Locked Cells, Locked Records: Retaliation, Deaths, and Secrecy across VADOC

(Prepared for members of the Virginia General Assembly and oversight bodies)

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I. Purpose & Overview

This report summarizes urgent concerns about **retaliation, torture-like practices, medical neglect, and deaths in custody** at three Virginia Department of Corrections (VADOC) facilities:

- **River North Correctional Center (RNCC)**
- **Red Onion State Prison (ROSP)**
- **Wallens Ridge State Prison (WRSP)**

The report focuses on:

1. The case of **Kenneth "Punch" Evans (#1446064)**, a whistleblower and material witness who reports that he witnessed the hallway stabbing of a correctional officer at River North and the brutal beating of the accused prisoner, and who has since been:
    - Tased multiple times with a **shock belt**,
    - Transferred to Red Onion,
    - Held **indefinitely in segregation with no charge or hearing**,
    - Housed in a prison where the **major is the slain officer's cousin**.
2. Corroborating testimony from **other incarcerated witnesses**, including **Eric Thompson**, describing:
    - Collective punishment and lockdowns of entire units,
    - Aggressive uses of force and **chemical agents**,
    - **Suicide watch** used as punishment,
    - **Sexualized strip searches recorded on body cameras**,
    - Withholding of tablets and communication devices, and
    - An **overdose death** at Red Onion after staff failed to make required rounds.
3. Multiple **deaths in custody** in the same region, including:
    - **Michael Hailey** (Red Onion) – family reports they are still waiting on toxicology and that he had documented abuse in letters,
    - **Bobby Nicholson Jr.** (Red Onion),
    - **Aubrey McKay** (Wallens Ridge) – whose body reportedly showed shackling-type injuries and a fractured larynx.
4. **FOIA stonewalling and misuse of "record of incarceration" exemptions**, including a recorded call in which VADOC's FOIA Officer first claims requested records are "not releasable," then admits that the relevant code section is **discretionary** and that the Department is choosing not to release them.

Collectively, the evidence suggests systemic violations of:

- **Virginia Code §§ 53.1-32 and 53.1-39** (humane treatment, prohibition on cruel or unauthorized punishment),
- VADOC Operating Procedures on discipline, use of force, and restrictive housing,
- The **Eighth and Fourteenth Amendments** to the U.S. Constitution,
- The **UN Standard Minimum Rules for the Treatment of Prisoners (Nelson Mandela Rules)** and the **UN Convention Against Torture (UNCAT)**,
- The spirit of the **federal Death in Custody Reporting Act** and **Va. Code § 9.1-192.1**.

II. Case Study: Kenneth “Punch” Evans (#1446064)

A. Who Kenneth “Punch” Evans Is

- **Name:** Kenneth Evans
- **Nickname:** “Punch”
- **Number:** #1446064
- **Current Facility:** Red Onion State Prison (ROSP) – Western Region, VADOC
- **Status at time of writing:**
  - Held in **segregation (“the hole”)** at Red Onion,
  - With **no written disciplinary charge**,
  - **No institutional hearing**,
  - **No new criminal (“street”) charge**.

He reports he has **never been this close to release** and fears the Department is trying to “take everything for nothing” at the very point he should be preparing to go home.

B. Witness to a Hallway Stabbing & Beating

On and after **November 17, 2025**, when Correctional Officer **Jeremy Hall** was fatally stabbed in B3 at River North:

- Kenneth states that he **did not see** the fatal stabbing in B3. That incident occurred outside his line of sight.
- He **did** personally see:
  - A **white male prisoner**, later identified as **John Holomon Russell**,
  - **Stab a “dog man” officer in the face** in a hallway at River North.
- He reports that following this incident, he saw staff **“beat [Russell’s] ass to a pulp… stomping him and everything”** while Russell was down and under control.

This makes Kenneth a **material witness** with first-hand knowledge of a key hallway incident and the subsequent use of force on the accused prisoner.

C. Retaliation: Shock Belt, Transfer, and Filthy Intake Cell

Two days after the killing, on **November 19, 2025**:

- A Special Response Team at River North placed a **shock belt** on Kenneth.
- He reports being **tased four times** until he **lost consciousness**, then **tased again** after he woke up.
- That same day, he was **transferred to Red Onion**.

At Red Onion:

- Staff told him he was there for **"probable involvement in a murder"** while he was **completely naked**, an explicitly humiliating framing.
- He was placed in an intake cell that was:
  - **Smeared with feces and blood**,
  - Without a **mattress for two days**,
  - Without **soap, toilet paper, pen, paper, or sheets**.
- He spent a day and a half cleaning the cell himself and pushing to receive basic cleaning supplies and bedding.

This sequence—shock-belt tasing, immediate transfer, degrading intake conditions—is not accompanied by any documented disciplinary charge or hearing.

D. Indefinite Segregation With No Charge & Conflict of Interest

Kenneth is now held in **administrative segregation** at Red Onion:

- With **no written charge**,
- **No ICA review or hearing**,
- Labeled a **"threat to staff and inmates"**.

Critical conflict of interest:

- The officer killed at River North was **Jeremy Hall**.
- The **Major at Red Onion is Major Hall**, who Kenneth reports is **Jeremy Hall's first cousin**.
- Kenneth is being held in **the cousin's prison**, framed as connected to the killing.

Kenneth repeatedly states he believes he will be killed if he remains in the Western Region:

> "I feel like I'm on borrowed time… I'm a sitting duck… these people are going to kill me."

E. "Influence," Organizing, and Why He's Being Targeted

Kenneth reports that classification staff at Red Onion:

- Described him as a **"high-ranking Blood,"**
- Explicitly refused to place him in **C-building** (where many Bloods are housed) because "**he got influence**,"
- Told him: "We're not putting a whole in C building with all them Bloods, because he got influence. We got somewhere for him."

Instead, they placed him in a different pod, which he interprets as an attempt to **neutralize his organizing power**.

He has also:

- Publicly reported **collective punishment, blackout tactics, and chemical agent abuse** at River North,
- Spoken about **TB-testing falsification**,
- Named specific officers and patterns of retaliation tied to family advocacy (e.g., **Cameron X. Harper, Miss K's son**).

Taken together, the evidence suggests Kenneth is being targeted primarily for his **role as a witness and whistleblower**, not for any adjudicated act related to the Hall death.

III. Pattern of Torture-Like Practices at Red Onion & Western Region

The testimonies of Kenneth Evans and other prisoners, including **Eric Thompson**, describe a **consistent pattern** of harsh conditions and abusive practices at Red Onion and across the Western Region (Red Onion, Wallens Ridge, River North, Keen Mountain, Pocahontas).

A. Chemical Agents & "Suicide Watch" as Punishment

Kenneth describes a recurring pattern:

- Prisoners are:
  - Sprayed with **chemical agents (O2/OC)**,
  - **Stripped** and placed in thin smocks,
  - Put on "**suicide watch**" in **cold, bare cells**,
  - **Denied showers** to wash off chemicals,
  - Left to burn and scream for hours.

He names **Javon "Baby Jay" Aaronson**:

- "Orange" from the spray,
- **Naked on a mattress with no sheets**,
- Begging for a shower and relief from the burning.

He also describes a **Hispanic man** who:

- Refused to strip,
- Had his door cracked just enough for staff to **gas him repeatedly**,
- Was left struggling to breathe, while officers "get a thrill" out of doing this specifically to Hispanic prisoners.

This appears to be the use of **chemical agents and suicide watch as informal torture**, not as legitimate, clinical suicide prevention.

B. Degrading Strip Searches and Body-Cam Misuse

At Red Onion, Kenneth reports:

- Being required to submit to **routine strip searches** where officers order him to:
  - “Spread your butt cheeks, left side, right side, until we see a wink.”
- He calls this degrading, sexualized, and in violation of VADOC Operating Procedure 135.
- He reports that:
  - At least one officer attempted to **record strip searches on body-worn cameras**,
  - Other prisoners have been forced to strip on camera, transforming body cams into **tools of humiliation** rather than accountability.

C. Filthy Cells, Vent Contamination, and Hygiene Deprivation

Kenneth describes:

- His initial Red Onion cell **smeared with feces and blood** and lacking basic supplies.
- In his current pod, a neighbor’s **toilet intentionally filled with feces for over twenty days**, with the stench forced into his cell through the **vent system**.
- He receives only **minimal, low-quality soap and toothpaste**; staff tell his family he has hygiene and is “fine,” even while denying him meaningful hygiene.

These conditions pose clear risks to **health, safety, and dignity**, and are inconsistent with Virginia’s duties of humane care.

D. Neo-“Viking” Guard Clique and Orchestrated Set-Ups

Kenneth describes:

- A recurring **“Viking” or pagan-style tattoo** seen on multiple officers:
  - On the forearms of younger guards,
  - From elbow up on older officers.
- A distinctive handshake used among these officers.
- He refers to this as a **“secret society, a brotherhood.”**

He links officers with this clique, including a lieutenant named **McCoy**, to:

- **Weapon “plants”** – instances where a prisoner is taken through a scanner, then a weapon is “found” in his cell, and he is “jacked up” and sent to the hole.
- **Orchestrated prisoner-on-prisoner assaults**, including attempts to have prisoners stab one targeted man (Miss K’s son) in exchange for favors, followed by long-term segregation and threats of out-of-state transfers.

While the full meaning of the tattoos remains unknown, the pattern indicates an **organized guard subculture** with **coordinated retaliation and violence**, not isolated bad actors.

E. Eric Thompson’s Testimony: Collective Punishment & Retaliation

In a recorded call from Red Onion, prisoner **Eric Thompson** describes:

- Guards who “come here every day and try to make your life miserable,” constantly taking recreation, TVs, and tablets from entire units when **one inmate** is found with a knife.
- A **Western Region bloc**—“Red Onion, Wallens Ridge, Keen Mountain, Pocahontas, River North”—that he characterizes as a **“racist ass area”** where the prisons are “in cahoots.”
- Longstanding patterns where:
  - People are punished **collectively** for isolated incidents,
  - Staff threaten to move toward **23-and-1 lockdown**,
  - There is talk of obtaining **live rounds** for guns in the pods.
- Tablets with phone capability sit unused for months because **Major Hall** has decided JPay must “shake” them first—effectively denying people their property and communication.
- Since he began reporting conditions externally, his cell has been searched **five times in three weeks**, and Major Hall told him that’s what he “deserves” for being a “fucked-up inmate.”

Eric explicitly connects these practices to the killings of staff and deaths of prisoners, saying the combination of **constant harassment, collective punishment, and abuse** is exactly what produces explosive, lethal incidents.

IV. Deaths in Custody: Overdose, Abuse, and Lack of Transparency

Several deaths in and around these facilities have raised serious red flags for families and advocates.

A. Suspected Overdose Death at Red Onion – Likely Michael Hailey

Before any names were public, Eric Thompson reported that:

- A man at Red Onion **overdosed**,
- Was taken to **medical**,
- Was found **dead hours later**,
- And that staff had **failed to make rounds** and check on people in their cells.

Separately, a family member contacted UPROAR regarding **the death of Michael Hailey** at Red Onion:

- She reported that the family is **waiting on toxicology reports**,
- That state examiners “still don’t know why he died,”
- That he had told his brother about **mistreatment**, and that his brother has **letters documenting abuse**.

Based on the **timing, location, and description**, there is strong reason to believe that:

> The overdose death described by Eric Thompson is the same incident now known to be **the death of Michael Hailey**, though the state has not yet officially confirmed this link.

Either way, both the witness account and the family’s experience point to:

- A death in custody with **unexplained cause**,
- **Prior documented abuse**,
- And **insufficient transparency**.

B. Death of Bobby Nicholson Jr. (Red Onion)

Family members of **Bobby Nicholson Jr.** have also reported his death at Red Onion **after the killing of Officer Hall**. At the time of the FOIA call, advocates believed he might be the man who had died at Wallens Ridge; it is now clear there have been multiple deaths in the Western Region.

Families have not received clear, timely explanations about:

- The circumstances leading up to his death,
- Whether force or chemical agents were used,
- Whether staff followed required procedures for rounds, medical checks, and reporting.

C. Death of Aubrey McKay (Wallens Ridge)

Earlier in 2025, **Aubrey McKay** died at Wallens Ridge State Prison following:

- A sequence of **staff stabbings**,
- Heightened repression and lockdown,
- Reports of restraints and force that allegedly left his body with:
  - **Shackling-type injuries**,
  - A **fractured larynx**.

As with other deaths, his family has faced obstacles obtaining records and a clear, independent accounting of what happened.

D. Death in Custody Reporting Obligations

These deaths occur in a system that is already:

- Under strain from collective punishment and blackouts,
- Routinely using chemical agents and segregation in ways that may compromise health,
- Failing, according to prisoners, to make **regular rounds** in segregation and medical areas.

Under the **federal Death in Custody Reporting Act** and **Va. Code § 9.1-192.1**, Virginia has obligations to:

- Track and report deaths in custody,
- Provide meaningful information to appropriate authorities,
- Ensure that deaths trigger adequate review.

The experiences of these families—particularly the Hailey and Nicholson families—suggest that in practice, the **flow of information is restricted and inconsistent**, and that families must push aggressively simply to learn that their loved one has died and under what circumstances.

V. FOIA Stonewalling & Discretionary Secrecy

A recorded FOIA clarification call on **December 2, 2025** illustrates how VADOC's **information practices amplify harm and erode public trust**.

A. FOIA Officer's Initial Claim: "Not Releasable"

In response to a FOIA request about whether **Mr. Nicholson** had died in custody and for records such as:

- Facility of death,
- Cause of death,
- Next-of-kin notification,
- Use-of-force reports,
- Investigative status,

VADOC FOIA Officer **Anne-Cabrie Forsythe** stated that:

- "The majority of this information is not going to be releasable through FOIA,"
- Because, if he was deceased, it would be part of his **"record of incarceration."**

This framing strongly implied that **the law itself prohibited release**.

B. Admission: The Exemption Is Discretionary

When the requester pointed out that the "record of incarceration" provision is **discretionary**—i.e., it allows the agency to withhold, but does not require it—the FOIA Officer conceded the point:

- **"We would take advantage of the exemption clause, not that we must… the code uses the word discretion."**
- **"We can… it's up to our discretion whether or not we're going to take the exemption."**
- **"We can choose whether or not we're going to exercise our discretion."**

The requester noted that:

- The FOIA office had initially said they **"can't"** release the information,
- When in fact they are **choosing not to** release it—even where deaths, abuse, and public safety are at stake.

The FOIA Officer did not dispute this; she simply maintained that they would "most likely" give only a **page count** and exercise their discretion to withhold.

C. Implications for Oversight & Reform

This call shows that:

- VADOC is **not legally required** to keep these records secret;
- It is making an **affirmative policy choice** to withhold information about deaths and use of force;
- Families, advocates, and legislators **cannot rely on voluntary transparency** from FOIA or Communications when trying to understand patterns of staff violence and deaths.

Meaningful oversight will require:

- **Narrowing or clarifying the "record of incarceration" exemption**,
- Creating **mandatory disclosure requirements** for key categories of death- and abuse-related information,
- Ensuring that records related to deaths and serious use of force are **subject to independent custody and review**, not solely controlled by VADOC.

VI. Greensville: Deaths, FOIA "Discretion," and a Systemwide Pattern

The problems documented at River North, Red Onion, and Wallens Ridge are **not confined to the Western Region**. Recent reporting from Greensville Correctional Center shows the **same combination of unexplained deaths, family stonewalling, and FOIA "discretion"** at work elsewhere in VADOC.

A. Christopher Armentrout – Death at Greensville & 256 Pages Withheld

On October 13, 2025, WRIC reported on the death of **40-year-old Christopher Armentrout**, who died unexpectedly at **Greensville Correctional Center** on September 14, 2025. His family was called around 5:30 a.m. and told only that he had been **found dead in his cell at 4:18 a.m.**; staff could not explain whether he had suffered a medical event, been assaulted, or any other circumstances surrounding his death. Facebook

Key points from the family's account and public reporting:

- Christopher was halfway through a 15-year sentence and had a projected release date; his family fully expected him to come home alive.
- The initial notification call provided **no cause or context**, and when his stepmother was told to call back to speak to the warden, he **was not available** and did not speak with her for more than 24 hours.
- Christopher had written about his experience in what VADOC calls **"restorative housing" (solitary confinement)**, describing:
  - Guards **beating prisoners**, and
  - Handcuffs applied so tightly that his **hands turned blue**.

In response, Christopher's stepmother filed a **FOIA request** for:

- Mental-health records,
- A log of which officers were on duty the morning he died,
- Video surveillance and related records.

VADOC responded that there were **256 pages** responsive to her request but that the Department was **"exercising its discretion"** and would not release any of them. She publicly asked, "What are you covering up? What are you hiding behind?"—underscoring that the problem is **not lack of records**, but **affirmative, discretionary secrecy**.

Public data cited in the same report show that **Greensville had 23 of the 97 VADOC deaths in 2024**—nearly a quarter of the system's total. Yet families like the Armentrouts are told almost nothing about how their loved ones died.

B. Michael Dove – Mental Health Neglect and a Death with No Answers

In May 2025, WRIC reported on the death of **38-year-old Michael Dove**, who died at **Greensville Correctional Center** at 3:49 a.m. on April 4, 2025. His mother, **Rhonda Dove**, described a son struggling with addiction and mental-health issues who was supposed to be released in 2028. Facebook

Her account reveals several systemic issues:

- Michael told his mother the day before his death that he had **asked for mental-health help** and had been told he would have to **wait until Monday**. He never lived to see that Monday.
- After his death, staff told Rhonda that they could not share information because, allegedly, **"he wasn't in their custody anymore"**—a claim for which 8News could find **no supporting Virginia law**.
- Rhonda reports that Michael:
  - Did not receive his **personal property** after a transfer,
  - Had **thyroid issues** that made eating difficult without proper medication,
  - Repeatedly requested his medications and was told only to "be patient,"
  - **Attempted suicide in February** by hanging and was moved to another block with a new counselor, which she believes deepened his crisis.
- Since his death, Rhonda has:
  - Called VADOC repeatedly,
  - Been **hung up on multiple times**, and
  - Received only the standard statement that the case is "under active investigation" and no further information can be shared.

Dove's death certificate lists his time of death, but the family remains in the dark about the **conditions leading up to it**, including whether:

- He was properly monitored after a prior suicide attempt,
- He had access to required medical and mental-health care,
- Required rounds and checks were conducted in the hours before he died.

C. FOIA "Discretion" as a Systemwide Policy Choice

The Greensville cases mirror the **FOIA behavior** we document earlier in this report:

- In **Christopher Armentrout's case**, VADOC explicitly told his stepmother that it had hundreds of pages of responsive records but was "**exercising its discretion**" not to release any of them.
- In the **December 2, 2025 FOIA call** about another death, VADOC's FOIA officer first said the information was **"not releasable under FOIA,"** then admitted that the relevant "record of incarceration" exemption is **discretionary** and the Department is simply **choosing to withhold**.

The language—*"exercising its discretion"*—is the same in both contexts. Combined, these incidents demonstrate that:

1. **VADOC has the legal ability to release records related to deaths and serious abuse**;
2. It is nonetheless **choosing secrecy** as a default response;
3. Families across multiple facilities (Greensville, Red Onion, Wallens Ridge) experience **delay, non-answers, and opaque invocations of "investigation" or "state law"** when they seek the truth.

D. Evidence of a Department-Wide Pattern

When we zoom out, the pattern is clear:

- At **Red Onion / Western Region**, families and prisoners report:
  - Beatings, chemical torture, suicide-watch abuse, sexualized strip searches, retaliatory segregation, and deaths with little information;
  - A FOIA officer stating on tape that VADOC can “choose whether or not we’re going to exercise our discretion” to withhold records.
- At **Greensville**, families of **Christopher Armentrout** and **Michael Dove** report:
  - Sudden deaths with **no meaningful explanation**,
  - Notification calls that provide **almost no detail**,
  - Misstatements about “state law” preventing communication,
  - FOIA responses that acknowledge hundreds of pages of records but refuse to release any of them, again citing **“discretion.”**

These are **not isolated errors** by a single facility or officer. They indicate a **systemwide practice** in which:

- Deaths in custody and serious abuses are **common**,
- Families are routinely kept **in the dark**,
- FOIA is used as a **shield** rather than a transparency tool, and
- The phrase “exercising its discretion” is deployed to **avoid accountability**.

Any serious reform effort must therefore address VADOC’s **information practices** and FOIA exemptions alongside conditions of confinement, use of force, and mental-health care.

VII. Legal & Policy Framework Implicated

The patterns documented here implicate a range of legal and policy standards, including:

A. Virginia Statutes

- **Virginia Code § 53.1-32**
  Requires the Department to provide for the **safekeeping, health, and humane treatment** of people in its custody.
- **Virginia Code § 53.1-39**
  Prohibits **cruel or unusual punishment** and any **corporal punishment not authorized by law or rules**; forbids punishment beyond what is necessary to maintain discipline.
- **Virginia Code § 9.1-192.1**
  Addresses **death-in-custody reporting**, reflecting an expectation of transparency and accountability when people die under state control.

B. VADOC Operating Procedures

- **OP 861.1 – Offender Discipline**
  Requires **individualized, adjudicated, time-limited sanctions**; does not authorize blanket punishments or long-term segregation of entire pods for one person's conduct.
- **Use-of-Force and Restrictive Housing Procedures**
  Limit force to what is **necessary and proportionate**, and require:
  - Documentation of force,
  - Medical and mental-health checks after serious incidents,
  - Specific criteria and reviews for **restrictive housing** and **"Level S"** status.
- **Strip Search and Body-Cavity Search Policies (e.g., OP 135)**
  Regulate when strip searches may occur and prohibit **abusive, sexualized practices** or unnecessary humiliation, particularly on camera.

C. Constitutional Law

- **Eighth Amendment (via the Fourteenth Amendment to the states)**
  Prohibits:
  - **Excessive force** against restrained or compliant prisoners,
  - Conditions of confinement that pose a **substantial risk of serious harm**,
  - **Deliberate indifference** to serious medical needs.
- **Fourteenth Amendment (Procedural Due Process)**
  Requires **notice and a hearing** for serious disciplinary actions; indefinite segregation with no charge, no hearing, and no defined end point raises serious due process concerns.

D. International Standards

- **UN Standard Minimum Rules for the Treatment of Prisoners (Nelson Mandela Rules)**
  Particularly:
  - **Rules 1 & 11** – Respect for inherent dignity and non-discrimination,
  - **Rules 24–27** – Equivalence of healthcare, clinical independence, and prompt access to treatment,
  - **Rules 43–45** – Prohibitions on **collective punishment**, strict limits on **solitary confinement**, and bans on **prolonged or indefinite solitary**.
- **UN Convention Against Torture (UNCAT)**
  Obligates states to **prevent, investigate, and punish torture and cruel, inhuman, or degrading treatment** in places of detention, including:
  - Beatings of prisoners who are already under control,
  - Deliberate denial of basic hygiene and medical care,
  - Use of chemical agents and "suicide watch" as punishment,
  - Sexualized strip-search practices and humiliation.

VIII. HB611, the 2024 Deaths in Custody Report (RD402), and VADOC's Information Monopoly

The cases in this report show, from the ground up, how families and witnesses are shut out of information when someone is abused or dies in custody. The **2024 Civilian Deaths in Custody**

report (RD402) shows the same problem from the top down.

A. HB611's Goal vs. What Actually Happened

In 2024, the General Assembly passed **HB611** to bring transparency to deaths in law-enforcement and correctional custody. The law tasked the **Department of Criminal Justice Services (DCJS)** with collecting data and issuing recommendations to reduce preventable deaths.

When **RD402** was published in July 2025, it reported that:

- There were **97 deaths in VADOC state adult correctional facilities in 2024**, and
- The HB611 recommendations group **"was not able to review cases from state adult correctional facilities, as this data was not approved to be shared."**

The working group went on to say that the available information was **not sufficient** to make meaningful recommendations to reduce deaths.

In practice, this means:

- HB611 created a *framework* for oversight,
- But VADOC could still **block access to prison death files by "not approving" data sharing**,
- Leaving the core of the prison system effectively **outside the law's reach**.

B. The Same Pattern We See in Individual Cases

What RD402 describes at the systems level matches what families and advocates experience in individual cases:

- In **Christopher Armentrout's** case at Greensville, VADOC told his stepmother there were **256 pages of responsive records** but that the Department was **"exercising its discretion"** and would not release any of them.
- In the December 2, 2025 FOIA clarification call about **Bobby Nicholson Jr.**, VADOC's FOIA officer:
  - First said that the requested information was "not releasable under FOIA,"
  - Then explicitly admitted that the key "record of incarceration" exemption is **discretionary**, and that the Department **chooses** not to release these records.
- Families of **Hailey, Nicholson, McKay, Armentrout, Dove** and others all report:
  - Minimal or misleading early notification,
  - No clear timeline or account of what happened,
  - FOIA denials couched in vague references to "state law" or "active investigation."

RD402 confirms that this is not just bad practice at a handful of prisons. It is a **system-wide information monopoly**: the same agency whose actions are in question controls what anyone else can know about those actions.

C. Why This Matters for the General Assembly

For members of the General Assembly and oversight bodies, the implications are serious:

- A law you passed—**HB611**—could not function as intended for prisons because **VADOC declined to share the underlying case files**.
- The same discretionary secrecy is being used against **families, journalists, advocates, DCJS, OSIG, and the legislature itself**.
- As long as VADOC can unilaterally decide which death records are "approved to be shared," **you cannot reliably prevent future deaths** or evaluate whether current policies protect either prisoners or staff.

The detailed cases in this report (River North, Red Onion, Wallens Ridge, Greensville) show what it looks like on the ground when that information monopoly is exercised. RD402 shows that **the structural problem is already on the record**: an oversight framework that depends on VADOC's consent to obtain evidence.

The Recommendations that follow build on this reality: they are not only about changing prison practices, but also about **breaking the information choke point** that has kept legislators, families, and the public in the dark.

IX. Recommendations

The testimonies and cases in this report, together with the systemic failure documented in **RD402**, point to two intertwined problems:

1. **Immediate, concrete danger** to people currently held in and working at River North, Red Onion, Wallens Ridge, and related facilities; and
2. A **structural information monopoly** that allows VADOC to block scrutiny of deaths and serious abuses—even under HB611.

To respond meaningfully, the General Assembly and oversight bodies need to act on both levels at once.

1. Immediate Protection and Independent Investigation

a. Protect named witnesses and whistleblowers

Drawing on the cases summarized above (Sections II–IV), we urge the General Assembly and relevant agencies to:

- Ensure that **Kenneth "Punch" Evans (#1446064)** is:
  - Removed from the direct control of staff with clear conflicts of interest (including family of the slain officer and staff named in use-of-force or retaliation allegations);
  - Either released from indefinite segregation or provided with written notice, a timely hearing, and meaningful review of any alleged infraction;
  - Guaranteed safe access to phone, kiosk, mail, medical/mental-health care, legal counsel, and contact with OSIG and legislators.
- Extend similar protections to other **named witnesses and whistleblowers** in this report (including Eric Thompson, Javon "Baby Jay" Aaronson, Javaris Williams, the son of "Miss K," and others), making it explicit in writing that:
  - Their testimony is **protected speech**, and
  - Any retaliation will itself be treated as a matter for oversight and potential sanction.

b. Independent investigation of key incidents

We recommend that **OSIG, DCJS, and, where appropriate, the U.S. Department of Justice Civil Rights Division** be asked to open or deepen investigations into:

- The hallway beating and subsequent treatment of **John Holomon Russell** after the killing of Officer Jeremy Hall;
- The **shock-belt tasing, transfer, intake conditions, and segregation** of Kenneth Evans;
- Deaths in custody highlighted in this report (including the probable overdose at Red Onion and deaths at Red Onion / Wallens Ridge that families are still seeking answers about);
- The use of **chemical agents, suicide watch, strip searches, and engineered assaults** as described in Sections III–IV.

Investigators should be granted access to:

- All relevant video (tier, hallway, intake, transport, and any body-worn cameras),
- Use-of-force and restraint documentation,
- Housing/segregation and rounds logs,
- Medical and mental-health records,
- Grievances and emergency grievances,
- Incident and classification records.

2. Direct Engagement With Families and Community Witnesses

Given VADOC's control over written records, **family testimony and lived experience are themselves critical evidence** about how the system functions.

We urge members of the **Senate Rehabilitation & Social Services Committee**, **House Public Safety Committee**, and other relevant committees to:

- Hold structured **listening sessions** with families of the people whose deaths are discussed in this report (e.g., Michael Hailey, Bobby Nicholson Jr., Aubrey McKay, and others), as well as families from Greensville and other facilities experiencing similar barriers.
- In those meetings, specifically document:
  - Notification timelines and what was initially said;
  - Any contradictions between VADOC statements and medical examiner findings;
  - FOIA responses, including where "record of incarceration" and "discretion" were invoked;
  - The practical and emotional impact of prolonged secrecy.

These sessions should produce **written summaries and clear follow-up items**, not just expressions of sympathy. They should be framed explicitly as part of a broader effort to understand **how VADOC's information monopoly operates in practice.**

Committees should also:

- Invite **currently and formerly incarcerated people** from River North, Red Onion, Wallens Ridge, Greensville, and similar units to submit written testimony or appear by remote video, focusing on:
  - Collective punishment and lockdowns,
  - Use of chemical agents and suicide watch,
  - Sexualized strip searches and camera practices,
  - Retaliation for grievances, media contact, or collaboration with outside advocates.

3. Public Hearings on Collective Punishment, Force, and "Suicide Watch"

We recommend public hearings focused on **patterns**, not isolated incidents, with particular attention to:

- **Collective punishment and prolonged lockdowns** as normal operating tools;
- Use and misuse of **chemical agents, tasers, shock belts, and restraints**;
- The practice of "suicide watch" as described in this report—cold, bare cells, extended exposure to chemical agents, and humiliation—versus any clinical standards for suicide prevention;
- **Strip-search practices**, including sexualized commands and the use of cameras;
- Retaliation against prisoners and families who speak up;
- Discrepancies between **VADOC narratives** and **medical examiner findings** in death cases.

Witnesses should include:

- VADOC leadership and regional/warden-level staff,
- OSIG and DCJS,
- Medical and mental-health professionals,
- Families and community advocates,
- Currently/formerly incarcerated witnesses.

These hearings should be designed to produce **specific commitments**—for example, timelines for releasing certain categories of records, revising policies, and re-training staff—rather than general assurances.

4. Confronting the Information Monopoly and HB611's Practical Failure

Building on Section VIII (HB611 / RD402), we urge the General Assembly to use its existing authority to test and challenge VADOC's information monopoly **even before any new statute is drafted**, by:

- Formally requesting **complete case files** for a representative sample of deaths in custody (including those discussed in this report and a subset of the 97 deaths identified in RD402), and requiring:
    - That any refusal or heavy redaction be accompanied by a **written justification** citing specific legal authority and explaining why less restrictive release is impossible.
- Requesting formal **briefings from DCJS and OSIG** on:
    - How often they have been denied access to VADOC records,
    - How that denial affected HB611 implementation and RD402,
    - What legal and structural changes they believe are needed to ensure access to prison-death files.

These steps will:

- Generate a clear public record of where the current framework breaks down;
- Provide a factual basis for future **Deaths in Custody transparency legislation** if the General Assembly chooses to go that route;
- Signal to VADOC that blanket secrecy around deaths and serious abuse is no longer acceptable as a matter of policy.

5. Ongoing Collaboration and Oversight

UPROAR and the families we work with are prepared to:

- Provide **transcripts, affidavits, and supporting documentation** related to the cases described here;
- Facilitate contact between legislators/oversight staff and families and witnesses;
- Assist in designing hearings, document requests, and potential reforms that address the **underlying structures** (collective punishment, retaliation, information control), not just individual incidents.

We encourage the General Assembly to view this not as a one-off crisis but as an area for **ongoing oversight**, with regular progress check-ins and public reporting.

X. Conclusion

This report began with specific names and stories:

- A corrections officer, **Jeremy Hall**, killed in a facility that people inside had already described as a “pressure cooker” of collective punishment and daily abuse;
- A prisoner, **John Holomon Russell**, accused in that killing and reportedly beaten “to a pulp” afterward;
- A material witness and whistleblower, **Kenneth “Punch” Evans**, subjected to shock-belt tasing, degrading intake conditions, and open-ended segregation in a prison where the slain officer’s cousin holds power;
- Multiple deaths in custody in the same regional system, where families still struggle to learn basic facts about what happened to their loved ones;
- A culture in which chemical agents, suicide watch, strip searches, and engineered cell assignments are described by those inside in terms that closely mirror torture and retaliation.

As the report moved outward, it showed that these are **not isolated Western Region anomalies**. FOIA practices at Greensville, the testimonies of families like those of **Christopher Armentrout** and **Michael Dove**, and the behavior of VADOC's own FOIA office point to a **system-wide pattern of discretionary secrecy.** RD402, the first statewide Deaths in Custody report under HB611, confirms that:

> Even when the General Assembly creates a framework for oversight, **VADOC can effectively nullify it** by refusing to share prison death files.

The result is a closed loop:

- **Harsh, retaliatory conditions** inside prisons,
- **Deaths and serious abuses** that emerge from those conditions,
- **Families and communities shut out** of information,
- **Oversight bodies denied access** to the records they need,
- And a Department that can publicly invoke "investigations" and "state law" while keeping the evidence to itself.

This loop endangers:

- **Incarcerated people**, whose lives and health depend on standards of humane treatment that are routinely violated;
- **Corrections staff**, who are asked to work in environments where unresolved grievances, despair, and abuse amplify the risk of explosive violence;
- **The legitimacy of the Commonwealth itself**, when laws like HB611 exist on paper but cannot function in practice.

The testimonies collected here—from Kenneth Evans, Eric Thompson, other incarcerated witnesses, and bereaved families—should be treated as **evidence**. They are not the final word, but they are a clear warning that:

- The combination of **collective punishment, retaliation, and secrecy** is producing predictable, preventable harms; and
- Without structural change, both incarcerated people and staff will continue to pay the price.

UPROAR offers this report as:

- A **warning** about what is already happening,
- A **map** of concrete steps the General Assembly and oversight bodies can take now, and
- An **invitation** to work in genuine partnership with families, currently and formerly incarcerated people, and community organizations to build something better.

We ask that you respond not only with sympathy but with **action**: protecting named witnesses, meeting directly with families, opening up the records, and using the tools already available to you to confront VADOC's information monopoly and the conditions it conceals.

For follow-up contact:

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