ACLU Virginia

To: **Virginia Corrections Ombudsman**

From: **ACLU of Virginia**

Date: **October 2, 2025**

Re: **Conditions at Red Onion State Prison**

The ACLU of Virginia represents the plaintiffs in the class action lawsuit *Thorpe v. VDOC*, which has been pending in federal court since 2019. The lawsuit alleges that the Step-Down Program operated at Red Onion (and, previously, Wallens Ridge) violates prisoners' rights under the Eighth Amendment and Due Process clause of the Fourteenth Amendment to the U.S. Constitution. Through this litigation and our conversations with people incarcerated at Red Onion, we have acquired a wealth of information regarding the Step-Down Program and conditions at Red Onion. Additionally, in recent months, we have conducted extensive outreach to people in various housing units at Red Onion regarding current conditions across the prison. Many of these individuals have given us permission to share their experiences with the Office of the Corrections Ombudsman, and we would be happy to provide their names if the office is interested in speaking with them directly.

This memo summarizes information we have learned about issues that significantly impact the health, safety, and well-being of the population incarcerated at Red Onion State Prison, and fall within the Corrections Ombudsman's purview to investigate and make recommendations to improve. We also provide recommendations on priority areas for investigation and how the Ombudsman can use its statutory powers to conduct effective inquiries and issue public findings that drive meaningful corrective action and policy reforms.

We focus here on five overarching issues[1]:

(1) Staff abuse of prisoners, including verbal and physical abuse and excessive force, explicit racism, abusive use of canines, and retaliation for constitutionally protected activity like speaking to lawyers and participating in litigation;

---

[1] While this memo does not address inadequate medical care, we are aware that people at Red Onion face significant obstacles to even being seen by medical staff, and then frequently fail to receive adequate diagnostic care and treatment for potentially serious medical conditions. We encourage your office to carefully investigate complaints of inadequate medical care, in addition to the issues summarized here.

(2) Extreme isolation and harsh conditions in restorative housing and other special purpose units such as Alt-GP, including indefinite confinement in the Step-Down Program;

(3) Inadequate mental health care, including a lack of therapy or programming;

(4) The futility of the grievance process; and

(5) Inadequate provision of food, especially for people in the Step-Down Program and any other housing unit where access to commissary is restricted.

We acknowledge that there may be other issues of which we are not aware, or that disproportionately impact only certain individuals or housing units. Where possible, we have included sworn statements from individuals and other non-confidential documentation that reflect the information summarized. While some of these statements are now several years old, our recent conversations with individuals currently in the Step-Down program demonstrate that conditions have not improved over time, and in many ways, are worse today than they were before the pandemic. In addition, many of the VDOC staff identified in these statements are still employed at ROSP or within VDOC. Accordingly, we view these statements as highly relevant to understanding the experience of people currently housed in the Step-Down Program and to identifying issues of health and safety that exist at the prison today.

Finally, we note that policies and practices seem to be shifting rapidly at Red Onion and other maximum-security institutions over the last few months, including the issuance of various policy/procedure memos and new Inmate Handbooks. These new policies and practices are raising additional concerns, including policies that lead to the routine use of excessive force, collective punishment, and sexual harassment, creating new risks to the health and safety of the entire incarcerated population, including those people in general population.

STAFF ABUSES:

Over the course of the *Thorpe* litigation, we have received regular reports that prison staff are verbally and physically abusive, and that such abuses are at best tolerated and at worst condoned. In recent months, these reports have increased in number and severity and reflect a belief among the prison population that VDOC leadership and prison administration have encouraged the harsh treatment of prisoners. This belief is substantiated by recent policy announcements involving the use of force and collective punishment.

Reports from people in the Step-Down Program:

The attached documentation contains descriptions of specific incidents of staff abuses, and we have received many reports of similar incidents. Often, these abuses are likely retaliation against prisoners who file grievances against specific staff, speak to lawyers (including the legal team representing the plaintiffs in *Thorpe v. VDOC*), or file lawsuits on their own regarding the conditions of confinement in the prison. Prisoners of every race at Red Onion have corroborated that officers use racist language specifically against Black and Latino prisoners, and are more

likely to retaliate against Black prisoners who file grievances or lawsuits than non-Black prisoners.

Common reports that we receive include:

- Verbal abuse, including the use of racial epithets. This includes name calling, goading or taunting, insults, threats, and even sexual harassment, particularly when officers carry out the daily strip search procedure.
- Physical abuse. This includes everything from excessive force incidents of hitting, punching, and kicking that cause serious injury to using too-tight handcuffs in order to cause discomfort. Staff frequently manipulate security procedures as a pretext to justify the use of force. In addition, canines are used at Red Onion and are frequently used improperly in order to intimidate prisoners or to injure prisoners who are actually complying with commands and instructions.
- Abuse of position. We receive frequent reports that staff abuse their position to harm or punish prisoners. For example:
    - Staff regularly abuse the strip search procedure to humiliate prisoners and to deny prisoners privileges such as recreation without cause, based on a purported noncompliance with some aspect of the lengthy strip search procedure.
    - Staff routinely destroy personal property during cell shake-downs, including photographs, legal papers, and items purchased from commissary.
    - Staff have been observed to contaminate food trays with spit or urine, or withhold food at meal times.
    - Prisoners are left in ambulatory restraints, locked in the showers, or chained to the tables in the pod for hours at a time with no food, water, or access to the bathroom. During these periods, staff fail to check on their condition or return them to their cells.
- Specific abusive staff: Specific staff are known to prisoners as particularly tyrannical and abusive. Those long-time staff include: Larry Collins, James Lambert, Dwayne Turner, and Major Johnny Hall.

These abuses have resulted in a deluge of litigation by prisoners – usually pro se – whose rights have been violated. But because of the legal requirements for bringing such cases and the limitations on the remedies available to prisoners, these lawsuits are highly unlikely to result in compensation or other relief for the plaintiffs.

The physical and mental harms caused by staff abuses can be severe. For example, one of our plaintiffs in the *Thorpe* litigation suffered an unwarranted dog bite that was so severe he had to stay in the medical unit for 30 days for treatment. He later won a jury verdict based on a finding that the use of the canine was excessive force and violated his constitutional rights.[2] Another class member in the *Thorpe* litigation was beaten severely and suffered a head injury for

[2] See the attached declaration of Gary Wall.

which he did not receive adequate diagnosis and treatment, and from which he still suffers symptoms today.

It is well known that in the medical wing at Red Onion, there are several "blind spots"—areas not recorded by any security cameras—to which officers bring prisoners in order to beat them. Officers turn off their body-worn cameras during these incidents. Prisoners report that medical staff understand that they are not to interfere with the activities of security staff, and medical staff regularly ignore and even actively cover up staff abuse of prisoners.

The abusive treatment of people in the Step-Down Program continues to the present. On September 24, 2025, we spoke to William Tanner, who is the IM pathway of the Step-Down Program. He described a recent incident in which he was violently slammed face-first onto the floor in response to him trying to turn around to witness officers physically abusing another prisoner. He sustained a gash above his left eye that required stitches, and he suspects that he also sustained a concussion and a broken nose, though medical staff refused to evaluate him for a concussion or take X rays of his head and face. He was then placed in ambulatory restraints and left in a cell flooded with toilet water while wearing only boxers for over 7 hours.

Such reports are not unique or even particularly exceptional. Because prisoners' fear abuse by prison staff is so pervasive, they often choose not to leave their cell for the limited amount of recreation time they are offered, or even for showers. This exacerbates the extreme isolation and idleness that they are already subject to in the Step-Down Program.

Recent policy changes and systematic abuse:

In recent months, in the wake of an incident at Wallens Ridge State Prison where correctional officers were stabbed by one or more prisoners, there has been a marked escalation in reports of abuse by staff towards prisoners at Red Onion. For instance, many persons of Latino/Hispanic ethnicity who were not involved in the stabbing incident report being rounded up at facilities across Virginia and transferred to Red Onion based on, at best, suspected ties to Latino gangs—though in reality the targeting seemed to rest on little more than their Latino background.[3] Once at Red Onion, they were subjected to an extreme version of solitary confinement—not grounded in any VDOC policy—where they were deprived of their property and stripped of basic necessities like clothing, hygiene supplies, and even toilet paper, denied access to the phone, denied any out-of-cell time except occasional showers, had food trays withheld for more than two days,[4] and had their cell windows obscured by cardboard for weeks,

[3] We have also received multiple independent reports of persons more closely connected to the Wallens Ridge stabbing incident, who report being badly beaten while restrained—several sustaining broken hands and fingers—and then, after being transferred to Red Onion, denied medical care for their injuries.

[4] Several people reported that they received fake trays containing no food, apparently to make it appear to surveillance cameras that they received a tray at meal time.

obstructing any view outside of their cells and impairing staff's ability to monitor their well-being.

Then, the warden issued a memorandum setting forth various procedures governing out-of-cell time for prisoners in general population units at Red Onion, including strict requirements about where they may stand or move and how quickly they must complete any activities and return to their cell door at the conclusion of out-of-cell time.[5] Notably, the memo states repeatedly that officers may use force to compel inmates into compliance with the rules. This memo is included in the attached documents.

Since the memo's issuance, we have heard consistent reports from persons in general population units that because of the new policy, officers who witness minor rule violations, such as stepping across a red line, respond by shooting incarcerated persons with non-lethal munitions, such as rubber bullets and pellets containing chemical irritants. When a person is shot they are often removed from the pod and placed in restrictive housing, but at other times they are brought back within minutes and placed back in their cell—suggesting that the person was shot was found not to have committed any infraction. Although the written policy indicates that, upon witnessing a rule violation, audible warnings should be issued to allow persons to come into compliance, prisoners uniformly report that shootings regularly occur without any warning whatsoever. We have received reports of prisoners being injured by these rounds.

When force is used on any person, prisoners are forced to lie down and officers run into the unit with K-9 dogs and cans of mace, and the unit is placed on a modified lockdown for a week, during which everyone in the housing unit receives only one hour of indoor out-of-cell time every few days, rather than the typical 7 hours of (indoor and outdoor) out-of-cell time per day. Because of the frequency with which force is used, prisoners in general population units have reported not receiving any outdoor recreation time for weeks and months at a time. And some have reported that they are hesitant to take the little out-of-cell time they do receive, or socialize with others, out of fear that they may be perceived as having violated a rule and be shot without warning.

Even more recently, we understand that a new Inmate Handbook was issued for Red Onion, containing a new policy that an entire housing pod will be punished for the actions of one or a few prisoners in that pod.[6] Prisoners report that pod-wide sanctions have already been imposed in some units, including the loss of access to JPay kiosks for a week, based on non-violent infractions by only certain people (for example, flooding one's cell in protest of mistreatment). As documented in memos from prison administration, several pods have lost access to their JPay tablets for 30-day periods for the actions of one or a few people.

---

[5] A similar policy was instituted at Wallens Ridge State Prison at the same time, and has been implemented in a similar manner.

[6] This policy was also introduced at Wallens Ridge State Prison, and the memo setting out that policy is included in the attached documents.

Because rules and policies are so arbitrarily enforced by prison staff, prisoners understand that it will be impossible to avoid collective punishment under this policy. The threat of collective punishment thus undermines any incentives people might otherwise have to comply with prison rules and policies, and instead is creating a powder keg of hostility and resentment between the incarcerated population and staff. This poses risks to the health and safety of both incarcerated people and prison staff.

CONDITIONS IN RESTORATIVE HOUSING

Although VDOC chose to relabel units like the Step-Down Program "restorative housing,"[7] the conditions in those units are harsh, punitive, and harmful to the well-being of persons held there. The severe social isolation and forced idleness that people endure mean that the conditions in the Program constitute a form of "solitary confinement" that has been conclusively shown in the scientific literature to cause both mental and physical harm.

For most phases of the Step-Down Program, incarcerated people are allowed at most 4 hours out of cell per day. However, during periods of lockdown or whenever the prison has insufficient staff, they might remain in their cells for 24 hours a day. In addition, we receive frequent reports that staff arbitrarily deny people out-of-cell time, including by falsely asserting that someone has failed the strip search procedure.

The only out-of-cell activities that people in most phases of the Step-Down Program are provided are outdoor recreation, during which people spend 3-4 hours alone in an empty rec cage with no ability to use the bathroom or drink water; indoor recreation, during which people are handcuffed and shackled to a table in the pod for hours with no ability to move, eat, drink, or use the bathroom; to go to the shower three times a week; and to use the kiosk at a frequency that depends on their privilege level. The vast majority of out of cell time is spent in solitary conditions that are physically uncomfortable, and this, combined with the demeaning strip search procedure, often deters people from participating in out of cell time.

The ability of people in the Program to communicate with each other or with their loved ones in the community is severely restricted. In the initial phases of the Program, people get only two 20-minute phone calls per month, and no visits (video or otherwise). They have very little

---

[7] Even though people in Level S at Red Onion are considered to be in restorative housing, and are in the "Restorative Housing Reduction Step-Down Program," VDOC has apparently decided that its Level S units do not need to comply with Va. Code § 53.1-39.2, despite its clear application to all restorative housing units. As such, it does not make the step-down program policies and procedures publicly available, as required by Va. Code § 53.1-39.2(F). Nor does it comply with other provisions of the law, such as the requirement of "four hours of out-of-cell programmatic interventions or other congregate activities per day aimed at promoting personal development or addressing underlying causes of problematic behavior." Va. Code § 53.1-39.2(5). *See also* the attached documents under Tab 14.

Further, VDOC does not consider certain Level 6 units, including the IM-Closed units, to be restorative housing, even though the conditions are nearly as isolated and restrictive as in Level S units. *See* Tab 22.

access to email, and are not permitted to have a TV in their cell. They can have a maximum of only four library books per month. The main way that they are able to communicate with other prisoners is by shouting through the vent in their cells to the three other people who share that vent.

People in the Program have little access to programming, and any programming they do get is done by themselves in their cells in writing. They report that it is meaningless and of no benefit. Contrary to written policy, they are offered no group programming whatsoever. They are also generally ineligible to hold jobs or attend most educational programs (other than programs done entirely in their cell at their own expense). They are unable to attend congregate religious services, so all religious programming is done through the television or tablet while isolated in their cells.

As a result of the new requirement that people in the Step-Down Program sign a Safety Agreement, several people in the Step-Down Program who have refused to sign the agreement have lived without power to the outlets in their cells since January of this year. This means they have no access to their television or tablets, which provide the main source of communication, religious programming, and entertainment for people in restrictive housing.

People in the Program spend years in these conditions, and often have no idea whether or when they will be able to return to general population, even in the absence of any significant disciplinary charges. Although the program purports to offer some persons a way out of these restrictive conditions upon satisfying various objectives, in practice it traps people in these conditions indefinitely, requiring them to repeat its phases for years due to arbitrary triggers such as minor disciplinary violations, failure to get a specific number of positive grades in behavioral goals like "showing respect" that are subjectively and inconsistently assessed, or failure to complete certain workbooks without regard to a person's cognitive or linguistic abilities or whether they have already completed the books successfully.

To take just one (publicly-disclosable) example, a VDOC mental health associate noted in 2018 that, under the Step-Down Program, an individual who had been in restrictive housing for more than 12 years had "no viable pathway out of long-term restrictive housing" despite the fact that there were "no violent charges in his record to indicate a continued need to remain in Level S." Thus, "he is currently in Level S due to his suspected cognitive deficits and his inability to read or write English or Spanish and his inability to appropriately understand English." Even after this note, the individual remained in the program for nearly another year until after the ACLU of Virginia filed suit on his behalf. Although this note was written in 2018, the program's requirements have not materially changed and people in the Program continue to remain in isolation for months and years on end.

As a result of the isolation they experience over this length of time, combined with the abuse they experience, many people in the Step-Down Program experience emotional and psychological harm. This includes the exacerbation of pre-existing mental illness, and the development of new symptoms and conditions they had not previously experienced. These harms often persist long after the person returns to general population, and may be permanent.

INADEQUATE MENTAL HEALTH CARE

Given the harsh conditions of confinement at ROSP, most especially in the Step-Down Program, but present throughout all housing units, the mental health care available at the prison is shockingly inadequate. VDOC continues to place people with serious, known, mental health conditions in restrictive housing, fails to adequately monitor prisoners for mental deterioration, and fails to offer adequate treatment options for mental illness.

Failure to Screen and Identify People with Serious Mental Illness:

It is universally accepted that people with Serious Mental Illness (SMI)[8] are at drastically higher risk of psychological harm from the isolated and harsh conditions in restrictive housing units like the Step-Down Program. As a result, various prison systems have recognized that people with SMI should be diverted from restrictive housing settings, or if absolutely necessary to house them in those settings, they should be provided with additional mental health monitoring and treatment services. VDOC fails to do either, especially at Red Onion.

First, referrals to the Step-Down Program are made by security staff with no input from mental health staff. VDOC fails to screen people being referred to the Step-Down Program for known, pre-existing mental illness or other history that would pose an increased risk of psychological harm from the conditions in the program. VDOC also fails to account for the role that mental illness might have played in the circumstances leading to the referral to the programs, since disciplinary hearings typically do not involve mental health staff. These failures result in people entering the Step-Down Program even if they have a diagnosis that should be considered a SMI. We have spoken to many people over the years who are in the Step-Down Program while having diagnoses of major depressive disorder, bipolar disorder, PTSD, and schizo-affective disorder, and whose conditions have deteriorated during their time in the program, including individuals whose declarations are attached.[9]

---

[8] See https://www.samhsa.gov/mental-health/serious-mental-illness/about: "SMI is defined by someone over 18 having (within the past year) a diagnosable mental, behavioral, or emotional disorder that substantially interferes with a person's life and ability to function. SMIs include conditions like bipolar disorder, major depressive disorder, and schizophrenia."

[9] While VDOC insists that people with Serious Mental Illness (SMI) are no longer housed in the Step-Down Program, this assertion relies on a definition of SMI that is underinclusive and would not be supported by any independent mental health practitioner. VDOC defines Serious Mental Illness as: "Psychotic Disorders, Bipolar Disorders, and Major Depressive Disorder; any diagnosed mental disorder (excluding substance use disorders) currently associated with serious impairment in psychological, cognitive, or behavioral functioning that substantially interferes with the person's ability to meet the ordinary demands of living and requires an individualized treatment plan by a qualified mental health clinician." OP 730.1, p. 3.

People in other housing units, including general population, are frequently subjected to similar conditions, especially during periods of lockdown. And harm can occur even from short periods of isolation, or as a result of traumatic interactions with prison staff.

VDOC's own reported statistics indicate the unusually high rate of mental illness among the population of the Step-Down Program. During FY2024 (the most recent report available), 79% of people in Level S had a mental health classification of MH2[10], which means they had a diagnosis of mental illness that impaired functioning, generally requiring treatment with medication.

Failure to Treat Mental Illness:

Despite these high rates of mental illness and known risk of harm, VDOC does not adequately monitor or treat mental illness at Red Onion. In the Step-Down Program underqualified and under-trained mental health staff conduct rounds only once a week. They do only a cursory evaluation of mental status, and many people do not trust them enough to accurately report their mental status. Further, these staff act as gatekeepers for appointments with the psychiatrist, the only licensed mental health provider who actually provides treatment at Red Onion. Prisoners report waiting weeks or months to see the psychiatrist.

Once someone is able to see the psychiatrist, those appointments are usually not confidential, taking place through the cell door, as opposed to in an office. The only treatment offered is medication management. There is no individual or group therapy offered at Red Onion, in any housing unit. Thus, people for whom medications do not work, cause intolerable side effects, or provide only partial relief of symptoms, essentially receive no mental health care, regardless of their diagnosis.

INADEQUATE NUTRITION

People housed at ROSP uniformly report serious concerns with the meals provided by the prison, including that meals provide insufficient nutrition on their own; that food is often spoiled or inedible; and, as described above, that prison staff is able to contaminate or withhold food as a means of abuse.

Nearly everyone at ROSP who is forced to survive on prison meals without access to food purchased from commissary at their own expense reports losing weight. This is especially true for people in the early phases of the Step-Down Program, where access to commissary is restricted for months or years. In the initial phases of the Step-Down Program, where people spend a minimum of 4-7 months and typically longer, prisoners are not allowed to purchase any food items from commissary. In subsequent phases, the amount of money people are allowed to spend on food items is very limited. The attached declarations document significant weight loss simply as a result of starvation without access to commissary. In addition, our former client, Nicholas Reyes, lost 50 pounds while in the Step-Down Program.

[10] https://vadoc.virginia.gov/media/2268/2024-rd579-restorative-housing-in-the-virginia-department-of-corrections-fy2024-report-october-1-2024.pdf. *See also* OP 730.2.

We have received a number of consistent reports across housing units that officers adulterate trays or withhold food altogether as a means of punishing prisoners. When officers want to withhold food, they will serve "ghost trays" to make it look on video footage as if they have given the person his meal, but the tray is empty. Multiple people have reported seeing officers spit in food or pour urine or other unidentified liquid on trays before serving them to prisoners. Other times, they serve food on styrofoam trays that do not have dividers, which leads to the various components of the meal becoming mixed together in an unappetizing way.

The quality of food provided also frequently renders it inedible. Prisoners who work in the kitchens often report unsanitary conditions and practices. Because VDOC is responsible for oversight of its own kitchens, accurate and transparent information about the food service conditions is not readily available. There is no independent inspection or oversight of VDOC's food services.[11]

Due to the persistent problems with food services at Red Onion, the direct relationship of these problems to the health and safety of the incarcerated population, and the lack of any other oversight mechanism, it is especially important that the Corrections Ombudsman request comprehensive records, conduct unannounced inspections of facility kitchens, interview kitchen workers and prisoners, and report its findings, in order to ensure that incarcerated people are receiving adequate nutrition and edible food.

GRIEVANCE PROCEDURE

The grievance procedure at Red Onion is so riddled with barriers and deficiencies that it is neither accessible to prisoners nor effective in resolving their complaints. As a result, the mere fact that a grievance was denied or unfounded cannot reasonably be taken to mean that the underlying concern lacked merit or was adequately addressed. For this reason, your office should not rely on grievance outcomes to assess whether a complaint had merit. At the same time, it should scrutinize the grievance system itself, which more often than not undermines accountability rather than advancing it.

People at Red Onion often express difficulty in obtaining the necessary forms to file grievances or informal complaints because they must typically rely on officers—sometimes specific officers with whom they do not regularly come into contact—to make them available. This is especially true for persons in special housing units such as restorative housing who receive limited or no unrestrained time out of cell. Officers, in turn, greatly discourage written complaints, and make it known that prisoners who file them are marked as troublemakers among staff, with potential enduring negative consequences for their quality of life and opportunities on the inside. Sometimes, officers refuse requests for forms altogether; at other times, they promise to resolve the issue if the person withdraws their complaint, and then fail to follow through after the complaint is dropped. In such cases, the person may not be able to file another complaint or grievance regarding the issue if the time limit has run.

[11] *See*, *e.g.*, https://theappeal.org/virginia-prison-food-department-of-health/.

People also report that after they manage to submit a form, they often do not receive a grievance receipt and are left without evidence that their form was ever submitted. Individuals often suspect that their forms are intentionally misplaced or discarded when they fail to receive a receipt, particularly when their complaints or grievances relate to employee misconduct. At least two VDOC employees have sworn under oath in recent years that they personally witnessed officers rip up or discard complaint forms rather than ensure they are processed correctly. But as far as we are aware, no employee has ever been disciplined for such behavior. Nor, to our knowledge, has any employee been disciplined for retaliating against persons who file complaints, despite such retaliation being one of the most commonly reported issues at Red Onion.

This may be because the investigation process for complaints against staff—including for retaliation—appears designed to shield prison officials and employees from legal action rather than determine whether a grievance is valid. Based on a review of thousands of grievances and informal complaints on VACORIS (from Red Onion as well as other facilities), the staff member's account is invariably believed against the account of the incarcerated person without any attempt to verify or corroborate their story. For example, a typical response to a complaint asserting that a staff member deprived someone of a privilege might read as follows:

> "I have spoken to [staff] and they deny these allegations. You are afforded the opportunity to receive [privilege,] per policy and procedure. All staff conducted themselves in a professional manner at all times. . . . This grievance is considered UNFOUNDED, as procedures were properly applied."[12]

Notably, we have **never** seen an instance of an investigation into a complaint or grievance relating to staff misconduct towards prisoners (setting aside sexual misconduct which is investigated through a separate PREA process under Operating Procedure 038.3), where the investigator took any of the following basic investigative steps to determine the veracity of a complaint:

- Interview another incarcerated person who might be in a position to corroborate the account of the person who filed the complaint;
- Seek and review staff body camera footage to corroborate the complaint;[13] or
- Review past grievances and complaints to determine whether other incarcerated people have filed similar allegations against the complained-of staff.

---

[12] This specific example is taken from a grievance report received in response to a FOIA, although the wording mirrors many responses to similar grievances we have reviewed.

[13] While we are aware of instances where officers review *surveillance camera* footage during disciplinary hearings or investigations by the special investigations unit (SIU), and we understand that SIU investigators occasionally review body camera footage as part of their investigations, we are not aware of instances where such footage is reviewed as part of an investigation into complaints or grievances of staff misconduct.

Finally, although a legal settlement secured by the ACLU of Virginia led VDOC to establish Operating Procedure 801.7—mandating that individuals with limited English proficiency (LEP) be identified and provided language assistance to access the grievance process—Spanish-speaking persons at Red Onion consistently report that no such assistance is offered. We have recently heard from Spanish speakers who were never informed that language assistance exists and who have never been provided assistance despite their obvious inability to communicate in English, including with respect to the grievance process. While Spanish-language grievance forms may technically be available in the law library upon request,[14] prisoners are neither informed of this fact nor provided Spanish-language orientation packets. Nor are they advised of the existence or identity of the Red Onion LEP monitor or the VDOC LEP Coordinator, who are jointly responsible for identifying language service needs and ensuring the provision of assistance.

RECOMMENDATIONS

In light of the serious and recurring issues at Red Onion State Prison, we recommend that the Office of the Corrections Ombudsman use its authority under Virginia Code 53.1, Article 4 to focus its investigation into Red Onion on the following areas:

(1) **Staff abuses and misconduct**. The investigation should investigate the policies, practices and culture that permit, condone, or fail to remedy pervasive physical and verbal abuse of incarcerated people, including the use of excessive force, racial epithets, sexual harassment (including during strip searches of persons in special housing), destruction of property, denial of recreation and other privileges, and food tampering.

(2) **Conditions of confinement in special housing units**. Such units include short-term RHU, Level S and Level 6 units including the Level 6 Re-entry pod, and Alt-GP, and the Ombuds' review should include whether strip searches and access to out-of-cell time and other privileges such as visitation and programming are consistent with VDOC's own policies, Virginia's Restorative Housing law (Va. Code 53.1-39.2), and best practices.[15] Such a review should determine whether VDOC has improperly exempted certain housing units from the requirements of Va. Code 53.1-39.2 by failing to classify them as "restorative housing," and whether persons who have been placed in such units at their own request or for their own protection are properly identified and treated in accordance with the law's requirements.

---

[14] Spanish-language grievance information is also not available on VDOC's website.

[15] A useful example comes from the New Jersey Office of the Corrections Ombudsperson, which in 2023 conducted unannounced inspections of multiple RHUs, distributed anonymous surveys to incarcerated persons, and reviewed official out-of-cell time logs. The report included a detailed description of the investigation methodology and results, along with concrete recommendations. New Jersey Office of the Corrections Ombudsperson. (2023, October). *Out of cell time in Restorative Housing Units: Special report.*

(3) **Access to medical care and mental health care**. This includes whether people have timely access to medical care, including outside appointments and specialty care; whether individuals are properly screened for serious mental illness; whether mental health needs are adequately monitored and treated; whether psychiatric care is timely, confidential, and not limited to medication management; and whether persons with mental health issues have access to appropriate programming, including reentry services prior to being released to the community.

(4) **Efficacy of Grievance Procedure**. This includes policies and practices for informal or written complaints, grievances and emergency grievances, including access to required forms, nature of investigations of grievances, and the adequacy of responses to complaints, grievances, and appeals.

Utilize Broad Statutory Authority to Conduct Focused, Independent Investigations

For any investigation to be effective, the Ombudsman must use its broad grant of statutory authority to conduct a thorough, independent assessment of relevant practices, rather than relying on conclusory information provided by VDOC officials. Reviews that are comprehensive but focused on a smaller number of issues are preferable to surface-level reviews of a broader set of practices.

In reviewing allegations of abuse or misconduct, for example, the Ombudsman might choose to review an illustrative sample of incidents to evaluate whether VDOC officials investigated and resolved them appropriately.[16] Such a review should involve identifying and reviewing all relevant records--such as video footage, incident reports, disciplinary reports, grievances, medical documentation, etc. If VDOC employees withhold documents in violation of § 53.1-17.4(D) and/or § 53.1-17.4(G), the Ombudsman should document the obstruction for inclusion in public reporting and follow up by issuing a subpoena in accordance with § 53.1-17.4(F).[17]

[16] A recent investigation by Washington's Office of the Corrections Ombuds illustrates the importance of rigorous, independent review. The OCO conducted repeated site visits, a thorough records review, and in-depth interviews, and this investigation exposed systemic violations and resulted in actionable recommendations for reform. Office of the Corrections Ombuds. (2025, June). *Use of force and restrictive housing policy violations at Washington Corrections Center for Women.*

[17] Although the Ombudsman does not have the power to request confidential personnel files under § 53.1-17.4(D), nothing in statute prevents the Ombudsman from inquiring into the existence or outcome of any investigations into alleged misconduct or abuse, and in fact the Ombudsman has the duty to do so as part of its mandate to assess compliance with policies, laws,

The Ombudsman should also interview an adequate and representative number of incarcerated persons and staff, as authorized by § 53.1-17.4(A), to evaluate whether policies and best practices were appropriately applied at each step. These interviews must be confidential to assure incarcerated persons and staff alike that they can share concerns candidly without fear of retaliation.

A focused audit of use-of-force practices at Red Onion is likewise essential. This review should examine the full range of tactics employed at Red Onion, whether force is used in a lawful, proportionate, and transparent manner, and whether incidents are adequately documented. In that regard, the Ombudsman should pay special attention to whether body camera policies and practices—including their use in subsequent investigations—are in accordance with best practices.

Finally, the Ombudsman should conduct multiple unannounced inspections of Red Onion,[18] including both special housing and general population units, as well as the kitchen and cafeteria around mealtimes. Random, unannounced inspections ensure that oversight is meaningful and responsive to the urgent issues that incarcerated people face.

Protect the Ability of the Corrections Ombudsman to Carry out its Mission

Effective oversight depends on the Ombudsman's visibility and accessibility. Yet conversations with incarcerated people suggest that few at Red Onion know the Corrections Ombudsman exists or understand its role. At the July 15, 2025, stakeholders meeting, the Ombudsman shared that majority of the complaints received by the Office are either "non-covered issues," submitted anonymously, or consist of mass campaign emails lacking sufficient detail to process effectively.

To strengthen the complaint process, the Ombudsman Office should take steps to ensure all incarcerated persons are informed of its mission, investigative powers, and the ways they can contact the Office. It should also provide clear guidance regarding the types of issues it investigates, establish a process to follow up on complaints that lack sufficient detail, and

---

and best practices pertaining to the health, safety, welfare, and rehabilitation of incarcerated persons.

[18] New Jersey's Ombudsperson provides useful guidance here as well. At Northern State Prison, the Ombuds conducted weekly tours, two unannounced inspections, and one unannounced inspection within the first six months of the RHU's reopening. The combination of ongoing oversight and surprise visits allowed the Ombuds to observe problems firsthand, and then confirm improvements such as consistent access to showers and hygiene products, increased access to phones, the grievance system, and outdoor recreation, and a reduction of assaults on staff. New Jersey Office of the Corrections Ombudsperson. (2024, October). Inspection report: Northern State Prison, Restorative Housing Unit (RHU).

maintain open communication with persons they have already interviewed and gather additional information as needed.

Just as important, the Ombudsman should ensure that both VDOC employees and incarcerated people understand that communications with the Ombudsman's Office will be kept confidential, under § 53.1-17.4(B), to the extent permitted by law.

The Ombudsman must also safeguard against retaliation to ensure the integrity of its factfinding and build trust in the complaint process. It should actively investigate instances where individuals face retaliation for using the grievance process, communicating with legal counsel, or contacting the Ombudsman. If VDOC conducts internal disciplinary reviews of staff in response to the Ombudsman's investigation, those reviews should themselves be subject to Ombudsman oversight to ensure they are fair and objective.

Issue Detailed Corrective Action and Reports on Compliance

Independent investigations are only effective if followed by transparent reporting and meaningful corrective action. The Ombudsman should therefore issue detailed public reports describing its investigations, findings, any response by VDOC to those findings, and clear recommendations for corrective action.

Where significant issues concerning health, safety, welfare, or rehabilitation of incarcerated people are uncovered, the Ombudsman should escalate these findings to the Governor, the Attorney General, the Senate Committee on Rehabilitation and Social Services, the House Committee on Public Safety, the Correctional Oversight Committee, and the Director of VDOC.

Finally, the Ombudsman should recommend policy reforms where VDOC practices enable routine use of excessive force, prolonged isolation, collective punishment, or sexual harassment. This requires reviewing and evaluating new policies and procedures issued by VDOC, assessing whether they comply with constitutional and statutory standards, and recommending rescission where they do not. The Ombudsman should also advise the General Assembly where statutory changes are required to strengthen oversight and accountability.

CONCLUSION

The conditions at Red Onion pose an ongoing threat to the health, safety, and constitutional rights of the people incarcerated there. The General Assembly has vested the Ombudsman with broad authority to investigate, monitor, and report on such systemic failures. Exercising its authority is not only consistent with the Ombudsman's statutory mandate but essential for ensuring legitimate complaints are heard, harmful practices are corrected, and that the state treats all people in its custody with humanity, dignity, and fairness.

Table of Contents—Supporting Documentation

Tab	Date	Description	Issues
1	8/2025	Incentives and Sanctions Policy (from Wallens Ridge, but identical policy in place at ROSP)	Isolation; staff abuses; collective punishment.
2	5/20/25	Red Line Compliance Memorandum	Staff abuses.
3	2/26/25	Letter from ACLU-VA to VDOC and declarations of S. Bowman regarding Safety Agreement given to people in Step-Down Program.	Inadequate mental health care; retaliation
4	9/2024	Emails among VDOC staff discussing how to respond to the series of self-inflicted burns among people incarcerated at ROSP, including charging for medical care and pressing criminal charges.	Health & safety; retaliation for mental illness.
5	9/25/23	Declaration of P. Mukuria describing experience in the Step-Down Program. This was submitted to the court in Thorpe v. VDOC and is a public record.	Isolation; inadequate mental health care; unsafe and unsanitary conditions; inadequate nutrition; lack of programming; staff abuses; grievance procedure.
6	9/22/23	Declaration of S. Bowman describing experience in the Step-Down Program. This was submitted to the court in Thorpe v. VDOC and is a public record.	Isolation; inadequate mental health care; unsafe and unsanitary conditions; inadequate nutrition; lack of programming; staff abuses; grievance procedure.
7	9/22/23	Declaration of M. McClintock describing experience in the Step-Down Program. This was submitted to the court in *Thorpe v. VDOC* and is a public record.	Isolation; inadequate mental health care; unsafe and unsanitary conditions; lack of programming; staff abuses.
8	9/6/23	Declaration of F. Hammer describing experience in the Step-Down Program. This was submitted to the court in *Thorpe v. VDOC* and is a public record.	Isolation; inadequate mental health care; unsafe and unsanitary conditions; lack of programming; staff abuses.
9	9/5/23	Declaration of J. Arrington describing experience in the Step-Down Program. This was submitted to the court in *Thorpe v. VDOC* and is a public record.	Isolation; inadequate mental health care; unsafe and unsanitary conditions; inadequate nutrition; lack of programming; staff abuses.
10	9/1/23	Declaration of B. Cavitt describing experience in the Step-Down Program. This was submitted to the court in *Thorpe v. VDOC* and is a public record.	Isolation; inadequate mental health care; unsafe and unsanitary conditions; inadequate nutrition; lack of programming; staff abuses; grievance procedure.
11	9/1/23	Declaration of G. Wall describing experience in the Step-Down Program. This was submitted to the court in *Thorpe v. VDOC* and is a public record.	Isolation; inadequate medical and mental health care; unsafe and unsanitary conditions; inadequate nutrition; lack of programming; staff

Tab	Date	Description	Issues
			abuses; retaliation; grievance procedure.
12	9/1/23	Declaration of D. Cornelison describing experience in the Step-Down Program. This was submitted to the court in *Thorpe v. VDOC* and is a public record.	Isolation; inadequate medical and mental health care; unsafe and unsanitary conditions; inadequate nutrition; lack of programming; staff abuses; grievance procedure.
13	9/1/23	Declaration of S. Riddick describing experience in the Step-Down Program. This was submitted to the court in *Thorpe v. VDOC* and is a public record.	Isolation; inadequate medical and mental health care; unsafe and unsanitary conditions; inadequate nutrition; lack of programming; staff abuses; grievance procedure.
14	7-8/2023	Grievances from D. Venable with responses showing that VDOC does not consider Va. Code Section 53.1-39.2 (applicable to restorative housing units) to apply to the Step-Down Program.	VDOC compliance with applicable laws.
15	2/2/23	Declaration of Dan Pacholke, corrections expert, documenting staff retaliation and abuse against prisoners speaking and cooperating with counsel in *Thorpe v. VDOC*.	Retaliation; staff abuses.
16	6/20/22	Declaration of Peter Mukuria, describing experience in Step-Down Program	Grievance procedure; isolation; inadequate medical and mental health care; staff abuses; lack of programming.
17	4/14/22	Declaration of J. Arrington describing staff intimidation to dissuade communication with counsel.	Retaliation; staff abuses.
18	4/14/22	Declaration of K. McDuffie describing staff intimidation to dissuade communication with counsel.	Retaliation; staff abuses.
19	4/14/22	Declaration of S. Riddick describing staff intimidation to dissuade communication with counsel.	Retaliation; staff abuses.
20	2/23/20	Excerpts of Deposition of Nurse Terie Boyd	Grievance procedure.
21	12/21/19 5/30/15	Declarations of T. McCurdy, former VDOC employee, regarding staff culture at ROSP.	Staff abuses; racism; retaliation; grievance procedure.
22	December 2018	Vera Institute Report with Recommendations re: Restrictive Housing	Isolation; lack of programming.
23	1/18/18	Clinical Supervisor Notes re: Nicolas Reyes	Isolation; inadequate medical and mental health care; lack of programming.
24	Aug. 2025	Memos re: collective punishment	Staff abuses.