2025 CONDITIONS OF CONFINEMENT REPORT

CONNECTICUT OFFICE OF CORRECTION OMBUDSMAN

Executive Summary

This Annual Conditions of Confinement Report is submitted to the Connecticut General Assembly pursuant to Conn. Gen. Stat. § 18-81qq and Public Act 25-161. It covers the period from September 1, 2024 through December 31, 2025 and represents the first annual conditions of confinement report issued since the Office of the Correction Ombuds ("OCO") was re-established in September 2024.

During this inaugural reporting period, the OCO operated with only one staff member—the Correction Ombuds. The Office lacked investigators, analysts, administrative staff, and, critically, a Health Care Consultant for most of the period. These limitations constrained the number and depth of investigations that could be conducted simultaneously. Nevertheless, the OCO exercised its full statutory authority to investigate both systemic conditions and discrete incidents where the severity of alleged harm, the vulnerability of affected individuals, or the nature of the allegations warranted focused inquiry. Accordingly, the findings in this report should be understood as conservative rather than exhaustive. That the conditions described herein emerged so consistently, across so many facilities, despite limited oversight capacity, underscores the seriousness and pervasiveness of the issues confronting Connecticut's correctional system.

Based on complaints received by the OCO, site visits and tours of Department of Correction (DOC) facilities, review of records and correspondence, and sustained engagement with wardens, facility staff, and central office leadership, this report documents a correctional system experiencing persistent, systemwide breakdowns in the delivery of legally required services. Across nearly every core domain evaluated—staffing and operations; medical and mental health care; sanitation, hygiene, and environmental conditions; food services; legal access; communication and visitation; and institutional safety—the OCO identified recurring failures that materially affect conditions of confinement. These are not isolated lapses or temporary disruptions. They are structural deficiencies, embedded in daily operations. In many respects, DOC appears to be failing to fulfill its statutory mandates.

Throughout the reporting period, DOC relied heavily on modified and full facility lockdowns as a routine operational response to staffing shortages rather than as limited measures reserved for genuine emergencies. Lockdowns repeatedly resulted in the suspension of visitation, recreation, educational and therapeutic programming, religious services, access to showers and hygiene, medical movement and sick call, and access to law libraries and communication services. The OCO received numerous complaints—and confirmed through site visits—that individuals were confined to their cells for days at a time, missed medical appointments, were denied showers for multiple days, and lost visits with family members who had traveled long distances. Lockdowns occurred predictably around weekends, holidays, funerals, and other anticipated staffing stress points, reflecting an institutional dependence on confinement as a substitute for adequate staffing. While DOC has attributed these conditions to workforce attrition, vacancies, and call-outs—pressures the OCO acknowledges—the evidence demonstrates that DOC has no enforceable minimum staffing standards, objective limits on the frequency or duration of lockdowns imposed for non-emergency reasons, nor service-continuity requirements to preserve baseline conditions of confinement when staffing falls short.

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Medical and mental health complaints constituted the largest category of complaints received by the OCO during the reporting period. The Office documented recurring patterns of delayed diagnosis and treatment, fragmented continuity of care following transfers, inconsistent intake screening, prolonged specialty-care backlogs, and failures to timely identify and accommodate individuals with disabilities. These findings are corroborated by independent oversight. In December 2025, Disability Rights Connecticut issued findings concerning sexual assault and systemic safety failures at York Correctional Institution, particularly affecting individuals with disabilities. That report documented breakdowns in supervision, protection, and institutional response—failures inseparable from staffing shortages, inadequate training, and weak internal controls. Similarly, in late 2025, the Office of the Child Advocate issued findings regarding repeated and unjustified uses of force against youth at Manson Youth Institution, identifying deficiencies in training, supervision, and accountability. These findings reflect the human cost of a system that responds to mental illness with control rather than care.

Across facilities, the OCO observed and received consistent reports of unsanitary and degrading living conditions, including mold-contaminated ventilation systems, rodent infestations, sewage odors and backups, broken showers, inadequate ventilation, and prolonged denial of hygiene supplies and shower access—conditions frequently exacerbated by extreme heat. Food services complaints described spoiled food, insufficient portions, and failure to accommodate documented medical and dietary needs, often overlapping with sanitation failures. These deficiencies directly threaten health and dignity. They also affect correctional staff, who work prolonged shifts in environments that pose significant occupational health and safety risks.

DOC increasingly relies on digital platforms to replace or supplement in-person services. The OCO documented systemic failures in tablet access, digital law library functionality, video visitation administration, and communication reliability. Families reported canceled video visits after extended waits, and incarcerated individuals reported inability to access legal materials when physical law libraries were unavailable due to lockdowns or staffing shortages. The OCO's investigation into the Inmate Legal Assistance Program revealed deficiencies so significant that the Office initiated enforcement litigation to obtain records from a state contractor performing constitutionally significant services. That such litigation was required to secure basic oversight cooperation is itself a serious concern.

DOC's operational instability is further compounded by persistent weaknesses in fiscal and administrative governance. The Auditors of Public Accounts' FY2022-2023 audit identified numerous deficiencies, the majority of which were repeat findings from prior audits, including improper extended paid administrative leave, weaknesses in overtime and payroll controls, asset and inventory management failures, and repeated noncompliance with statutory reporting requirements. The recurrence of these findings over multiple audit cycles reflects a failure to implement corrective action—failures that directly affect staffing availability, infrastructure maintenance, transparency, and public trust.

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In 2024, the Department of Correction reported 33 in-custody deaths, including five deaths by suicide. In 2025, DOC reported 22 in-custody deaths. While lower than the prior year, the number of deaths reflect a need for continued oversight and evaluation of delivery of services. Moreover, these outcomes must be evaluated in the context of delayed medical care, restricted movement during lockdowns, limited observation capacity, and strained staffing conditions documented throughout this report.

The OCO acknowledges and appreciates the professionalism and cooperation of DOC wardens, facility staff, and central office leadership who engaged with the Office during the reporting period. Many staff facilitated site visits, responded to inquiries, and engaged with oversight despite demanding operational conditions. This report is not an indictment of individual dedication; it is an evaluation of systemic performance.

This first annual conditions of confinement report presents a clear conclusion: Connecticut's correctional system is operating in a state of sustained institutional failure. Staffing collapse has become normalized. Lockdowns have replaced reliable service delivery. Health care, sanitation, food, legal access, and communication remain inconsistent. Governance failures persist despite repeated warnings. These conditions are foreseeable, preventable, and correctable—but only with sustained legislative oversight, enforceable standards, and adequate resourcing of independent oversight. The Office of the Correction Ombuds submits this report as both a record and a warning: absent decisive intervention, Connecticut risks entrenching a correctional system defined by instability, isolation, and preventable harm.

DeVaughn L. Ward, Esq.
Correction Ombuds

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Statutory Authority

The Office of the Correction Ombuds ("OCO") is an independent oversight entity established by Connecticut law to monitor, investigate, and evaluate conditions within the state's correctional system. The Correction Ombuds is expressly authorized to evaluate the delivery of services provided by the Department of Correction ("DOC") to incarcerated individuals, including health care, food services, sanitation, safety, access to programs, and other conditions of confinement.[1]

In conducting investigations, state law directs the Office to rely on multiple sources to corroborate concerns raised by incarcerated individuals and others, and provides that, **where validation of particular incidents is required, the Correction Ombuds shall endeavor to rely on communications from incarcerated persons who have reasonably pursued resolution of their complaints through existing DOC grievance procedures.**[2]

Connecticut law further requires the Correction Ombuds to prepare and submit an annual public report to the General Assembly regarding conditions of confinement in the state's correctional facilities and halfway houses, detailing the Office's findings, investigations, and recommendations.[3] Together, Conn. Gen. Stat. § 18-81qq and Public Act 25-161 establish the legal foundation for this Annual Report and guide the Office's evaluation of conditions of confinement statewide.

[1] Conn. Gen. Stat. § 18-81qq(a)(2)(A).
[2] Conn. Gen. Stat. § 18-81qq(e).
[3] Conn. Gen. Stat. § 18-81qq(m).

Methodology

The findings, observations, and recommendations set forth in this Annual Report are based on a qualitative review of information gathered by the Office of the Correction Ombuds ("OCO") between September 2024 and December 2025. During this reporting period, the OCO received and reviewed complaints submitted by incarcerated individuals, family members, attorneys, legislators, and other stakeholders through multiple intake channels, including mail, email, and telephone. These complaints informed the identification of recurring issues, systemic concerns, and facility-specific conditions.

In addition to complaint review, the OCO conducted site visits and tours of DOC facilities across the state. These visits included direct observation of housing units, program areas, medical and mental health spaces, food service operations, and environmental conditions. Observations from these visits were supplemented by conversations, meetings, and interactions with a broad range of Department personnel, including facility-level custody staff, supervisory staff, wardens and deputy wardens, central office administrators, and contracted and in-house health services staff.

The OCO also considered information obtained through informal inquiries, targeted document review where appropriate, and follow-up communications with Department representatives in response to issues identified during site visits or raised through complaints. Collectively, these sources were used to assess conditions of confinement, the delivery of services, and compliance with applicable policies, administrative directives, and legal standards. This methodology reflects the OCO's statutory oversight role and its reliance on firsthand accounts, direct observation, and engagement with both incarcerated individuals and Department staff to support independent, objective reporting to the Governor and the General Assembly.

Sanitation and Hygiene Across Facilities

Sanitation and hygiene are foundational components of humane conditions of confinement and directly implicate the health, safety, and dignity of incarcerated individuals. Adequate access to clean living spaces, functioning ventilation, showers, hygiene supplies, pest control, and environmental maintenance is essential not only to prevent the spread of disease, infection, and environmental illness, but also to mitigate the compounding risks posed by extreme heat and humidity. As documented in the Office of the Correction Ombuds' Heat Mitigation Report, deficiencies in ventilation, moisture control, shower access, bedding changes, and environmental cleanliness are frequently interconnected with elevated temperatures, amplifying health risks and exacerbating already unsanitary conditions.

These conditions do not affect incarcerated individuals alone. Correctional staff are likewise required to work, supervise, and remain stationed within these environments for extended periods—often eight to sixteen hours per shift, day after day. Prolonged exposure to excessive heat, poor ventilation, mold, pest activity, and unsanitary conditions raises occupational health and safety concerns for staff, contributes to fatigue and illness, and undermines the safe and effective operation of facilities. Addressing sanitation and hygiene deficiencies therefore serves not only the health and dignity of residents, but also the well-being, safety, and sustainability of the correctional workforce.

Interior hallway at MacDougall Correctional Institution.

Complaints from Incarcerated Individuals and Families

The Office of the Correction Ombuds ("OCO") received recurring complaints from incarcerated individuals and their families concerning unsanitary living conditions, inadequate access to hygiene facilities and supplies, mold and pest infestations, and environmental conditions exacerbated by extreme heat. These complaints were consistent across multiple facilities and custody levels and frequently overlapped with concerns raised during the Office's Heat Mitigation investigation, suggesting interrelated and systemic deficiencies rather than isolated incidents.

On October 20, 2025, OCO received the following complaint the father of someone housed at York Correction Institute:

> ***"I am writing to express my deep concern about the living conditions at York Correctional Institution, where my daughter is being held. According to her recent message, the facility has been under lockdown for several days this past week, as we already know these lockdowns have become a regular occurrence with no apparent effort to address the issue. She also mentioned seeing a news report about the ongoing ventilation problems in state correctional facilities. Specifically, she told me that the air ducts in her unit are clogged and dirty, releasing constant dust and creating an unhealthy environment. Furthermore, she reported that bed linens have not been changed for over a month, leading to unsanitary conditions, particularly due to heat, perspiration, and basic feminine hygiene needs".***

Mold present on a shower ventilation unit at Hartford Correctional Center.

On June 5, 2025, the Office of the Correction Ombuds (OCO) received the following complaint from a loved one of an individual housed at New Haven Correctional Institution regarding conditions at the Whalley Detention Center:

> *"I am writing regarding mice running through the Whalley Detention Center. Hav[ing] mice in your cell on your bed is disturbing and unsanitary."*

On July 9, 2025, OCO received the following complaint from a loved one of an individual housed at Bridgeport Correctional Institution:

> *"Hello I'm writing on behalf of inmates at the Bridgeport Correctional Facility! There are complaints of unsanitary conditions[,] sewage back up into the cells of inmates, feces and urine throughout the facility[,] all over the floor.*
>
> *There's no power[,] there's no AC[,] just over 100° in the facility. Just trying to find out what is going on[,] if there's gonna be any help coming to those inmates there."*

On September 11, 2025, OCO received the following complaint from a loved one of an individual housed at Hartford Correctional Institution:

> *"On my last two[,] three visits to the facility to visit my son I have noticed several unsanitary conditions. For example[,] there is a spray bottle with about two ounces of what I believe to be just water for several visitors to use to wipe down phones/sitting areas that are dirty.*
>
> *The receiver on the phone that I used smelled like someone's saliva and the watered down spray did nothing to sanitize it. I also noticed that the visiting room is not cleaned because it had the same trash of used paper towels on the floor from my last visit there.*
>
> *Also my son asked an officer for spray or paper towel to wipe his phone off and was told that they didn't have it. Another inmate who told my son that he was diagnosed with shingles on his face/eye was also unable to clean his phone before he used it.*
>
> *But my question is, did the phone get disinfected after it was used so that the next person won't get shingles or any other infection? Also my son tells me the jail is infested with rodents."*

On December 11, 2024, OCO received the following complaint from a woman housed at York Correctional Institution regarding hygiene supplies and sanitation:

> ***"We have been getting ripped off for toiletries, chemical[s] to clean are basically water. On every Monday we are suppose[d] to get 4 rolls of toilet paper and 4 tampons, 4 pads per cell. And guess what we got on Monday[,] the entire compound got one roll per cell and the mental health unit and the medical unit had to choose which one needed it more.***
>
> ***The staff do the supplies and they keep saying that there's not enough money in the budget for supplies so they have to cut back. It's a necessity not a privilege to get basic needs in here. They made a memo that inmates need to purchase their own toilet paper from commissary[,] which is crazy cause (1) not everyone in the facility has money and (2) the State of CT released a memo that sanitary items and toilet paper are given as needed. Most of the time people use paper towels for toilet paper. It all screwed up here."***

On the same date, OCO received an additional complaint from another woman housed at York Correctional Institution regarding environmental and maintenance conditions:

Shower area at York Correctional Institution.

> ***"The lights and power just came back on this morning at 5:30 a.m. and it was only the 1-South building and 0-North/South buildings. It was so freaking hot in here, there was no air on.***
>
> ***Now the hot water don't work. Maintenance is a joke around here. Our showers are broke down. In most units there's only one shower per tier and no water pressure.***
>
> ***You could share anything I send you on this facility. Someone needs to take action. Oh and forewarning[,] they throw some paint on the walls and buff the floors to make the place look good for walk throughs."***

Site Observations

The Office observed and received reports of sanitation, environmental health, and hygiene concerns across multiple Department of Correction ("DOC") facilities, indicating system-wide challenges.

During tours of MacDougall–Walker Correctional Institution conducted in November 2024, January 2025, May 2025, and August 2025, the Office observed apparent black mold on facility surfaces, ventilation vents heavily coated with dust and debris, surveillance cameras partially obstructed by accumulated buildup, and shower areas exhibiting visible mold and deterioration. These conditions raised concerns regarding routine cleaning, preventive maintenance, and environmental health oversight. The Heat Mitigation Report further documented debris-covered ventilation systems and fans at multiple facilities, reducing airflow and exacerbating heat retention within housing units, particularly during periods of extreme heat.

Similar concerns were documented at Hartford Correctional Center. Tours conducted in December 2024 and July 2025 revealed significant mold in shower areas and persistent ventilation deficiencies. While Hartford was slated for roof and HVAC-related improvements, the Office observed shower ventilation vents heavily coated in gray mold, raising concerns regarding moisture control, humidity management, and the effectiveness of interim remediation efforts. During heat-related inspections in summer 2025, residents also reported excessive condensation on floors and walls caused by inadequate ventilation combined with fan use, further degrading sanitation conditions and increasing slip and fall risks.

Bathroom ceiling exhibiting mold growth and condensation at Hartford Correctional Center.

At Garner Correctional Institution, an August 2025 site visit revealed a strong odor of urine upon entering a specialized housing tier designated by the Department for residents requiring enhanced mental health and daily living support. Facility leadership reported that incarcerated individuals on the unit had not been released from their cells to shower for approximately three days over a weekend.

These conditions raised serious concerns regarding access to basic hygiene, sanitation, and dignity—particularly for individuals with significant mental health needs. Heat-related investigations have consistently emphasized the importance of increased shower access during hot weather to mitigate health risks; prolonged denial of showers under such conditions compounds sanitation failures and elevates health risks.

Capital improvements to shower facilities at York Correctional Institution have been ongoing for nearly a year. During tours in December 2024 and April 2025, incarcerated women reported that only one or two operational showers were available for approximately twenty-five residents, resulting in extended wait times and unsanitary conditions.

During a September 2025 site visit, residents further reported recurring shortages of women's hygiene and sanitation products. Individuals stated that essential items were not consistently available and that, at times, residents resorted to using toilet tissue in place of appropriate hygiene products—when toilet tissue itself was available. These reports mirror heat-mitigation findings documenting the heightened importance of regular hygiene, laundry, and shower access during periods of elevated temperature and humidity.

The Office also received multiple reports of rodent activity across DOC facilities. During summer 2025, rodent infestation at Hartford Correctional Center reportedly became severe enough that the facility kitchen was closed for approximately three to four weeks to allow for remediation. According to information provided to the Office, rodents accessed food preparation areas by chewing through doors and other entry points, raising serious food safety and sanitation concerns. During this period, food preparation operations were temporarily rerouted to MacDougall–Walker Correctional Institution. Elevated heat and humidity conditions documented in the Heat Mitigation Report further increase the risks associated with pest infestations by accelerating spoilage, bacterial growth, and exposure risks.

Mouse observed in the dining area at Osborn Correctional Institution.

Interior of oven used for food preparation at Cheshire Correctional Institution.

Although the Department maintains contracts with pest control vendors providing weekly or bi-weekly services, incarcerated individuals continued to report persistent rodent activity, suggesting deficiencies in either the effectiveness or oversight of pest management efforts.

Similar reports were received regarding Cheshire Correctional Institution, particularly within kitchen areas. During an early-morning visit conducted to observe food preparation operations, the Office did not observe active rodent presence. However, facility staff acknowledged that rodent control remains an ongoing challenge due to the age and porous infrastructure of the facility. Staff reported reliance on bi-weekly pest control services with additional visits as needed.

Findings

- The Office observed and received credible reports of recurring sanitation, mold, ventilation, pest, and hygiene deficiencies across multiple DOC facilities, indicating systemic issues rather than isolated facility-specific failures.

- Environmental conditions documented during both sanitation and heat mitigation inspections—particularly debris-covered ventilation systems, mold, inadequate fan maintenance, and moisture accumulation—compound heat exposure and exceed the scope of routine cleaning, requiring specialized remediation.

- Prolonged lack of access to showers, inadequate hygiene supplies, soiled bedding, rodent infestations, and poor ventilation—especially during periods of extreme heat—pose significant health risks and undermine basic standards of sanitation, dignity, and humane treatment.

- While contracts for pest control, maintenance, and capital improvements are in place, the persistence of these conditions suggests deficiencies in monitoring, verification, and sustained follow-through to ensure effective remediation.

Shower door corroded with rust at Cheshire Correctional Institution.

Recommendations

The Office of the Correction Ombuds recommends that the Department of Correction undertake a comprehensive, system-wide sanitation and environmental health initiative in 2026. This initiative should address accumulated debris, mold, ventilation systems, shower facilities, bedding, pest control, and other sanitation concerns that are not adequately resolved through routine cleaning practices, particularly in facilities lacking climate control.

Kitchen floor at Hartford Correctional Institution.

The Office further recommends:

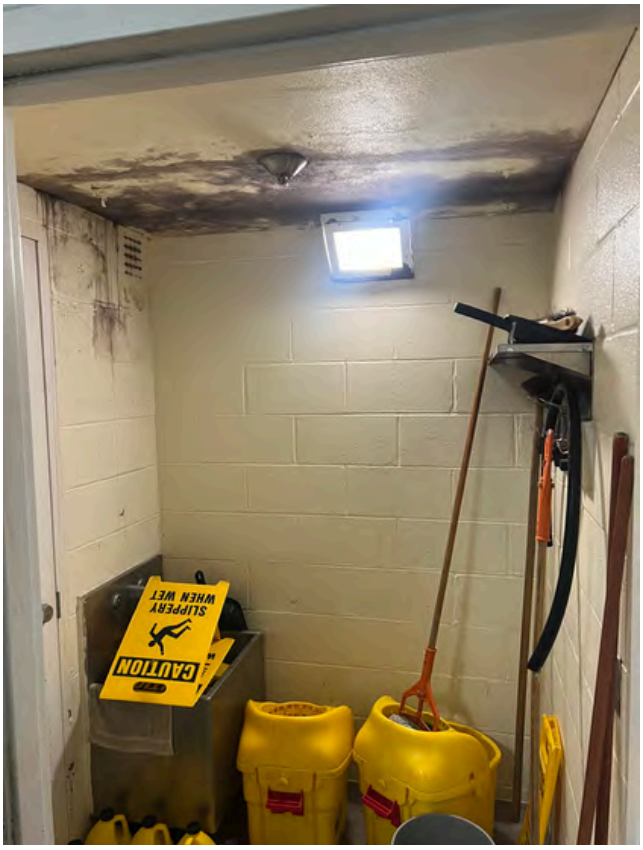
- Remediation of environmental hazards—including mold, debris-covered ventilation systems, contaminated fans, and pest infestations—should be performed by qualified professional contractors, including environmental or hazardous-materials specialists where appropriate, rather than by incarcerated workers.

- The Department should formalize and strengthen documentation, verification, and auditing mechanisms for sanitation, hygiene, pest control, and remediation efforts, including follow-up inspections to ensure that identified deficiencies have been fully corrected and do not reoccur.

Recommendations Cont.

- Shower access, bedding exchange, and laundry frequency should be increased and formally codified during periods of elevated heat and humidity, consistent with public health guidance and the findings of the Heat Mitigation Report. DOC has agreed to adopt several findings of the Heat Mitigation Report.

Soiled bedding issued at Bridgeport Correctional Center.



Mold-contaminated supply closet at Cheshire Correctional Institution.

Mold-contaminated shower vent at Cheshire Correctional Institution.

Rusted shower door at Cheshire Correctional Institution.

Bathroom ceiling with black mold and condensation at Hartford Correctional Center.

Shower lacking slip-resistant mats and exhibiting soap residue at MacDougall Correctional Institution.

Water damage adjacent to a light fixture at Garner Correctional Institution.

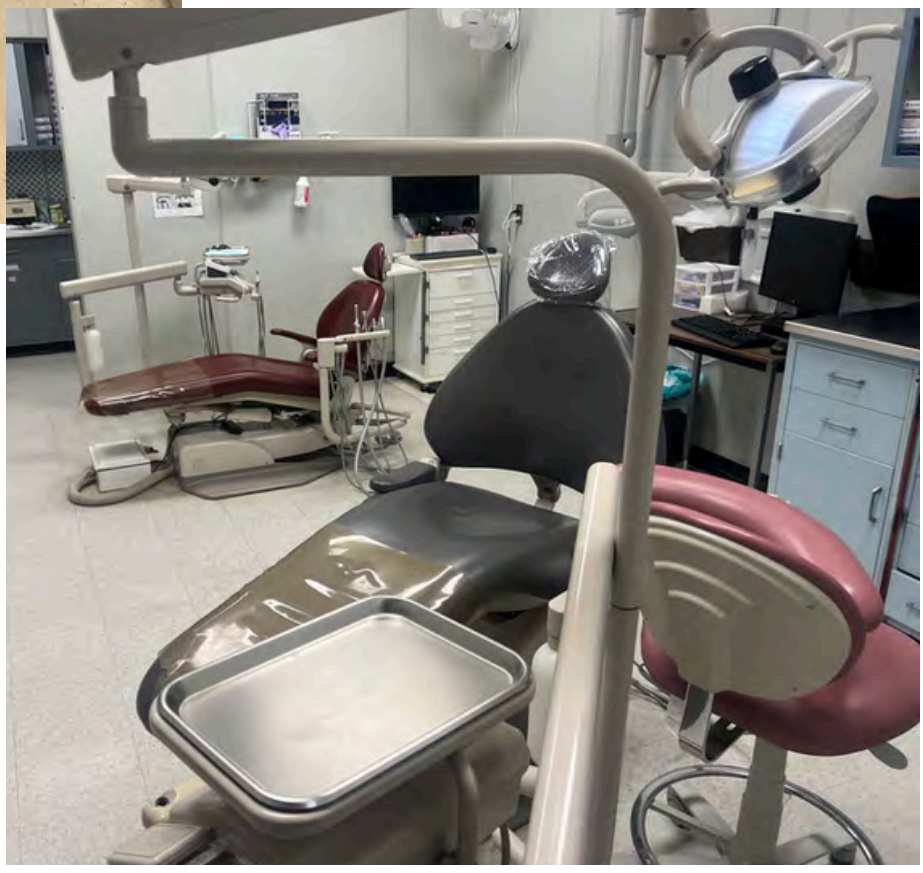
Medical Services

The Connecticut Department of Correction (DOC) is responsible for providing medical services to an incarcerated population exceeding 11,000 individuals statewide in 2025. Complaints received by the Office of the Correction Ombuds (OCO), together with record review, site visits, and communication with DOC officials, reflect recurring patterns affecting access to medical care across facilities.

While the clinical circumstances of individual complaints vary, matters reviewed during the reporting period consistently demonstrate delays in diagnosis and treatment, fragmented continuity of care, inconsistent intake assessments, and structural barriers that impede timely and effective medical intervention.

Legal and Administrative Framework

The provision of medical and mental health services within Connecticut correctional facilities is governed by statute and Department administrative policy. Pursuant to Connecticut General Statutes § 18-81, the Commissioner of Correction is responsible for the custody, care, and supervision of all individuals committed to the Department, including responsibility for ensuring access to necessary medical and mental health care consistent with constitutional standards.



Dental treatment rooms at York Correctional Institution and Cheshire Correctional Institution.

DOC Administrative Directive 8.1, Health Services, establishes the Department's internal framework for the delivery of medical, mental health, dental, and specialty care. The Directive provides that incarcerated individuals shall have access to medically necessary care delivered in accordance with generally accepted professional standards and assigns responsibility for intake screening, continuity of care, and coordination between on-site and outside providers.

Public Act 22-133 further described standards for correctional health care services, including mental health care, substance use disorder treatment, dental services, discharge planning, and related staffing requirements. In addition, pursuant to Section 264(b) of Public Act 25-168, the DOC Commissioner was required, on or before October 1, 2025, to develop a plan for the provision of health care services for individuals incarcerated under the Department's jurisdiction.

Intake Screening and Early Identification of Medical and Disability Needs

Intake screening is intended to serve as the primary mechanism by which the Department identifies acute medical needs, chronic conditions, mental health status, and disability-related accommodation requirements at the outset of incarceration. DOC Administrative Directive 8.1 contemplates timely medical and mental health screening upon admission, appropriate classification, and continuity of care for preexisting conditions. The illustrative cases described below—including delayed orthopedic care, interruption of psychiatric medication, inadequate assessment of dementia and mobility impairments, and failures to identify sensory disabilities—indicate recurring breakdowns in intake assessment and early intervention processes. These breakdowns have downstream consequences for treatment timeliness, housing placement, safety, and access to appropriate accommodations.

Complaints and Illustrative Case Examples

Complaints regarding medical services constitute the most frequent category received by the Office of the Correction Ombuds. Since September 2024, the OCO has received more than 143 health-services-related complaints.

On June 24, 2025, the Office of the Correction Ombuds received a complaint from a family member of an individual incarcerated at Carl Robinson Correctional Institution concerning prolonged illness and lack of access to medical care. The complainant reported that the individual had been experiencing flu- or COVID-like symptoms for an extended period and had repeatedly requested medical attention without being seen.

According to the complaint, the individual subsequently began experiencing significant rectal bleeding, which had persisted for some time. Despite weeks of reported requests for medical evaluation, the individual was allegedly informed by medical staff that his name was not on the list to be seen, notwithstanding ongoing complaints and worsening symptoms.

On April 4, 2025, the Office of the Correction Ombuds received a complaint from a family member of an individual incarcerated at Osborn Correctional Institution who had been in custody since July 10, 2024. The complainant reported that since December 2024, the individual had experienced persistent chest pain and identified a palpable lump in the center of his chest. According to the complaint, the individual repeatedly sought medical evaluation but was not referred for hospital-based assessment or advanced diagnostic testing. Instead, he was initially prescribed ibuprofen and advised that the symptoms might be attributable to heartburn.

The complainant, who identified herself as a medical professional employed at Yale New Haven Hospital, expressed concern that persistent chest pain and a chest mass require thorough medical evaluation to rule out serious underlying conditions, particularly given the individual's reported risk factors, including being overweight and a history of medical issues.

On October 17, 2025, the Office of the Correction Ombuds received a complaint from a family member of an individual incarcerated at York Correctional Institution concerning delayed treatment for a known ear condition. The complainant reported that the individual had a history of ear and ear-canal issues and prior surgery and sought medical attention after recognizing signs of recurrence. The individual was eventually transported to UConn Health, where a specialist advised that earlier intervention could have prevented the need for additional surgery.

Instead, the individual was informed that two surgical procedures would now be required. The complainant further reported that although the specialist prescribed antibiotics, facility medical staff were not administering the medication as ordered. The Office of the Correction Ombuds contacted the Health Services Director to facilitate administration of the prescribed antibiotics.

Delayed Diagnosis and Orthopedic Care – York Correctional Institution

On January 15, 2025, the OCO received a complaint from a family member of a 66-year-old individual incarcerated at York Correctional Institution concerning prolonged knee pain, delayed diagnosis, and lack of follow-up treatment. The individual began experiencing significant knee pain and swelling in August 2023 and submitted multiple written requests seeking medical evaluation. Imaging performed in November 2024 revealed torn knee cartilage; however, no definitive treatment followed.

An orthopedic specialist whose records were reviewed by the OCO noted that conservative measures were unlikely to resolve the condition and that minimally invasive surgery could improve function. After an outside specialty visit that resulted only in an injection, the referral was marked "completed," removing the individual from the specialty-care queue despite continued symptoms. As of January 2025, the injury remained unresolved, resulting in approximately seventeen months of ongoing pain and instability.

Vision Care and Access to Corrective Lenses

Eyeglasses – York Correctional Institution

On April 21, 2025, an individual formerly housed at York reported that eyeglasses were confiscated and not replaced for nearly four weeks. Replacement glasses duplicated an outdated prescription without an eye examination, despite the individual having astigmatism and both near- and far-sightedness. Similar issues were reported by others at the facility, including delays in replacement, denial of original frames, and receipt of incorrect prescriptions.

Eyeglasses – Osborn Correctional Institution

On October 3, 2024, a family member reported that an individual had sought an eye examination for more than two years while being transferred among multiple facilities. Osborn Correctional Institution—housing approximately 1,200 incarcerated individuals—had not had an on-site optometrist for roughly two years. Attempts to obtain a simple eyeglass prescription were met with a requirement to pay for production of extensive medical records.

System-Level Context and Continuity of Care Across Transfers

DOC Quality Improvement data for the third quarter of 2025 reported 960 individuals receiving diabetic chronic care and 310 optometry or eye examinations statewide. Several complaints reviewed by the OCO reflect disruption of medical care associated with inter-facility transfers, including missed appointments, restart of referral processes, and prolonged delays in care.

Because transfers are a Department-controlled operational decision, these disruptions raise systemic concerns regarding continuity of care and coordination across facilities.

Contact Lenses – York Correctional Institution

On May 2, 2025, a family member reported prolonged denial of medically necessary contact lenses for an individual approved to wear contacts for approximately fourteen years. Two shipments of contact lenses were denied without notice. Although an ADA accommodation was later approved, resolution ultimately required outside transport and direct intervention by senior DOC leadership, with final resolution occurring on August 28, 2025.

Gastrointestinal Specialty Care and ADA Accommodations – MacDougall–Walker Correctional Institution

On October 3, 2024, the OCO received a complaint concerning prolonged delays in gastrointestinal specialty care and an ADA accommodation request related to chronic incontinence. An outside specialist recommended a colonoscopy in November 2023; the referral remained pending nearly a year later despite reaffirmation by a DOC physician. An ADA request for single-cell housing was denied after months of review, notwithstanding medical documentation requiring contact precautions.
As of the denial, the colonoscopy had not been scheduled. DOC data reflects similar attrition statewide between screening and diagnostic follow-up.

Acute Orthopedic Injury – Osborn Correctional Institution

On September 25, 2025, the OCO received a complaint concerning an acute knee injury sustained in July 2025. Initial treatment consisted of ibuprofen and delayed imaging. MRI later revealed multiple ligament tears requiring surgery, complicated by stiffness and muscle atrophy attributable to delayed definitive care. As of October 7, 2025, surgery had not been scheduled. Given the individual's lengthy sentence, the functional consequences of delayed care are likely to result in prolonged pain, extended rehabilitation, and increased long-term medical costs borne by the State.

Acute and Chronic Care Delays

The complaints reviewed during the reporting period reflect delays affecting both acute injuries and chronic or routine medical conditions. Delays across both categories increase the risk of preventable harm, prolong suffering and functional impairment, and may result in more complex and costly interventions over time.

Psychiatric Medication Management – Corrigan Correctional Institution

Beginning in October 2024 and formalized in February 2025, complaints alleged that individuals with documented psychotic disorders were taken off antipsychotic medications upon admission or transfer and gradually re-prescribed medications, resulting in periods of untreated psychosis. Alleged consequences included psychiatric decompensation, increased competency-to-stand-trial evaluations, and suicidal behavior. During the reporting period, the OCO did not have a Health Care Consultant Ombuds, limiting independent clinical assessment. DOC audits identified intake workflow inconsistencies and lack of standardized training.

ADA Accommodations and Access for Deaf and Disabled Individuals – Hartford Correctional Center

During a site visit to Hartford Correctional Center, the OCO encountered a deaf incarcerated individual with multiple disabilities, including wheelchair use, frequent urination requiring a portable urinal, and a colostomy bag. The individual, deaf since birth, had difficulty communicating through writing and lacked effective assistive communication technology. Placement decisions were driven by physical barriers in celled housing rather than an individualized accommodation plan.

Facility staff reported reliance on an informal "buddy system" involving other incarcerated individuals to assist with communication and daily needs. Attempts to use TTY technology to communicate with the individual's deaf mother were unsuccessful, and Wi-Fi limitations restricted access to tablet-based interpreter services. The OCO has observed similar conditions at other facilities, including individuals who are blind or deaf not being adequately assessed at intake and left to rely on untrained incarcerated individuals for basic assistance. These practices raise safety concerns and do not constitute consistent ADA compliance.

Responsibility for ADA accommodations appears fragmented across medical staff, custody staff, facility ADA coordinators, and central office personnel, contributing to delays, inconsistent implementation, and reliance on ad hoc solutions.

Observations

During the reporting period, Health Services Unit acknowledged that the Department does not maintain a centralized system for tracking sick-call wait times or wait times for outpatient or specialty medical services across facilities. In the absence of centralized tracking, the Department lacks the ability to systematically monitor delays, identify backlogs, or assess compliance with internal timelines or external standards of care. This limitation constrains both internal quality-improvement efforts and external oversight.

Showers lacking slip-resistant mats at Cheshire Correctional Institution.

During tours of multiple correctional facilities conducted in the reporting period, OCO staff observed that several shower areas lacked slip-resistant flooring or mats within shower stalls and immediately outside shower entrances. The absence of slip-resistant surfaces raises safety concerns, particularly for older individuals, individuals with mobility impairments, and those with chronic medical conditions that increase fall risk. Falls in institutional settings present a significant risk of injury and create substantial liability exposure for the State, particularly where hazards are readily identifiable and preventable.

Delayed diagnosis and treatment may increase long-term medical costs borne by the State and increase exposure to grievances and litigation. In several matters described above, issues were not resolved during the reporting period or required elevated intervention by senior Department leadership to achieve resolution.

Pursuant to Public Act 25-168 and C.G.S. § 18-81pp, the DOC Commissioner was required to develop a comprehensive health care services plan by October 1, 2025. When the OCO inquired on October 9, 2025, DOC indicated the plan was under Office of Policy and Management review and would be released shortly. A follow-up inquiry on November 19, 2025, received no response. As of the close of the reporting period, the plan had not been provided.

The OCO did not have a Health Care Consultant Ombuds during the reporting period. Accordingly, findings are based on complaint review, records, site visits, and communications rather than independent clinical judgment. Future reports are expected to provide more detailed clinical analysis once that capacity exists.

Findings

- The Department has not demonstrated which provisions of Public Act 22-133 are fully implemented, partially implemented, or unimplemented as of 2025.
- The absence of updated staffing data and facility-level metrics prevents independent assessment of compliance with statutory health care mandates.
- Previously acknowledged staffing shortages across clinical disciplines have not been shown to be resolved or mitigated.
- Compliance with statutory requirements for mental health, substance use disorder treatment, and dental care cannot be verified.
- Discharge-planning practices lack demonstrated change or outcome-based measures.
- The health care services plan required by Public Act 25-161 was not provided by the close of the reporting period.
- The absence of required reporting limits transparency and meaningful oversight.
- Intake assessment and accommodation of individuals with disabilities is inconsistent, with individuals relying on untrained incarcerated persons for assistance.
- ADA processes lack clarity and timeliness, contributing to delayed accommodations.
- Taken together, these deficiencies prevent determination of whether statutory reforms have improved access to care or conditions of confinement.

Recommendations

Due to the absence of a Health Care Consultant Ombuds during the reporting period, the Office does not issue clinical recommendations. The Office makes the following process- and safety-based recommendations:

ADA Appeals Process

The Department of Correction should revise Administrative Directive 9.6 to remove outdated language suggesting that a meeting with a Unit ADA Coordinator is a prerequisite to filing an ADA appeal, align the directive with Administrative Directive 10.19, and establish a defined timeframe for the issuance of substantive written responses to ADA appeals, rather than limiting existing timelines to acknowledgment of receipt. Clear and timely ADA determinations are necessary to ensure prompt access to accommodations.

Slip-Resistant Shower Safety Assessment and Remediation.

The Department should conduct a comprehensive assessment of all correctional facilities to determine whether shower areas, including shower stalls and immediately adjacent exit areas, are equipped with adequate slip-resistant flooring or mats. Based on that assessment, the Department should procure and install appropriate slip-resistant surfaces where deficiencies are identified. This assessment and procurement process should be completed no later than **July 1, 2026**, in order to reduce fall risk, enhance safety for individuals with medical and mobility impairments, and mitigate preventable injury and liability exposure to the State.

Food Services

Food services are a critical component of conditions of confinement and directly affect the health, dignity, and safety of incarcerated individuals. The adequacy of meals, the sanitation of food preparation and service areas, and the accommodation of medical and dietary needs are integral to institutional operations and public health within correctional settings. Deficiencies in food services may contribute to adverse health outcomes, exacerbate chronic medical conditions, and compound environmental concerns already present within facilities. The DOC serves approximately 35,000 meals daily through a centralized food service system. Hartford Provision Company serves as the primary food service vendor, with additional vendors supplying bread and milk. Food procurement is administered through the Department of Administrative Services, and a cook-and-chill system is utilized at select facilities to prepare meals distributed statewide.

During the reporting period, the Office of the Correction Ombuds ("OCO") received multiple complaints from incarcerated individuals and family members across facilities raising concerns regarding food quality, sanitation, portion size, and the adequacy of medical and dietary accommodations, indicating that food services remain an ongoing area of concern within the Department of Correction ("DOC").

Breakfast meal tray issued at Cheshire Correctional Institution.

Statutory and Administrative Framework

Food services within Connecticut correctional facilities are governed primarily by DOC Administrative Directive 10.18, Nutrition and Food Services. This directive requires DOC to provide nutritionally adequate meals in a cost-effective manner while maintaining appropriate standards of safety, sanitation, and cleanliness.

It further mandates the use of a standardized 28-day master menu designed to meet or exceed Recommended Dietary Allowances and requires reasonable accommodations for medical, therapeutic, and religious dietary needs. Administrative Directive 10.18 incorporates applicable public health standards and national correctional food service guidelines.

Complaints from Incarcerated Individuals and Family Members

During the reporting period, OCO received complaints alleging that food services were unsafe, nutritionally inadequate, or inconsistently administered across multiple facilities.

On September 26, 2024, an incarcerated individual at York Correctional Institution reported receiving food that was "old with fungus," alleged the presence of rodent feces in meals, and described repeated service of rotten milk. The individual further reported moldy bread and characterized the experience as "dehumanizing."

On December 11, 2024, an incarcerated individual at York Correctional Institution submitted the following complaint regarding food services:

> ***"The food is barely edible. Much of it has freezer burn or is as hard as hockey pucks. They recently stopped providing peanut butter with breakfast on Thursdays, which had been part of the regular menu for decades. Kitchen staff told us that peanut butter is 'too expensive,' which is hard to believe. While incarcerated individuals are served whatever is put together, kitchen staff use the same state-provided food to prepare meals for themselves, including burgers and French fries—items that incarcerated individuals do not receive. Staff reportedly cut up fresh potatoes to make their own lunches. Additionally, the milk has frequently been rotten or contains very little product in the container."***

On September 10, 2025, an incarcerated individual at Osborn Correctional Institution reported that meal portions were insufficient to meet the caloric needs of an adult male and alleged that portion sizes did not align with established nutritional standards.

On November 17, 2025, a family member of an incarcerated individual at Bridgeport Correctional Institution reported that her father, who has diabetes and documented food allergies, could not safely consume meals provided due to their carbohydrate-heavy composition and incompatibility with his medical needs.

On September 26, 2024, multiple incarcerated individuals at York Correctional Institution reported that facility diets contributed to adverse health outcomes, including diabetes, hypertension, and high cholesterol. These individuals recommended coordination between medical providers and nutrition staff to develop healthier menus.

On November 17, 2025, a family member of an individual incarcerated at York Correctional Institution described meals as “slop,” reporting inadequate portions, excessive reliance on processed foods, poor storage practices, and limited accommodation for medical or dietary needs.

On December 31, 2025, an individual housed at Cheshire CI reported that he now has been identified as having high cholesterol despite never having such diagnosis before entering prison.

These complaints were consistent across facilities and custody levels and often overlapped with concerns raised in sanitation and medical care complaints.

OCO Observations During Site Visits

During site visits conducted throughout the reporting period, OCO staff observed conditions related to food services that were consistent with issues raised in complaints. These included visibly unclean kitchen equipment and food preparation areas and reports from incarcerated individuals regarding inconsistent meal quality and portion sizes. While OCO did not conduct formal public health inspections or food safety testing, these observations, when considered alongside recurring complaints, raise concerns regarding sanitation practices within food service operations.

During site visits, DOC staff informed OCO personnel that incarcerated kitchen workers are routinely assigned to prepare specialty or off-menu food items for staff that differ from meals served to the incarcerated population. These statements were provided voluntarily by staff and were not independently verified.

While not determinative of policy noncompliance, this information raises questions regarding food service practices and resource allocation that warrant further review.

Dinner meal tray issued at MacDougall Correctional Institution.

Nutritional Adequacy and Health Implications

According to the DOC's 2024 Common Fare Menu Nutritional Analysis, the standardized menu is designed to meet general caloric benchmarks, providing approximately 2,600 calories per day. However, the analysis reflects average sodium levels exceeding recommended limits and fiber intake below recommended levels.

Menu analyses reflect intended dietary standards but assume consistent preparation, portioning, and service. Complaints alleging spoiled food, improper storage, insufficient portions, and inconsistent substitutions limit the ability to assess nutritional adequacy based on menu analysis alone. These issues are particularly significant for incarcerated individuals with chronic medical conditions, including diabetes and cardiovascular disease, who rely on consistent, medically appropriate diets and have limited ability to supplement meals.

Dinner meal tray issued at MacDougall Correctional Institution.

Oversight Limitations During the Reporting Period

During the reporting period, the OCO did not have a dedicated Health Care Consultant. This limited the Office's ability to evaluate medical diet compliance, food-related health risks, and the intersection between food services and chronic medical conditions.

These limitations constrained the scope of OCO's review and highlight the need for enhanced subject-matter expertise in future reporting periods.

Findings

Based on complaints received, observations during site visits, and documentation reviewed, the Office of the Correction Ombuds makes the following findings:

- OCO received multiple complaints across facilities alleging unsafe food, inadequate portions, and insufficient accommodation of medical and dietary needs.
- Complaints and site observations raised concerns regarding sanitation within food preparation and service areas.
- Food services are centrally administered through a cook-and-chill system serving approximately 35,000 meals daily statewide.
- DOC staff reported that incarcerated workers prepare specialty meals for staff that differ from meals served to the incarcerated population, warranting further review of food service practices.
- Menu analyses indicate caloric adequacy by design but reveal elevated sodium levels and insufficient fiber.
- Complaints indicate that meals are frequently incompatible with therapeutic diets for individuals with chronic medical conditions.
- The absence of a Health Care Consultant limited OCO's ability to fully assess nutritional and medical impacts of food services.
- Food services represent an ongoing area of concern requiring continued oversight.

Recommendations

Consistent with recommendations made in the sanitation and medical care sections, the Office of the Correction Ombuds recommends:

- The DOC strengthen coordination between food services and medical staff to ensure effective accommodation of therapeutic diets.

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Dinner meal tray issued at Corrigan Correctional Institution.

Breakfast meal tray issued at Cheshire Correctional Institution.

Staffing Levels and Facility Lockdowns

Adequate staffing levels are essential to the safe, secure, and humane operation of correctional facilities. Staffing shortages affect nearly every aspect of institutional life, including access to visitation, recreation, education, medical care, religious services, hygiene, and basic out-of-cell time. During the reporting period, the Office of the Correction Ombuds (OCO) received numerous complaints alleging that insufficient staffing resulted in frequent modified or full facility lockdowns, often lasting multiple days and occurring predictably around weekends, holidays, and special events.

Available workforce data reflects the structural nature of these concerns. Between 2015 and 2024, the number of correctional officers declined from 3,936 in 2015 to 3,578 in 2024—an 11% decrease—according to figures from the State Comptroller. During the same period, the incarcerated population declined by approximately 34%, from 16,025 individuals in 2015 to 10,584 in 2024, based on Department of Correction (DOC) data. DOC has further reported that between January 2020 and June 2024, 565 correction officers left the Department. This figure does not include employees who exited the correction officer classification through transfer or promotion.

Staffing shortages have had systemwide operational consequences. According to the Connecticut Business and Industry Association (CBIA), Connecticut spends a higher share of its payroll on overtime than neighboring states—over 11% of total payroll in 2023, compared with 5.9% in Massachusetts, 4.7% in New York, and 4.2% in New Jersey.

DOC reportedly incurs more overtime than any other Connecticut state agency, a condition the Department has attributed to vacancies, staffing shortages, and call-outs.

Statutory and Administrative Authority

The Commissioner of Correction is vested with broad statutory authority over the supervision, management, and administration of correctional facilities, including staffing levels, post assignments, and operational responses to staffing shortages. While the Department relies on Administrative Directives ("ADs") to govern daily operations, no Administrative Directive establishes minimum staffing ratios or numerical staffing thresholds for housing units, shifts, or facility-wide operations. Staffing determinations remain a management function exercised by the Commissioner and facility administrators.

Several Administrative Directives are relevant to staffing levels and lockdown practices, although each conditions access to services on staffing availability rather than prescribing minimum staffing requirements:

- **Administrative Directive 2.1 (Administration and Organization)** – Establishes the authority of the Commissioner and facility administrators over institutional operations and personnel deployment.

- **Administrative Directive 2.17 (Facility Count and Supervision)** – Governs inmate supervision, movement, and counts, implicitly requiring adequate custody staffing.

- **Administrative Directive 5.1 (Inmate Classification**) – Relies on staffing availability to support appropriate housing assignments and movement consistent with classification decisions.

- **Administrative Directive 8.2 (Inmate Visitation) –** Permits modification or suspension of visits due to "security or operational needs," including staffing shortages.

- **Administrative Directive 8.6 (Recreation) –** Conditions access to recreation on the availability of staff to safely supervise activities.

- **Administrative Directive 10.1 (Health Services) –** Requires custody staff support for sick call, medical escorts, and access to treatment.

- **Administrative Directive 10.6 (Mental Health Services) –** Depends on custody staffing to facilitate evaluations, treatment, and movement.

Collectively, these directives acknowledge that staffing availability directly determines whether core services can be delivered, but they do not define objective staffing benchmarks or limit the duration or frequency of lockdowns resulting from routine staffing shortages.

Complaints Received

OCO received multiple complaints from incarcerated individuals, family members, advocates, and members of the public regarding frequent lockdowns and service disruptions attributed to staffing shortages.

A complaint received on April 4, 2025, from a loved one of an individual incarcerated at York Correctional Institution stated:

> ***"Last one I experienced was actually 2 days ago. I came from Ohio to La Guardia, rented a car, made hotel arrangements only to find out once there that the facility is in inhuman lockdown for the whole week."***

A complaint received on June 15, 2025, from a member of the public reported:

> ***"Cheshire CI is still having lockdowns every Wednesday at 7 and calling it training. Their website states there's supposed to be visits at that time. That hasn't been the case since at least last July."***

On June 30, 2025, the OCO received a complaint from the mother of an individual incarcerated at Cheshire Correctional Institution, who reported that staffing thresholds directly determined the level of lockdown imposed:

> ***"My son tells me it is modified lockdown (no gym rec or outdoors) when there are less than 40 on staff; full lockdown when less than 25."***

The complainant documented the following incidents:

- **February 9, 2025:** "Many COs called out, full lockdown 1st or 2nd shift, no showers, no rec — this was Super Bowl Sunday."
- **March 28, 2025:** "Lockdown, not enough coverage, no library the only day they get it; no visitation".
- **April 19, 2025:** "1st shift no gym rec, not enough staff (Easter weekend)."
- **April 20, 2025**: "No gym rec, not enough staff."
- **May 11, 2025 (Mother's Day):** "I had phoned Friday to confirm normal visitation hours for Mother's Day; when I arrived Sunday morning, there was a sign all visitation for that day was cancelled; I phoned from the parking lot to ask why and was told 'facility needs.'"
- **May 16–17, 2025:** "No gym rec, not enough staff."
- **May 23, 2025**: "Modified rec 1st shift."
- **June 15, 2025**: "Lockdown all day 1st and 2nd shift, not enough staff."

A complaint received from an advocate on July 13, 2025, stated:

"I'm sure you're very well aware and constantly getting information—as I am—about all the lockdowns occurring at all the prisons. I can't imagine this is typical, even for summer. It seems things could easily boil over, when being locked in a cell with another random, often mentally ill person for most of every day, combines with the extraordinary heat and hardly being allowed outside—leading to cancellation of treasured visits with loved ones, religious services, and other important events. It's truly a recipe for an explosion!"

The advocate further noted:

"It's general perception that on or around a holiday, there will be modified rec or full lockdown due to low staff, hence why my expectation this weekend will be impacted."

Findings

- Based on complaints received, site visits, and direct observations, OCO finds that staffing shortages have had a substantial and recurring impact on facility operations during the reporting period.

- Modified and full lockdowns were frequently used as a management response to insufficient staffing, resulting in the suspension of visitation, recreation, education, medical services, hygiene access, and other core activities. These conditions affected not only incarcerated individuals but also staff, who were required to work extended hours under increasingly strained conditions.

Recommendations

While investigations into staffing-related lockdown practices at Cheshire Correctional Institution and York Correctional Institution remain ongoing, OCO identifies the following preliminary, system-level recommendations aimed at mitigating the operational impacts of staffing shortages:

Expand Temporary Staffing Pathways:
Department of Correction should explore the expanded use of temporary reemployment of retired state employees (rehired retirees), consistent with state retirement and reemployment provisions, to supplement staffing during periods of acute shortages. This may include retired correctional officers returning in temporary capacities at facilities where they previously worked, subject to applicable eligibility and earnings limitations.

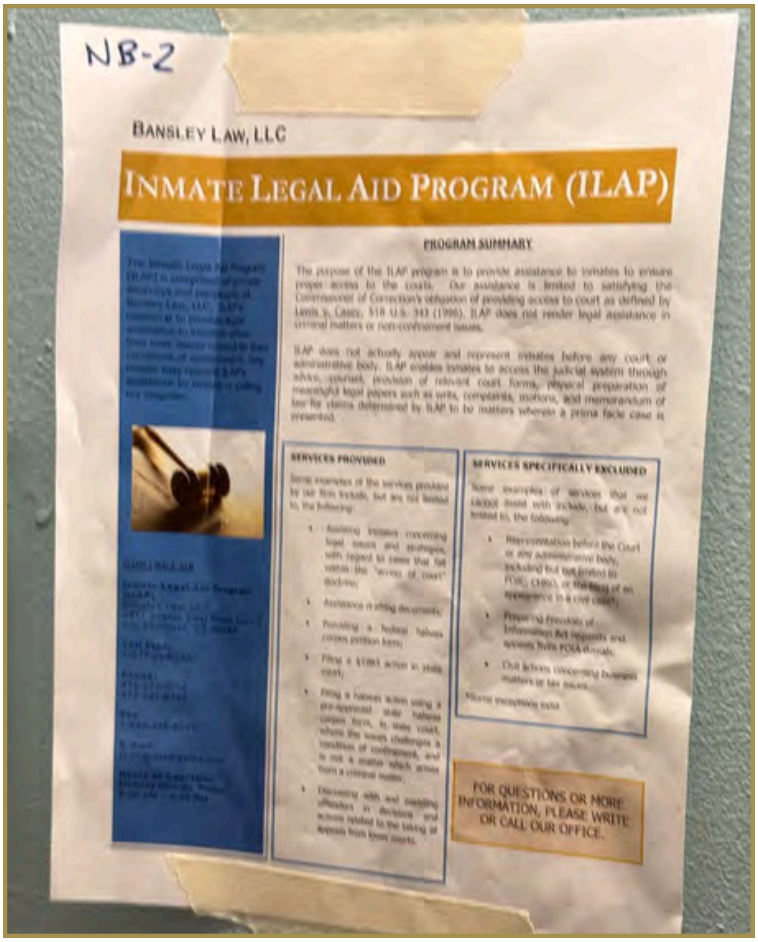
Broaden Non-Custody Support Roles:
DOC should assess opportunities to allow qualified counselors, addiction services workers, and other non-custody professionals to perform functions that do not require sworn custody authority, thereby reducing the operational burden on correctional officers and limiting the need for lockdowns driven by escort or supervision shortages.

Develop Contingency Staffing and Lockdown Mitigation Plans:
DOC should develop facility-specific contingency staffing plans that prioritize the continuation of core services—such as hygiene access, medical care, and visitation—during staffing shortages, and establish internal review mechanisms when lockdowns are repeatedly imposed for non-emergency staffing reasons.

Legal Services

Access to legal services is a foundational component of lawful confinement and a prerequisite to the meaningful exercise of constitutional rights. The United States Supreme Court has long recognized that incarcerated individuals must be afforded a "reasonably adequate opportunity" to present claimed violations of fundamental constitutional rights to the courts, either through access to law libraries or through alternative means such as legal assistance programs.[1]

While the Constitution does not guarantee appointed counsel or unfettered litigation, it does require that states provide a functional mechanism through which incarcerated individuals can research the law, prepare legal documents, and pursue nonfrivolous claims related to their convictions or conditions of confinement.[2]



Inmate Legal Assistance Program (ILAP) informational flyer at Cheshire Correctional Institution.

The complaints summarized below, coupled with observations from site visits and review of program data, raise serious questions regarding whether Connecticut's current Inmate Legal Assistance Program ("ILAP") and associated institutional practices are meeting this constitutional mandate in practice.

Inmate Legal Assistance Program (ILAP) Complaints Received During Reporting Period

During the reporting period, the Office of the Correction Ombuds ("OCO") received multiple complaints from incarcerated individuals regarding access to legal assistance, legal materials, and law library resources. These complaints were consistent across facilities and custody levels and were reinforced during OCO site visits.

On September 26, 2024, an individual housed at MacDougall–Walker Correctional Institution reported:

> ***"I wrote like 20 lawyers [regarding a medical grievance] but I never got a response back I even wrote ILAP they basically told me that I'm not going to get much out of the situation so I just left it alone cause I could not find any help."***

[1] Bounds v. Smith, 430 U.S. 817, 828 (1977).
[1] Lewis v. Casey, 518 U.S. 343, 351–55 (1996).

That same day, the OCO received an additional complaint from MacDougall–Walker stating:

> ***"The library is inadequate and is not kept updated with current events, information, applicable law. Inmate Legal Assistance Program (ILAP) is also inadequate. I know more and teach more to others then they do. They are more of a deterrence then assistance, should be called inmate legal deterrence program. What a waist of money, so a lot of condition of confinement issues goes unheard/unchallenged."***

On March 7, 2025, the OCO received a complaint from an individual housed at Corrigan Correctional Institution stating:

> ***"Every time I write to ILAP from this center, they never send me what I'm asking for. Can you look into the matter? I've written them twice, two times already while in the the RHU."***

On March 11, 2025, the OCO received a complaint from a legislator on behalf of a constituent whose son was incarcerated at Walker Correctional Institution and representing himself in court. According to the complaint, the incarcerated individual reported that he did not have access to the law library at MacDougall because he was assigned to the Walker Building, that his request for transfer to MacDougall was denied, and that he was advised that he *"must wait until he's convicted to gain access to the law library at MacDougall."*

In addition to formal complaints, during OCO site visits to York Correctional Institution in December 2024 and March 2025, incarcerated individuals raised concerns that the facility lacks a law library and that access to legal materials is limited. York is the State's only women's correctional facility, and the absence of a law library was repeatedly identified by incarcerated individuals as a barrier to accessing legal information and pursuing legal claims.

On March 11, 2025, in response to complaints regarding access to legal paperwork at Osborn Correctional Institution, the OCO contacted facility leadership. Facility staff reported that inmate library workers are not permitted to make copies and that legal documents must instead be copied by unit counselors, with form shortages addressed through school staff. These restrictions were attributed to security concerns, including prior instances of unauthorized copying of non-legal materials, and the absence of a librarian to review documents.

While acknowledging the importance of institutional security, the OCO raised concerns that requiring copies to be obtained exclusively through unit counselors may result in delays that impede timely access to courts or ILAP services, particularly in the absence of a functioning law library. Moreover, this structure may chill the filing of grievances or legal actions related to conditions of confinement, especially where staff involved in the copying or approval process may themselves be the subject of the grievance or contemplated litigation.

Program Structure and Constitutional Framework

The Department of Correction satisfies its constitutional obligation to provide incarcerated individuals with access to the courts through the Inmate Legal Assistance Program ("ILAP"), currently operated by Bansley Law LLC pursuant to a purchase-of-service contract. Under the current contract term, the State pays approximately $796,000 annually, with a maximum contract value of approximately $3.9 million over the two-year period.

ILAP is intended to provide legal assistance consistent with the standards articulated in Bounds v. Smith and Lewis v. Casey, including legal advice, assistance with court forms, and support related to conditions of confinement and habeas matters. The program does not generally provide court representation, and DOC has emphasized that Lewis does not require representation once access to the courts has been afforded.

Oversight History and Ongoing Investigation

The OCO initiated a comprehensive review of ILAP in 2024 in response to a growing volume of complaints regarding access to legal assistance, responsiveness, and the adequacy of legal resources across Department of Correction ("DOC") facilities. This review expanded during 2025 as concerns emerged regarding both the performance of the contractor, Bansley Law LLC, and the Department's administration and oversight of the ILAP contract.

Pursuant to Conn. Gen. Stat. § 18-81qq, the OCO reviewed ILAP's FY 2022–23 and FY 2023–24 Year-End Reports, monthly statistical submissions, and contract provisions governing performance, reporting, and cooperation with state oversight.

On July 31, 2025, the OCO issued a subpoena to Bansley Law LLC requesting production of records and testimony related to ILAP operations, reporting, staffing, caseloads, and compliance with contractual obligations. At Bansley's request, the OCO granted an extension and issued an amended subpoena on August 25, 2025, extending the compliance deadline to September 3, 2025.

On August 27, 2025, counsel for Bansley transmitted a written objection and asserted that the objection had been filed in Superior Court. The contractor thereafter declined to comply with either subpoena.

As a result of the contractor's refusal to produce records required by statute and by the ILAP contract—which independently mandates full cooperation with audits and inspections by the State and its agents—the OCO initiated enforcement proceedings in the Superior Court for the Judicial District of Hartford on October 8, 2025.

The initiation of litigation to obtain basic oversight records from a state contractor performing constitutionally significant services was an extraordinary step and materially delayed completion of the OCO's review.

On October 9, 2025, while enforcement proceedings were pending, the OCO issued interim recommendations to DOC pursuant to § 18-81qq. These recommendations included temporary suspension of the ILAP contract pending compliance with oversight obligations, withholding of payments until required reporting deficiencies were cured, and consideration of alternative service models following completion of the review. These recommendations were expressly framed as interim measures designed to secure cooperation and information necessary to complete the investigation, not as final determinations regarding ILAP's constitutional adequacy.

DOC responded by letter dated November 17, 2025, disputing aspects of the OCO's interpretation of performance metrics and asserting that ILAP satisfies the constitutional standard articulated in Lewis v. Casey. DOC acknowledged deficiencies in ILAP's reporting practices and advised that it had directed the contractor to begin including additional data points, including response times, case opening and closing intervals, and breakdowns of attorney and paralegal services. DOC further reported that between January 1 and September 30, 2025, ILAP staff generated 1,209 outgoing correspondences, initiated 656 telephone calls, and conducted ten visits to DOC Central Office to review preserved video evidence on behalf of 22 incarcerated individuals.

By correspondence dated December 9, 2025, DOC advised that it had received documentation from the contractor responsive to the OCO's records requests and declined to suspend the contract or withhold payments. DOC reiterated its position that ILAP is intended to provide assistance rather than representation and that case initiation and in-person visits are not constitutionally required in most circumstances.

Notwithstanding the Department's position, the OCO's investigation into ILAP remains ongoing. The OCO continues to evaluate the completeness and accuracy of records produced, the practical impact of ILAP's correspondence-based service model in light of documented delays in legal mail, and the relationship between reported performance metrics and the lived experience of incarcerated individuals seeking assistance. The OCO has also referred aspects of this matter to the State Contracting Standards Board, which has taken up review of the ILAP contract and associated oversight concerns.

The OCO emphasizes that its review is not limited to the actions of the contractor alone. The investigation also examines the structural implications of the Department of Correction serving as both the subject of conditions-of-confinement complaints and the purchaser and contract manager of legal services designed to facilitate those complaints.

Performance Data and Scope of Services

According to ILAP's Year-End Reports, 355 new incarcerated individuals contacted ILAP during FY 2022–2023, increasing to 471 new individuals in FY 2023–2024. During FY 2023–2024, ILAP reported 2,920 incoming written correspondences, 4,166 outgoing correspondences, 4,114 incoming telephone calls, and 2,023 outgoing telephone calls.

Despite this level of activity, ILAP reported initiating litigation in only four cases during FY 2022–2023 and two cases during FY 2023–2024, with zero court appearances in both fiscal years. As a result, litigation was initiated in less than one percent of matters in which incarcerated individuals sought assistance. DOC has asserted that this level of litigation activity is consistent with Lewis v. Casey and the scope of the ILAP contract.

While recognizing that court representation is not constitutionally mandated, the OCO notes that the extremely limited number of cases initiated, when viewed alongside the volume of requests for assistance and recurring complaints, raises questions regarding whether the current service model meaningfully supports access to the courts in practice, particularly for individuals housed in restrictive settings or seeking to challenge conditions of confinement.

Access to Legal Materials and Law Libraries

The OCO received recurring complaints regarding access to law libraries, legal forms, and copying services, particularly from individuals housed in units physically separated from designated law library locations

At present, four county correctional facilities and York Correctional Institution—the State's only women's correctional facility—do not have law libraries.

Resource center at Cheshire Correctional Institution.

The absence of a law library at York raises particular concern regarding equitable access to legal resources and potential differential treatment.

Library at Osborn Correctional Institution.

Findings and Recommendations

Findings:

- Access Concerns Raised by Incarcerated Individuals: Complaints and site-visit observations consistently reflect concerns regarding limited access to legal assistance, delays in receiving responses from ILAP, and difficulty obtaining legal materials, particularly for individuals housed in restrictive settings.

- Copying Practices and Chilling Effects: Facility-level copying practices requiring staff review or approval may delay access to courts and may chill the filing of grievances or legal actions related to conditions of confinement.

- Absence of Law Libraries: Four county correctional facilities and York Correctional Institution lack law libraries, a concern repeatedly raised during OCO site visits in December 2024 and March 2025.

- Limited Litigation Activity: Despite hundreds of incarcerated individuals seeking assistance annually, ILAP initiates litigation in fewer than one percent of matters and reports no court appearances.

- Oversight and Reporting Deficiencies: Contractor noncompliance with statutory and contractual oversight obligations materially impeded timely review and necessitated enforcement litigation.

- Structural Concerns: DOC's dual role as both the subject of conditions-of-confinement complaints and the purchaser and contract manager of legal services designed to facilitate those complaints raises concerns regarding structural independence and public confidence.

Library at Carl Robinson Correctional Institution.

Recommendations:

- Terminate the Inmate Legal Assistance Program (ILAP) contract at the conclusion of the current contract term, subject to completion of ongoing oversight and contracting review.

- Expand access to legal materials through Securus tablets, including state and federal judicial forms, supported by reliable printer availability and a uniform, statewide policy governing access and use.

- Establish or restore law libraries at the four county correctional facilities and at York Correctional Institution, staffed with inmate law clerks, to ensure equitable and meaningful access to legal resources.

- Beginning in May 2026, reevaluate the structure and administration of inmate legal services, including exploration of partnerships with the Office of the Public Defender or qualified legal service organizations, to satisfy Lewis and Bounds obligations while reducing actual or perceived conflicts of interest.


Library at Carl Robinson Correctional Institution.

Communication Services

During the reporting period, the Office of the Correction Ombuds ("OCO") received numerous complaints from incarcerated individuals and their loved ones regarding access to communication services within Department of Correction ("DOC") facilities. These complaints involved tablet availability and functionality, digital access, phone and electronic messaging reliability, customer service responsiveness, video visitation administration, and systemwide service disruptions.

DOC increasingly relies on technology-based communication platforms to facilitate family contact, deliver institutional information, support programming, and supplement or replace in-person visitation. As a result, failures in reliability, uneven implementation, or inadequate oversight of these systems have direct implications for conditions of confinement, access to courts, and institutional accountability.

This section addresses four related but distinct components of DOC communication services: (1) tablet-based digital access delivered through the JPay platform; (2) phone and electronic messaging services provided by Securus Technologies; (3) a systemwide communications outage that occurred in April 2025; and (4) video visitation services administered by DOC. Each component is addressed separately to distinguish vendor responsibility, operational challenges, and oversight findings.

Statutory and Administrative Authority

The Department of Correction possesses broad statutory and administrative authority to regulate, manage, and oversee inmate communications and visitation as part of its responsibility for the safe, secure, and orderly operation of correctional facilities. DOC exercises this authority through procurement contracts and Administrative Directives ("ADs"), including:

- **AD 10.7 – Inmate Visiting**, which governs visiting practices and authorizes DOC to regulate the manner, scheduling, and conditions of visitation, including video visitation as a regulated visiting modality.
- **AD 10.8 – Inmate Correspondence**, which governs communications between incarcerated individuals and persons outside the facility.
- **AD 10.10 – Inmate Telephone Calls**, which governs telephone access and authorizes DOC to contract with third-party providers, establish procedures, and oversee system operation.

Collectively, these directives establish DOC's authority and responsibility to select and oversee communication vendors, regulate the manner and method of communication, monitor system reliability, and ensure that communication services function consistently with security needs and institutional objectives. The existence of executed contracts, installed infrastructure, and established administrative authority demonstrates that current access limitations are not the result of statutory or regulatory prohibitions, but rather reflect policy, implementation, and oversight decisions.

Tablets, Digital Access, and Institutional Services

(JPay Platform)

Contract Overview

DOC utilizes a tablet-based platform operated through a system associated with JPay, Securus Technologies, to deliver inmate communication and digital services. Under the governing contracts, tablet hardware is structured as a loaner program and is provided at no direct cost to incarcerated individuals for initial issuance, with replacement available for malfunction not caused by intentional damage.

The contracts contemplate tablets functioning as a primary portal for communication with family, access to education and reentry content, receipt of institutional information, and participation in programming. The contracts also expressly contemplate access to law library and inmate legal assistance content at no additional cost through a DOC-supplied link embedded within the tablet interface.

Complaints and Access Concerns

Despite contractual provisions, OCO received repeated complaints that incarcerated individuals often wait extended periods to receive a tablet or are informed that tablets are unavailable due to backorders. Access was reported to vary significantly by facility, housing unit, and custody level. The contracts do not establish enforceable timelines for tablet distribution, minimum inventory requirements, or consequences for prolonged unavailability.

Because tablets function as a gateway to services that increasingly replace or supplement paper-based and in-person systems, prolonged delays in tablet access effectively deprive incarcerated individuals of communication, information, and programming services upon which DOC increasingly relies.

Kiosk Infrastructure Installed but Not Operationalized

The contracts also contemplate the use of inmate kiosks as part of the communication and digital services infrastructure. OCO confirmed that kiosk hardware has been installed throughout correctional facilities and housing units statewide. However, these kiosks were never operationalized.

As a result, kiosk units remain physically present but non-functional, occupying space without providing services. Incarcerated individuals consistently reported that kiosks are unusable and provide no access to communication or institutional services.

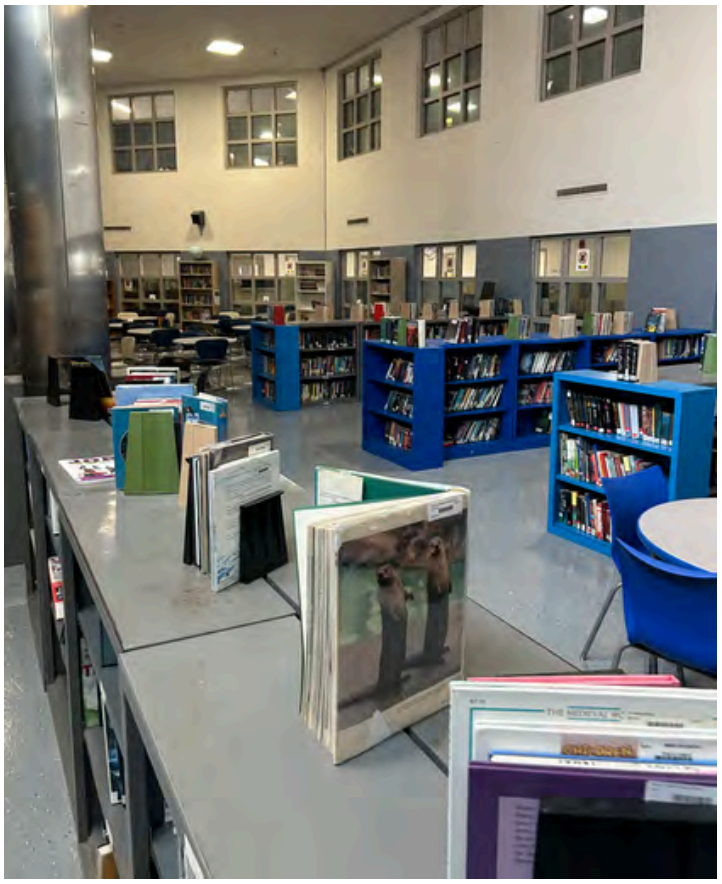
The contracts do not include enforceable activation requirements, minimum uptime standards, or corrective timelines once hardware is installed.

Inoperable Securus kiosks at Cheshire Correctional Institution and MacDougall Correctional Institution.

Law Library and Legal Materials

The contracts governing tablets expressly include access to law library and inmate legal assistance content at no additional cost. OCO nevertheless received persistent complaints that meaningful law library access through tablets is unavailable or non-functional, including broken or missing links, outdated materials, or the absence of digital legal resources altogether.

Where physical law library access is constrained by staffing shortages, lockdowns, or housing restrictions, the lack of functioning digital legal access may compound barriers to access to courts.



Law library at Manson Youth Institution.

Missed Opportunity: Paperless Grievances, Sick Call, and ADA Requests

In other correctional systems using the same platform, tablets are used to submit grievances, sick call requests, and medical concerns electronically. These systems reduce reliance on paper, generate auditable submission records, and allow agencies to track response times and wait periods.

Although Connecticut utilizes the same tablet platform, tablet-based submission for grievances, sick call, medical requests, or ADA requests has not been operationalized. Incarcerated individuals therefore continue to rely primarily on paper-based processes. OCO received complaints alleging delayed responses, uncertainty as to whether submissions were received, and difficulty tracking request status. Continued reliance on paper limits DOC's ability to monitor performance and identify systemic delays using infrastructure already in place.

Fee-Based Services and Revenue Sharing

While core services such as legal access, education, reentry content, and institutional communications are listed at no cost, the contracts authorize fee-based services, including entertainment content, printing, and media features, many of which involve revenue-sharing arrangements between the vendor and the State.

OCO observations indicate that fee-based services tend to be more consistently available than no-cost services tied to legal access, education, and institutional accountability. This structure raises concerns that financial incentives may unintentionally prioritize discretionary services over functions more directly related to rehabilitation, healthcare access, and legal rights.

Phone and Messaging Services

(Securus Technologies)

Complaints Received

OCO received multiple complaints describing recurring failures in phone and electronic messaging services provided by Securus Technologies, as well as significant barriers to customer service resolution.

October 21, 2025:

> ***"I am writing to formally report ongoing issues with Securus Technologies, the communication service used in Connecticut correctional facilities. These problems have significantly impacted my ability to communicate with my incarcerated loved one. Calls to customer service result in extremely long wait times, sometimes exceeding two hours, without ever reaching a representative.Representatives and supervisors I have spoken with have been consistently rude, dismissive, and unhelpful, showing no interest in resolving the issues. The Securus app frequently crashes, preventing video or phone communication. This appears to be a systemic issue affecting all users. I have attempted to address these issues directly with Securus, but my concerns were not resolved."***

February 28, 2025 (MacDougall–Walker Correctional Institution):

> ***"I am just sending an email in regards to an ongoing issue with the Securus system and not being able to contact my loved one on a consistent basis. The system constantly does not send messages back and forth the way it should and the Wi-Fi at MacDougall is constantly an issue, also the phones are not working. Over the course of the last 2–3 months, complaints have been given to admin, unit managers, COs, etc., and the inmates are told it's being fixed, but it will still be out for days at a time.It will work for maybe one or two days, then it goes down again.Currently, the Wi-Fi and phones have been out since Tuesday 2/25/25... There is never a solution....I would like to be able to reach my loved one and communicate with him."***

April 2025 Systemwide Communications Outage

(Securus Platform)

Timeline Summary

- **April 26–27, 2025:** OCO received multiple reports that inmate phone access was severely restricted statewide, including at MacDougall–Walker, Osborn, and Brooklyn Correctional Institutions.
- **April 28, 2025 (10:21 a.m.):** DOC Security advised internally: “This was a statewide issue that Securus has been handling all weekend…”
- **April 28, 2025:** DOC reported an unresolved system issue; no estimated time of resolution was available.
- **April 29, 2025 (2:40 p.m.):** DOC stated the issue was resolved while the vendor continued investigating.
- **May 13, 2025:** DOC Security later summarized the cause as: “A staff member inadvertently switched the amount of calls to 3.”

Observations

The April 2025 systemwide disruption resulted in incarcerated individuals statewide being limited to three phone calls per day for multiple days. DOC later confirmed that the restriction resulted from a manual system configuration change that propagated statewide through the Securus platform. While the systemwide disruption occurred during an active legislative session that included consideration of proposals affecting free electronic messaging services, OCO has identified no objective evidence establishing a causal link between legislative activity and the outage. The Office’s review of this incident remains ongoing.

The incident demonstrated that a single staff action was capable of materially restricting communication access across all facilities without immediate detection, notice to incarcerated individuals or families, or redundancy safeguards.

Video Visitation Services

(DOC-Administered via Microsoft Teams)

Overview and Complaints

DOC reported that video visitation is administered using Microsoft Teams at no cost to incarcerated individuals, family members, or the State. OCO nevertheless received multiple complaints describing canceled or missed visits despite timely participation.

November 29, 2024 (Corrigan Correctional Institution):

> ***"I wanted to let you know I DID NOT GET my video visit. I signed on 20 minutes before the call and they ignored me the entire 45 minutes. They didn't even greet me or check my ID."***

July 23, 2025 (Corrigan Correctional Institution):

> ***"I had a video call this morning at 9:30 a.m. and I was on the meeting at 9:20 a.m. waiting for them to let me in…I waited almost 30 minutes… and they canceled the visit…They told him I wasn't in the visit on time, when I was there 10 minutes before like I always do."***

OCO also reviewed correspondence regarding video visitation at Garner Correctional Institution describing limited simultaneous capacity facility-wide, resulting in frequent disruptions and failed connections. DOC acknowledged infrastructure limitations and indicated it was pursuing facility-wide Wi-Fi installation.

Complaint received on August 24, 2025, from loved one individual housed at York CI:

> ***"Sunday, August 24, at the last moment the scheduled video call with my daughter with her sister, her daughter, her nephews, and with me, her 78-year-old father was canceled without notice or reason. The explanation given: yet another lockdown.This has become routine. Arbitrary confinements are repeatedly imposed, canceling visits, calls, and activities, sometimes under the pretext of "security," when in reality they seem to cover up staff shortages and administrative failures.These are not protocols: they are abuses. To collectively punish incarcerated women is a violation of human rights and a reflection of a toxic institutional culture."***

Complaint received on September 12, 2025, loved one of individual housed at Garner CI:

> ***"I have a loved on a garner . Where I signed up for visits with him the communication at the facility is terrible because there is times they could just tell us that there's no visit. we sit in Video Visit for a long wait times sometimes the link along us out and we have to re-sign in every time we put in for a visit. It seems to get canceled, especially on weekends. Their facility has a lot of lockdowns then when you talk to people from the jail, they tell you they don't know what that means. That doesn't make sense if you work out of facility. It's bad enough we barely get communication."***

Observations

OCO observed inconsistency in video visitation administration across facilities. In addition to infrastructure and connectivity limitations, complaints suggested that staff availability, staff training, and local administrative practices contributed to missed or canceled visits.

Findings

OCO finds that:

- Communication service disruptions are recurring and systemic, materially impairing family contact across facilities.
- Tablet access and digital services are contractually available but inconsistently accessible in practice.
- Kiosk infrastructure was installed statewide but never operationalized.
- Digital law library access exists contractually but is often unavailable in practice.
- Tablet-based grievance, sick call, medical, and ADA request systems remain unused, preserving less transparent paper-based processes.
- Video visitation lacks consistent reliability and administration, resulting in canceled or missed visits even where families comply with requirements.
- The April 2025 outage revealed insufficient safeguards against statewide service restrictions caused by manual system configuration changes.
- Oversight mechanisms emphasize contractual compliance over user-centered access and reliability.

Because communication services are now integral to family contact, legal access, and institutional operations, persistent failures in these systems directly affect conditions of confinement and warrant continued legislative oversight.

Recommendations

The Office of the Correction Ombuds recommends that the Department of Correction:

- Adopt minimum tablet distribution timelines and inventory standards to ensure timely and equitable access across facilities and housing units.
- Activate tablet-based law library access statewide, including access to Inmate Legal Assistance Program (ILAP) forms, Connecticut General Statutes, and publicly available forms from the Connecticut Judicial Branch.
- Pilot electronic submission of grievances, sick call, medical, and ADA requests through tablets to improve transparency, tracking, and institutional accountability.
- Implement uniform protocols and staff training standards for video visitation administration to reduce inconsistencies and prevent avoidable cancellations or missed visits.
- Strengthen safeguards against systemwide service restrictions resulting from single manual configuration changes, including approval controls, auditing, and automated alerts.

Staff Professionalism and Institutional Integrity

Correctional facilities are inherently coercive environments in which staff exercise substantial authority over nearly every aspect of incarcerated individuals' daily lives, including movement, access to services, safety, and the ability to raise concerns. In such settings, staff professionalism and institutional integrity are essential to maintaining legitimacy, safety, and public trust. When staff conduct, symbolism, or operational decisions reasonably convey bias, favoritism, or hostility, they undermine residents' trust in institutional processes, discourage engagement with unit management, and chill access to grievance and oversight mechanisms.

This section addresses concerns related to staff professionalism, neutrality, retaliation, and institutional conduct that directly affect the integrity of correctional operations and residents' ability to access services without fear of bias or reprisal.

Statutory and Administrative Authority

The issues discussed in this section implicate the Department of Correction's obligations under multiple administrative directives governing staff conduct, professionalism, and accountability.

Administrative Directive 1.2 – Code of Ethics

Establishes expectations that DOC employees act with integrity, impartiality, and professionalism, and avoid conduct that undermines public confidence in the agency.

Administrative Directive 1.3 – Employee Conduct

Requires employees to conduct themselves in a manner that reflects favorably on the Department, both on and off duty, and prohibits conduct that compromises safety, order, or institutional integrity.

Administrative Directive 2.17 – Standards of Conduct

Sets forth behavioral standards for staff, including professionalism, respect, and adherence to departmental rules and procedures.

Administrative Directive 2.26 – Social Media

Governs staff use of social media and prohibits the posting of confidential information related to incarcerated individuals, staff, or facilities, as well as content that undermines the integrity or reputation of the Department.

Administrative Directive 6.6 – Inmate Grievance Procedure

Establishes the grievance system through which incarcerated individuals may raise concerns without fear of retaliation.

Administrative Directive 10.7 – Security Procedures and Post Assignments

Addresses staff responsibilities regarding post coverage, security procedures, and adherence to assigned duties.

Complaints

OCO received multiple complaints alleging conduct by correctional staff that undermined professional neutrality, institutional integrity, and residents' ability to access services without fear of reprisal. The following complaints are reproduced verbatim:

> ***"On October 22, 2025, at MacDougall Correctional Institution, a piano and violin musical program was presented to incarcerated residents. Following the conclusion of the program, a separate musical performance was held exclusively for correctional officers. In order to allow staff to attend this program, residents were placed on lockdown and denied access to recreation, the gym, and showers."***
>
> ***"2/9/25: Many correctional officers called out. Full lockdown first or second shift. Noshowers, no recreation. This was Super Bowl Sunday."***

OCO also received correspondence from legal counsel following a resident's engagement with the Office of the Correction Ombuds concerning a medical issue, which stated:

> ***"After you spoke with my client, he is now facing consequences with the correctional officers that appear to be in direct retaliation for his reaching out. Officers have made statements such as 'you threw us under the bus' and 'now you're in for it.'"***

Additional complaints alleged that facilities were placed on lockdown to accommodate staff holiday parties, retirement celebrations, or funerals of staff members' family members, resulting in the cancellation of recreation, programming, and showers.

Observations

During site visits, OCO directly observed the display of political and ideological symbols within Department of Correction facilities, including "Don't Tread on Me" (Gadsden) flags and "Blue Lives Matter" or thin blue line flags. These displays were observed in resident-facing areas, including on unit manager office doors.

OCO observed conduct inconsistent with professional standards, including staff parking in designated handicapped spaces and reports of officers leaving assigned posts during shifts to attend to personal matters.

In November 2025, following an incident involving a staff assault, OCO directly observed protected health information concerning the staff member's injuries being posted and circulated within correctional facilities to solicit financial contributions.

Unit manager office door at MacDougall Correctional Institution.

OCO also became aware of social media posts by DOC staff following a death by suicide in November 2025 that celebrated deaths in custody or expressed derogatory views toward incarcerated individuals. DOC leadership subsequently issued a statewide reminder emphasizing professional conduct and adherence to social media policy.

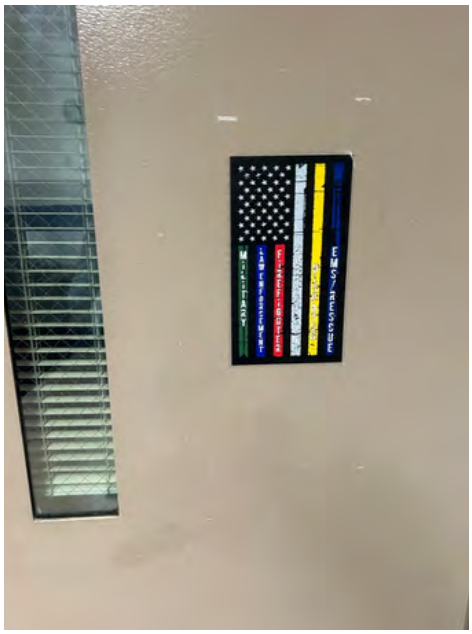
In addition, DOC staff have confidentially conveyed to OCO that incarcerated individuals are often retaliated against—both overtly and subtly—for speaking with OCO or seeking external oversight.

Flag displayed in kitchen area at Osborn Correctional Institution.

Unit manager office door at Osborn Correctional Institution.

Vehicle parked in a handicap-designated space without visible permit at MacDougall Correctional Institution.

Vehicle parked in a handicap-designated space without visible permit at Walker Correctional Institution.



Unit manager office door at Cheshire Correctional Institution.

Findings

OCO finds that:

- Political and ideological symbols were displayed in resident-facing areas, including on unit manager doors, undermining professional neutrality and institutional integrity.
- Lockdowns were imposed for non-security purposes, resulting in the denial of basic services and erosion of institutional legitimacy.
- Retaliation against residents for engaging with oversight entities remains a persistent concern, corroborated by confidential staff disclosures.
- Unprofessional conduct, including abandonment of posts and misuse of facility resources, negatively affects facility operations and trust.
- Protected health information was improperly disseminated within correctional facilities, reflecting significant boundary violations.
- Staff social media conduct following a death by suicide in November 2025 undermined institutional legitimacy and required intervention by DOC leadership.

Recommendations

OCO recommends that the Department of Correction:

- Immediately remove all political and ideological displays from all correctional facilities, including but not limited to “Blue Lives Matter,” thin blue line, and “Don’t Tread on Me” (Gadsden) flags, from all resident-facing and staff areas.
- Restrict the use of lockdowns to legitimate security or operational necessity, and prohibit lockdowns for staff convenience, celebrations, or non-emergency events.
- Strengthen anti-retaliation protections by developing clearer and more explicit guidance defining retaliation, including specific examples of prohibited conduct—such as hostile remarks, increased scrutiny, adverse housing or program changes, or other actions reasonably perceived as punitive following contact with oversight entities—and enforce these standards through training, supervision, and accountability mechanisms.
- Reinforce professional conduct standards, including requirements related to post assignments, appropriate use of facility resources, and compliance with accessibility and parking requirements.
- Prohibit the dissemination of protected health information or other sensitive personal information within correctional facilities, regardless of intent.
- Enhance training and enforcement of social media policies, with emphasis on the impact of staff online conduct on institutional legitimacy and public trust.

Connecticut Office of Correction Ombudsman
55 Farmington Avenue, Suite 427
Hartford, CT 06105
Correction.Ombuds@ct.gov