages and high call out rates.
17. Establish a proper tracking mechanism to ensure mandatory training is completed in a reasonable timeframe.
18. Ensure training is specific to OSH and decrease reliance on a "one size fits all" approach to training.
19. Reinstate a mentorship program when onboarding employees.
20. Explore ways of establishing residencies in OSH for mental health professionals.
21. Develop regional treatment facilities to serve patients' in their community.
22. Avoid mixing Populations (A&A, GEI, Civil Commitment) within the same location as differing security needs compromise therapeutic environments.
23. Increase capacity of OSH to allow for treatment of more patients.
24. Reconstitute the PICU directed at decreasing the frequency and length of seclusion events.
25. Improve the tracking and reporting of seclusion events.

Acknowledgements

This Grand Jury wishes to express gratitude to the many dedicated, hard-working, and tremendously capable individuals working at OSH. Without their passion for public service, OSH simply could not function.

Dated this 28 day of September, 2026.

X


Presiding Juror