COMMONWEALTH OF VIRGINIA
Office of the State Inspector General

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[redacted]

Dear [redacted],

The Office of the State Inspector General (OSIG) conducted an investigation based on complaints made to the Inmate Line, Case #OMB-2025-014. The complaints alleged inmates experienced racism, rights violations, medical and mental health neglect, retaliation, solitary confinement, inhumane conditions, and physical/sexual abuse by correctional officers leading to inmates burning themselves at Red Onion State Prison (ROSP).

The scope of the review was limited to relevant circumstances as specified in the complaints. Therefore, this inquiry was limited to interviews, video footage, policy, and documentation review. The period covered during this review was January 1, 2024, to June 1, 2025.

Background

ROSP is a maximum security prison housing an average of 840 inmates in level S (Step-down, which is the highest level of classification), 6, 5, and Cadre. The investigation focused on [redacted] inmates who burned themselves between January 1, 2024, and June 1, 2025. The [redacted] inmates were serving sentences ranging from two to fifty-five years for various crimes.

OSIG conducted interviews with [redacted]; [redacted] was not interviewed because [redacted] was released after serving [redacted] sentence, and is now [redacted]

Allegation 1

The complaints alleged that multiple inmates were subjected to racism and/or rights violations by correctional officers, leading inmates to burn themselves.

Findings of Fact

OSIG conducted interviews with [redacted] between January 1, 2024, and June 1, 2025. [redacted] did not report experiencing racism or violations of their rights. [redacted] reported that the environment at ROSP was racist, oppressive, harassing, and/or discriminatory. [redacted] reported that being subjected to racism was a factor that led them to [redacted]. None of [redacted] attributed a violation of rights as a contributing factor.

OSIG reviewed 533 written complaints and formal grievances submitted by [redacted] between January 1, 2024, and June 1, 2025, four of which related to allegations of racism and/or rights violations. [redacted] submitted a written complaint regarding racism and [redacted] submitted three written complaints regarding rights violations prior to burning themselves. All four written complaints were responded to by the facility; none were elevated to the formal grievance level by the inmates.

OSIG reviewed 77 Incident Reports involving [redacted] along with body-worn camera and MaxPro camera footage. The footage did not show evidence of Virginia Department of Corrections (VADOC) staff engaging in racist conduct or violating inmates' rights.

OSIG conducted interviews with 23 VADOC staff members to include [redacted], [redacted], and [redacted]. Staff consistently refuted allegations that inmates were subjected to racist conduct or that inmates' rights were violated by corrections officers.

Conclusion

Based upon the investigation conducted, OSIG finds the allegation that multiple inmates were subjected to racism and/or violations of rights is **inconclusive**.

Allegation 2

The complaints alleged that multiple inmates were subjected to retaliation by corrections officers for reporting concerns, leading inmates to burn themselves.

Findings of Fact

OSIG conducted interviews with [redacted] between January 1, 2024, and June 1, 2025. [redacted] reported that being subjected to staff retaliation was a contributing factor in [redacted]. [redacted] reported experiencing retaliation from staff, but did not indicate it was a contributing factor in [redacted] and did not provide specific instances of staff retaliation. The other [redacted] did not report being subjected to staff retaliation.

OSIG reviewed 533 written complaints and formal grievances submitted by [redacted] between January 1, 2024, and June 1, 2025, two of which related to allegations of staff retaliation. [redacted] submitted two written complaints regarding staff retaliation prior to [redacted]. Both written complaints were responded to by the facility; neither complaint was elevated to the formal grievance level by the inmates.

OSIG reviewed 77 Incident Reports involving [redacted] along with body-worn camera and MaxPro camera footage. The footage did not show evidence of VADOC staff engaging in reported claims of retaliation.

OSIG conducted individual interviews with 23 VADOC staff members to include the [redacted] and [redacted]. Staff consistently refuted allegations of any retaliatory actions towards inmates by staff. Staff explained that inmates who refused to comply with standard search procedures were not permitted to leave their cells for safety reasons, which could impact access to showers, phones, kiosks, recreation, and other scheduled activities.

Conclusion

Based upon the investigation conducted, OSIG finds the allegation that multiple inmates were subjected to retaliation for reporting concerns is **inconclusive**.

Allegation 3

The complaints alleged multiple inmates were subjected to medical and mental health neglect, leading inmates to burn themselves.

Findings of Fact

OSIG conducted interviews with [redacted] between January 1, 2024, and June 1, 2025. [redacted] reported that medical neglect was a contributing factor in [redacted]. [redacted] reported that mental health neglect was a contributing factor in [redacted].

OSIG reviewed 533 written complaints and formal grievances submitted by [redacted] between January 1, 2024, and June 1, 2025, related to allegations of medical and mental health neglect. [redacted] had submitted 10 written complaints about medical neglect and [redacted] had submitted four written complaints about mental health neglect prior to [redacted]. All 14 written complaints were responded to by the facility; none were elevated to the formal grievance level by the inmates.

OSIG reviewed 77 Incident Reports involving [redacted] along with body-worn camera and MaxPro camera footage. The footage showed evidence that inmates received medical assessments after each use-of-force incident.

OSIG conducted individual interviews with 23 VADOC staff members to include [redacted] and [redacted]. Staff consistently refuted allegations that medical or mental health care was denied to inmates. Staff explained that inmates who refused to comply with standard search procedures were not permitted to leave their cells for safety reasons, which could impact an inmate's medical or mental health appointments.

Staff explained that an inmate can submit a sick call request, an emergency grievance, or a facility request form to get either medical or mental health treatment. OSIG reviewed sick call requests, emergency grievances, facility request forms, and medical and psychiatric progress notes and did not find evidence of medical or mental health neglect.

Conclusion

Based upon the investigation conducted, OSIG finds the allegation that multiple inmates were subjected to medical or mental health neglect is **unsubstantiated**.

Allegation 4

The complaints alleged food was infested with maggots or inmates did not receive food for a day, leading inmates to burn themselves.

Findings of Fact

OSIG conducted interviews with [redacted] between January 1, 2024, and June 1, 2025. [redacted] reported that not receiving food for a day was a contributing factor in [redacted]. [redacted] reported food was infested with maggots.

OSIG reviewed 533 written complaints and formal grievances submitted by [redacted] between January 1, 2024, and June 1, 2025. None were related to allegations of food being infested with maggots or inmates not receiving food for a day prior to [redacted].

OSIG reviewed 77 Incident Reports involving [redacted] along with body-worn camera and MaxPro camera footage. The footage did not show inmates complaining about food being infested with maggots or not being fed for a day.

OSIG conducted individual interviews with 23 VADOC staff members to include the [redacted] and [redacted]. Staff consistently refuted allegations that food was infested with maggots or that inmates were denied food for a day. Staff indicated that on a rare occasion an inmate may find a hair or bug in the food. They reported that if there is an issue with a tray, such as the tray missing an item or the wrong type of tray, the staff would request a new tray from the kitchen.

OSIG also conducted several walk-throughs of the food service area, noting that the facility and food was clean and appropriate.

Conclusion

Based upon the investigation conducted, OSIG finds the allegation that multiple inmates were provided food infested with maggots or were not provided food for a day is **unsubstantiated**.

Allegation 5

The complaints alleged multiple inmates are subjected to extreme extended weeks in solitary confinement, leading inmates to burn themselves.

Findings of Fact

OSIG conducted interviews with [redacted] between January 1, 2024, and June 1, 2025. [redacted] reported that they were in solitary confinement. [redacted] reported that the facility still implements solitary confinement, but they call it the Level S program.

OSIG reviewed 533 written complaints and formal grievances submitted by [redacted] between January 1, 2024, and June 1, 2025. None were related to allegations of being subjected to extreme extended weeks in solitary confinement. [redacted] filed two written complaints about their assignment to long-term segregation prior to [redacted]. Both written complaints were responded to by the facility; neither were elevated to the formal grievance level by the inmates.

OSIG conducted individual interviews with 23 VADOC staff members to include [redacted] and [redacted]. Staff reported that some inmates chose not to participate in out-of-cell activities and others refused to participate in search

procedures. Reportedly, it is a safety concern when an inmate refuses to participate in search procedures and inmates are not allowed to leave their cell until they participate in search procedures.

Note: In 2011, VADOC phased out solitary confinement and introduced the Step-Down Program to reduce long-term restrictive housing. After the 2020 implementation of a minimum of four hours of out-of-cell time, the definition of "Restrictive Housing" was removed and VADOC now uses the term "Restorative Housing."

Conclusion

Based upon the investigation conducted, OSIG finds the allegation that multiple inmates were subjected to extreme extended weeks in solitary confinement is **unsubstantiated**.

Allegation 6

The complaint alleged multiple inmates are subjected to inhumane conditions at the facility, leading inmates to burn themselves.

Findings of Fact

OSIG conducted interviews with [redacted] between January 1, 2024, and June 1, 2025. [redacted] reported they were subjected to inhumane conditions at the facility which contributed to [redacted]. [redacted] reported that they were subjected to inhumane conditions but did not indicate it was a contributing factor in [redacted]

OSIG reviewed 533 written complaints and formal grievances submitted by [redacted] between January 1, 2024, and June 1, 2025, with some allegations related to inhumane conditions. [redacted] submitted 11 written complaints alleging inhumane conditions at the facility prior to [redacted]. All 11 written complaints were responded to by the facility; none were elevated to the formal grievance level by the inmates.

OSIG reviewed 77 Incident Reports involving [redacted] along with body-worn camera and MaxPro camera footage. The footage did not show evidence of inhumane conditions at the facility.

OSIG staff made one unannounced and two announced visits to the facility and did not observe any conditions that would be considered inhumane as defined by the United Nations Standard Minimum Rules for the Treatment of Prisoners or the ACA Performance Standards on Environmental Conditions, Sanitation and Hygiene, Offender Treatment, and Safety.

OSIG conducted individual interviews with 23 VADOC staff members to include [redacted] and [redacted]. Staff consistently refuted allegations that inmates were subjected to inhumane conditions at the facility.

Conclusion

Based upon the investigation conducted, OSIG finds the allegation that multiple inmates were subjected to inhumane conditions at the facility is **unsubstantiated**.

Allegation 7

The complaint alleged multiple inmates were subjected to physical and/or sexual abuse by corrections officers, leading inmates to burn themselves.

Findings of Fact

OSIG conducted interviews with [redacted] between January 1, 2024, and June 1, 2025. [redacted] reported that sexual harassment by a corrections officer was a contributing factor which led to [redacted]. [redacted] reported physical abuse was a contributing factor that led to [redacted].

OSIG reviewed 533 written complaints and formal grievances submitted [redacted] between January 1, 2024, and June 1, 2025, related to allegations of physical and/or sexual abuse by corrections officers. [redacted] submitted a written complaint about sexual harassment prior to [redacted] That complaint was responded to by the facility and was not elevated to the formal grievance level by the inmate. Additionally, [redacted] submitted eight written complaints regarding physical abuse by corrections officers prior to [redacted]. All eight written complaints were responded to by the facility and four were elevated to the formal grievance level by the inmate. All four formal grievances were responded to by the facility and the responses for all four were submitted for a Level I appeal by the inmate. The Level I appeals confirmed the formal grievance findings. The inmate initiated an appeal to Level II on all four formal grievances. Level II appeals upheld the findings of the Level I appeal in all four formal complaints.

OSIG found no evidence of noncompliance with VADOC's Grievance Process Operating Procedure (OP) 866.1. In accordance with the procedure, the administrative remedies process must be completed within a maximum of 180 days. OSIG determined that complaints and grievances submitted by [redacted] concerning allegations of physical and/or sexual abuse were appropriately addressed, and in each case, the inmate was notified upon the conclusion of the administrative remedies process.

OSIG reviewed 77 Incident Reports involving [redacted] along with body-worn camera and MaxPro camera footage. The majority of footage did not show evidence of physical and/or sexual abuse of inmates; [redacted]

OSIG conducted individual interviews with 23 VADOC staff members to include [redacted] and [redacted] Staff consistently refuted allegations that inmates were physically and/or sexually abused by corrections officers.

Conclusion

Based upon the investigation conducted, OSIG finds the allegation that multiple inmates were physically and/or sexually abused by corrections officers is **unsubstantiated**.

Additional Information

During the [redacted] interviews, inmates identified other contributing factors which led to [redacted]. Those factors included: unsanitary conditions of the facility, prolonged lockdowns, corrections officers lacking professionalism, poor treatment of inmates, corrections officer's failure to fulfill their basic job responsibilities, poor staffing levels, inability to access meaningful mental health programming, inconsistent access to phones, and concerns with the grievance process. Additionally, [redacted] indicated that they had experienced a death of a family member [redacted] which placed additional emotional stress on them prior to [redacted].

During the staff interviews, some staff expressed beliefs that the inmates [redacted] in an attempt to be transferred to another facility to be closer to family or to be taken to a medical facility in Richmond. Staff believed the inmates were under the misguided impression that if they were admitted to an outside medical facility, they would be able to have unlimited family visits, access to narcotics, and sexual intercourse.

During the investigation it was discovered that one of the events involving an inmate [redacted] was only documented via Internal Incident Report (IIR) and not documented as an Incident Report (IR) as required by department policy.

Recommendations

(1) Inmates are informed about procedures to access health services and procedures for submitting grievances at the time of admission/intake verbally and in writing; however, inmates could potentially improve self-advocacy skills and increase educational levels if a course in this topic area was offered or accessible for rehabilitation purposes on a regular schedule. Additionally, to facilitate a more efficient grievance process, VADOC

should consider making written complaints and grievance forms accessible through the JP6 player.

(2) It is recommended that the facility consistently enter events that involve the health of an inmate as an Incident Report as outlined in agency policy.

OSIG appreciates the assistance provided by the Virginia Department of Corrections, and specifically, Red Onion State Prison staff, during this investigation. Please provide a written response to OSIG within 30 days of the date of this report regarding the recommendations made in this report.

Please contact me with any questions at 804-625-3255 or michael.westfall@osig.virginia.gov.

Sincerely,

Michael C. Westfall, CPA
State Inspector General

cc: [redacted]

This report is to remain confidential. Any requests for distribution should be referred to OSIG.