U.S. DEPARTMENT OF HOMELAND SECURITY

OFFICE OF INSPECTOR GENERAL

OIG-25-22 May 1, 2025

FINAL REPORT

Results of an Unannounced Inspection of Nye County Detention Center in Pahrump, Nevada

OFFICE OF INSPECTOR GENERAL

U.S. Department of Homeland Security

Washington, DC 20528 | www.oig.dhs.gov

May 1, 2025

MEMORANDUM FOR: Todd M. Lyons
Acting Director
U.S. Immigration and Customs Enforcement

FROM: Joseph V. Cuffari, Ph.D.
Inspector General

JOSEPH V CUFFARI
Digitally signed by JOSEPH V CUFFARI
Date: 2025.05.01 08:19:04 -07'00'

SUBJECT: *Results of an Unannounced Inspection of Nye County Detention Center in Pahrump, Nevada*

Attached for your action is our final report, *Results of an Unannounced Inspection of Nye County Detention Center in Pahrump, Nevada.* We incorporated the formal comments provided by your office.

The report contains 11 recommendations aimed at improving care of detainees at Nye County Detention Center. However, in November 2024, ICE leadership terminated its contract with Nye County and no longer houses detainees at the facility. Your office did not concur or non-concur with all 11 recommendations. Because ICE no longer houses detainees at the facility, we have administratively closed all recommendations. No further reporting is necessary. If ICE signs a new contract and resumes housing detainees at Nye, we reserve the option to reopen all recommendations.

Consistent with our responsibility under the *Inspector General Act,* we will provide copies of our report to congressional committees with oversight and appropriation responsibility over the Department of Homeland Security. We will post the report on our website for public dissemination.

Please contact me with any questions, or your staff may contact Thomas Kait, Deputy Inspector General at (202) 981-6000.

Attachment

DHS OIG HIGHLIGHTS

Results of an Unannounced Inspection of Nye County Detention Center in Pahrump, Nevada

May 1, 2025

Why We Did This Inspection

In accordance with the *Department of Homeland Security Appropriations Act, 2024* (Pub. L. 118-47), we conduct unannounced inspections of ICE detention facilities to ensure compliance with detention standards. From July 30 to August 1, 2024, we conducted an in-person, unannounced inspection of ICE's Nye County Detention Center in Pahrump, Nevada.

What We Recommend

We made 11 recommendations to improve ICE's oversight of detention facility management and operations at Nye.

For Further Information:
Contact our Office of Public Affairs at (202) 981-6000, or email us at: DHS-OIG.OfficePublicAffairs@oig.dhs.gov.

What We Found

During our unannounced inspection of U.S. Immigration and Customs Enforcement's (ICE) Nye County Detention Center (Nye) in Pahrump, Nevada, we found that Nye's staff complied with National Detention Standards 2019 (NDS 2019) for classification, access to law library and legal services, segregation, and use of force. However, facility and ICE staff did not fully comply with standards related to medical care, grievances, staff-detainee communication, facility conditions, and telephone access.

We found that Nye medical staff did not perform transfer screening, indicate necessary follow-up care for abnormal vital signs and other health complaints, or accurately log its sharp instruments. We also found that Nye and ICE staff did not always provide timely responses to detainee grievances and requests. Finally, telephones in detainee housing units did not work, preventing detainees from making calls to ICE Enforcement and Removal Operations, free legal service providers, consular officials, and the Department of Homeland Security Office of Inspector General.

ICE's Response

Effective November 5, 2024, ICE removed all detainees from Nye and on November 18, 2024, formally terminated its contract with Nye. Due to these events, ICE neither concurred nor non-concurred with our 11 recommendations, and we are administratively closing all recommendations. If ICE signs a new contract and resumes housing detainees at Nye, we reserve the option to reopen all recommendations.

Background

U.S. Immigration and Customs Enforcement (ICE) houses detainees at roughly 109 facilities nationwide, and the conditions and practices at those facilities can vary greatly. ICE must comply with detention standards and establish an environment that protects the health, safety, and rights of detainees. Facilities that house ICE detainees must adhere to applicable detention standards, including the *National Detention Standards 2019* (NDS 2019). As mandated by Congress,[1] we conduct unannounced inspections of ICE detention facilities to ensure compliance with detention standards.

ICE began housing detainees at the Nye County Detention Center (Nye) in Pahrump, Nevada, in 2019 until November 5, 2024, when it removed all detainees due to Nye County's inability to reach agreement on a contract with the facility's medical provider.[2] The Nye County Sheriff's Office operates the facility, which houses county inmates. At the start of our inspection, Nye housed 60 male detainees and relied on a private contractor to provide medical care to both detainees and inmates.

The Office of Inspector General inspection team included inspectors and contracted medical professionals. We toured and inspected areas of the facility, including general housing units, kitchen, law library, special management unit,[3] recreation facilities, and the medical unit. During our inspection, we also collected and analyzed documents related to detainee requests and grievances, detention files, and special management unit records. The contracted medical professionals' inspection included a visual inspection of all areas where medical staff provide health services, document and health record reviews, and interviews with key health services team members.

Results of Inspection

During our unannounced inspection of Nye, we found facility staff complied with NDS 2019 standards for classification, access to law library and legal services, segregation, and use of force. However, facility and ICE staff did not fully comply with standards related to medical care, the grievance system, staff-detainee communication, facility conditions, and telephone access.

[1] *Joint Explanatory Statement Accompanying H.R. 2882, Further Consolidated Appropriations Act, 2024, Div. C, Department of Homeland Security Appropriations Act, 2024* (Pub. L. 118-47).
[2] On November 18, 2024, ICE officially terminated its contract with Nye County.
[3] ICE uses special management units to house detainees in segregation. Segregation is the process of separating certain detainees from the general population for disciplinary or administrative reasons.

Table 1. Summary of Areas of Non-Compliance from OIG's Unannounced Inspection of ICE's Nye County Detention Center in Pahrump, Nevada

Standard	Non-Compliance
Medical Care	**Facility Staff Did Not Comply with All Medical Standards Reviewed** • Nye medical staff did not perform transfer screening. • Nye medical staff repackaged unused medications. • Nye medical staff did not indicate necessary follow-up care for abnormal vital signs and other health complaints. • Nye medical staff did not accurately log its sharp instruments and reconcile inventory of these items weekly.
Grievance System	**Facility Staff Did Not Comply with All Grievance Standards Reviewed** • Nye staff did not always provide responses to detainee grievances within the required 5 days. • Nye staff did not report an allegation of facility staff misconduct to ICE.
Staff-Detainee Communication	**Nye and ICE Staff Did Not Comply with All Staff-Detainee Communication Standards** • Nye and ICE staff did not always respond to detainee requests in a timely manner. • Facility staff did not update ICE Enforcement and Removal Operations (ERO) contact information posted in detainee housing units.
Facility Conditions	**Nye Staff Did Not Comply with All Cleanliness and Sanitation Standards** • The sink in a segregation cell did not work properly, preventing a detainee from accessing potable water. • Medical staff did not clean the medical isolation room between medical isolation stays.

Source: Department of Homeland Security OIG analysis of key findings

Nye Staff Did Not Comply with All Medical Standards Reviewed

We found that Nye staff complied with medical standards for program administration, infectious disease prevention and control, suicide prevention and intervention, medication services, mental health screening and evaluation, non-emergency health care requests, and staffing.[4] However, Nye did not fully comply with medical standards for transfer screening, delivery of medication, health assessments, and safe handling of sharp instruments. These

[4] The Health Service Administrator limited the inspection team and medical contractors' access to medical areas. We discuss this issue in Appendix A: Objective, Scope, and Methodology.

deficiencies increase the risk of inadequate medical care, potential medication errors, and safety hazards for both staff and detainees.

Nye Medical Staff Did Not Perform Detainee Transfer Screening

NDS 2019 requires facilities to give advance notice to medical staff personnel prior to transferring a detainee to another facility so medical staff can provide any medical needs — such as health records and medication — to the receiving facility.[5] Nye and ICE staff did not inform medical staff of their intent to transfer detainees to other facilities. As a result, medical staff did not provide detainees' health records to receiving facilities, nor did they provide detainees with their medications when ICE transferred them to other facilities.

Nye Medical Staff Repackaged Unused Medications

NDS 2019 requires facilities to distribute medications according to specific instructions or procedures established by the health care provider and consistent with state laws and regulations.[6] U.S. Food and Drug Administration (FDA) guidance[7] recommends only licensed pharmacists repackage prescription medication. Our medical contractors observed Nye staff, who were not licensed pharmacists, repackaging[8] medications, potentially increasing the risk of medication errors.

Nye Medical Staff Did Not Indicate Necessary Follow-up Care for Abnormal Vital Signs and Other Health Complaints in Detainees' Health Assessments

NDS 2019 requires facilities to conduct and document a comprehensive health assessment on each detainee within 14 days of the detainee's arrival.[9] Our medical contractors reviewed 30 detainee medical files and found the health assessments for 15 detainees showed abnormal vital signs or health complaints, including elevated blood pressure, anxiety, hemorrhoids, and leg swelling. Nye medical staff did not indicate necessary follow-up care required for these detainees, increasing the risk of medical complications and worsening conditions.

[5] NDS 2019, Section 4.3 (II) (Q).
[6] NDS 2019, Section 4.3 (II) (L).
[7] *Repackaging of Certain Human Drug Products by Pharmacies and Outsourcing Facilities: Guidance for Industry*, FDA, January 2017.
[8] The FDA defines repackaging as the act of taking a finished drug product from the container in which it was distributed by the original manufacturer and placing it into a different container without further manipulation of the drug.
[9] NDS 2019, Section 4.3 (II) (E).

Nye Medical Staff Did Not Accurately Log Its Sharp Instruments and Reconcile Inventory of These Items on a Weekly Basis

NDS 2019 requires facilities to establish procedures to provide for the safe handling and disposal of needles and other potentially sharp instruments to prevent injury and to keep a running inventory of those items that is reconciled weekly.[10] While inventorying the sharp medical instruments in the stock room, the medical contractors found the log did not match the facility's inventory and staff had not reconciled it weekly. This discrepancy increases the risk of lost or misplaced sharp instruments, potentially compromising staff and detainee safety.

Nye and ICE Staff Did Not Comply with All Grievance Standards

NDS 2019 requires recordkeeping and file maintenance for detainee grievances, which requires "[a]t a minimum, the facility will maintain a Detainee Grievance Log."[11] To ensure compliance with this standard, we requested records of detainee grievances for the 6-month period preceding our inspection. The facility's log included both detainees and inmates, and facility staff could not separate the two populations without conducting a lengthy manual review. As an alternative, we provided the facility with 30 detainee names to search, but their search did not yield enough detainee grievances for analysis. We then requested all detainee grievances in sample 3-day time periods for each of the 6 months preceding our site visit. From these combined requests, we obtained 17 grievances for our analysis.

Nye and ICE Staff Responded Appropriately to Detainee Grievances but Did Not Respond to All Grievances in a Timely Manner

NDS 2019 requires facilities to establish a process to address grievances within 5 days.[12] This requirement ensures facility and ICE staff address detainee concerns in a timely manner, so they do not escalate. We reviewed the 17 detainee grievances and found that ICE and facility staff generally responded in an appropriate manner, but they took 8 days to respond to 2 (12 percent) grievances. ICE and facility staff responded to the other 15 grievances within 2 days of submission.

Nye Staff Did Not Report an Allegation of Facility Staff Misconduct to ICE

NDS 2019 requires facilities to "forward all detainee grievances containing allegations of staff misconduct to ICE."[13] This requirement ensures ICE performs an independent review of staff

[10] NDS 2019, Section 1.1 (II) (H) (2).
[11] NDS 2019, Section 6.2 (II) (E).
[12] NDS 2019, Section 6.2 (I), 6.2 (II) (A) (2) (a).
[13] NDS 2019, Section 6.2 (II) (F).

misconduct allegations. During our review of facility grievances, we found a detainee allegation related to facility staff misconduct. Specifically, the grievance alleged that an officer removed a curtain the detainee had hung to maintain privacy while using the bathroom. In its response to the grievance, facility staff said they reviewed the video surveillance footage and determined the detention officer did nothing wrong. However, because the detainee had alleged misconduct by a staff member, the facility should have forwarded the allegation to ICE for review. ICE personnel confirmed they were unaware of the allegation and that the facility had not notified them as required.

Nye and ICE Staff Did Not Comply with All Staff-Detainee Communication Standards

Per NDS 2019, "detainees shall have frequent opportunities for formal and informal contact with facility staff, including managerial and supervisory staff. Facility staff will address detainees in a professional and respectful manner."[14] To ensure compliance with this standard, while on site we requested records of detainee requests for the 6-month period preceding our inspection. However, like our request for a grievance log, facility staff could only provide a log for the entire facility, which included requests from county inmates. As an alternative, we provided the facility with 30 detainee names to search, but their search did not yield enough detainee requests for analysis. We made an additional request for all detainee requests made in sample 3-day time periods from each of the 6 months preceding our site visit. From this, we received 20 detainee requests for our analysis.

Nye and ICE Staff Responded Appropriately to Detainee Requests but Did Not Respond to All Requests in a Timely Manner

NDS 2019 states procedures must be in place to allow for formal and informal contact between detainees, ICE staff, and facility staff and shall permit detainees to make written requests to ICE staff and receive an answer in an acceptable timeframe.[15] NDS 2019 does not specify a timeframe. For our analysis, we chose a response time of 5 business days. We reviewed the 20 detainee requests and found that ICE and the facility appropriately responded to all requests. Nye staff and ICE staff did not respond to 2 (10 percent) requests within 5 days. Instead, they responded within 10 and 22 days respectively. They responded to the remaining 18 requests within 4 days of receipt.

[14] NDS 2019, Section 2.10 (II) (A).
[15] NDS 2019, Section 2.10 (I).

Facility Staff Did Not Update ICE ERO Contact Information Posted in Detainee Housing Units

NDS 2019 states, "[t]he facility shall provide contact information for ICE ERO and the scheduled hours and days that ICE ERO staff is available to be contacted by detainees at the facility."[16] To comply with this requirement, ICE posts the scheduled hours and ICE contact information on a flyer in detainee common areas. During our on-site visit, we observed outdated and incorrect ICE ERO contact information on these flyers, making it more difficult for detainees to contact ICE ERO staff. Once informed of the finding, on-site ICE ERO staff updated the postings during our onsite visit.

Facility Staff Did Not Fully Comply with Standards of Environmental Health and Safety

NDS 2019 states, "facility cleanliness and sanitation shall be maintained. All surfaces, fixtures, and equipment shall be kept clean and in good repair."[17] Additionally, detainees must have access to potable water.[18] During our inspection, we observed two sinks requiring repair. In one segregation cell, a detainee could not access potable water because the sink faucet only produced small amounts of water as shown in Figure 1. In a general population dorm, detainees could not prevent a faucet from continuously flowing, creating a potential safety hazard. We also observed that shower curtains throughout the facility did not prevent water from leaking onto the floor, potentially creating hazardous conditions.

[16] NDS 2019, Section 2.10 (II) (C) (4).
[17] NDS 2019, Section 1.1 (II) (I) (2).
[18] NDS 2019, Section 1.1 (II) (F).

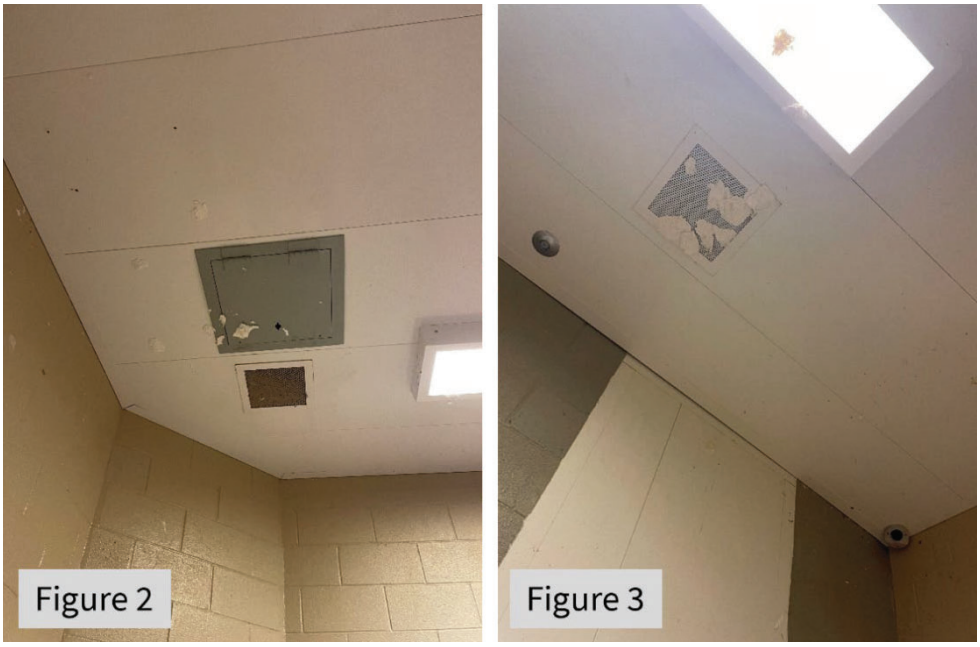
Figure 1. Broken Sink in Segregation Cell, Observed on July 31, 2024

Source: DHS OIG photo

NDS 2019 also states, "the medical facility will be kept clean and in working order."[19] During our inspection, we observed that medical staff did not clean the medical isolation room in between medical isolation stays. Additionally, wads of soaked toilet paper were stuck to the ceiling as shown in Figures 2 and 3, and there was graffiti on the walls throughout much of the room. Failure to thoroughly clean medical isolation rooms in between detainee stays increases the risk of disease transmission and other safety hazards for detainees and medical staff.

[19] NDS 2019, Section 1.1 (II) (I) (2).

Figures 2-3. Unclean Medical Isolation Room, Observed on July 31, 2024



Source: DHS OIG photos

Facility Staff Did Not Ensure Detainees Could Place Outgoing Calls to Support Entities

NDS 2019 requires facilities to allow for direct and free calls to many entities, including ICE ERO, free legal service providers, consular officials, and DHS OIG.[20] While on site, we found that detainees could not call these entities because the telephones did not permit outgoing calls. Detainees' inability to access working telephones may have prevented them from seeking legal assistance or contacting OIG and consular officials, potentially violating their rights.

Recommendations

Because ICE is no longer housing detainees at Nye,[21] we are administratively closing our recommendations upon report issuance. If ICE signs a new contract and resumes housing detainees at Nye, we reserve the option to reopen all recommendations.

[20] NDS 2019, Section 5.4 (II) (E).
[21] On November 7, 2024, ICE informed us via email that on November 5, 2024, it removed all detainees from Nye because Nye County was unable to reach a contract agreement with the facility's medical provider. On November 18, 2024, ICE terminated its contract with Nye.

We recommend the Executive Associate Director of Enforcement and Removal Operations direct the Salt Lake City Field Office, responsible for Nye:

Recommendation 1: Inform medical staff in the event of detainee transfers so they can provide a health record to the accepting facility and medication to detainees.

Recommendation 2: Ensure detainees' comprehensive health assessments indicate necessary follow-up care for abnormal vital signs and other health complaints.

Recommendation 3: Ensure sharp instruments are properly counted and inventories are reconciled at least weekly.

Recommendation 4: Ensure Nye staff maintain a separate detainee grievance log to document grievances, responses, and timeliness.

Recommendation 5: Provide responses to detainee grievances within 5 days.

Recommendation 6: Ensure Nye staff forward all detainee grievances containing allegations of staff misconduct to ICE.

Recommendation 7: Provide responses to detainee requests within 5 days.

Recommendation 8: Maintain a separate detainee request log to document response and timeliness to ensure proper oversight of the detainee request process.

Recommendation 9: Ensure telephones in detainee dorms are operational.

Recommendation 10: Ensure that sinks are working and shower water does not create potentially hazardous conditions in the facility.

Recommendation 11: Ensure that the medical isolation room is kept clean.

Management Comments and OIG Analysis

ICE provided written comments in response to the draft report and did not concur or non-concur with all 11 recommendations. Appendix B contains ICE's management comments in their entirety. ICE provided no technical comments on the draft report and affirmed there were no sensitivity concerns. Because ICE terminated its contract with Nye County, we have administratively closed all recommendations. If ICE signs a new contract and resumes housing detainees at Nye, we reserve the option to reopen all recommendations.

Appendix A:
Objective, Scope, and Methodology

The Department of Homeland Security Office of Inspector General was established by the *Homeland Security Act of 2002* (Pub. L. No. 107–296) by amendment to the *Inspector General Act of 1978*.

As mandated by Congress,[22] we conduct unannounced inspections of ICE detention facilities to ensure compliance with detention standards. We analyze various factors to determine which facilities to inspect. We review OIG Hotline complaints, prior inspection reports, and inspection schedules of other ICE and DHS inspection organizations. We also consider requests, input, and information from Congress and the DHS Office of Civil Rights and Civil Liberties to determine which facilities may pose the greatest risks to the health and safety of detainees. Finally, to ensure we review facilities with both large and small detainee populations in geographically diverse locations, we consider facility type (e.g., service processing centers, contract detention facilities, and intergovernmental service agreement facilities) and applicable detention standards.

We generally limit our scope to the NDS 2019 standards for health, safety, medical care, grievances, classification, use of segregation, use of force, and staff training.

Prior to our inspection, we reviewed relevant background information for Nye, including:

- OIG Hotline complaints;
- ICE NDS 2019; and
- ICE Office of Detention Oversight reports and other inspection reports.

Our objective was to determine whether Nye complied with select standards outlined in NDS 2019.

From July 30 to August 1, 2024, we conducted an unannounced, in-person inspection of Nye. During our inspection, we:

- inspected areas detainees used;
- reviewed the facility's compliance with key health, safety, and welfare requirements;
- interviewed ICE and detention facility staff;
- interviewed detainees; and
- reviewed documentary evidence, including medical files (reviewed by medical

[22] *Joint Explanatory Statement Accompanying H.R. 2882, Further Consolidated Appropriations Act, 2024, Div. C, Department of Homeland Security Appropriations Act, 2024* (Pub. L. 118-47).

contractors), grievances, and communication logs and files.

Per Management Directive 077-03, *Engagement by and Cooperation with the Office of Inspector General*, inspected entities must grant DHS OIG unrestricted access to personnel, documents, and facilities, ensuring a comprehensive and independent ability to conduct evaluations. Nevertheless, while on site, the Health Service Administrator limited the inspection team and medical contractors' access to medical areas, including the medicine room and medical staff (registered nurses, medical assistants, mental health professionals, and providers). We elevated access issues to facility and OIG leadership and gained the minimal access required to evaluate compliance with standards. Despite this, during our on-site inspection, our medical contractors were unable to observe medication passes, sick call clinics, and administrative segregation rounds. Instead, the medical team relied on documentation review to assess compliance in these areas.

We conducted this inspection under the authority of the *Inspector General Act of 1978*, 5 U.S.C. §§ 401–424, and according to the *Quality Standards for Inspections and Evaluations*, issued by the Council of the Inspectors General on Integrity and Efficiency.

DHS OIG's Access to DHS Information

During this inspection, ICE provided timely responses to our requests for information and did not delay or deny access to information we requested. However, the Health Service Administrator, who was contracted by Nye County, impeded our medical team's access while on site, which limited the scope of some elements of their review, as described above. Regional ICE personnel and facility leadership assisted us with efforts to resolve this issue during our inspection.

Appendix B:
ICE Comments on the Draft Report

Office of the Chief Financial Officer

U.S. Department of Homeland Security
500 12th Street, SW
Washington, D.C. 20536

U.S. Immigration and Customs Enforcement

BY ELECTRONIC SUBMISSION

April 9, 2025

MEMORANDUM FOR: Joseph V. Cuffari, Ph.D.
Inspector General

FROM: Jennifer Cleary
Chief Financial Officer and
Senior Component Accountable Official
U.S. Immigration and Customs Enforcement

JOSE M FABRE Digitally signed by JOSE M FABRE Date: 2025.04.09 13:00:19 -04'00'

SUBJECT: Management Response to Draft Report: "Results of an Unannounced Inspection of Nye County Detention Center in Pahrump, Nevada" (Project No. 24-002-ISP-ICE(c))

Thank you for the opportunity to comment on this draft report. U.S. Immigration and Customs Enforcement (ICE) appreciates the work of the Office of Inspector General (OIG) in planning and conducting its review and issuing this report.

ICE leadership is pleased to note OIG's positive recognition that during OIG's unannounced inspection conducted more than eight months ago of the Nye County Detention Center (Nye) OIG found that Nye's staff complied with National Detention Standards 2019[1] for classification, access to law library and legal services, segregation, and use of force. OIG also acknowledged that "ICE provided timely responses to requests for information and did not delay or deny access to information requested" during this inspection. Further, OIG credited ICE personnel with helping resolve an access issue with a Nye County contractor. ICE remains committed to enforcing the nation's immigration laws in a fair and effective manner, and securing individuals in custody while ensuring that detainees are provided safety, security, and a humane environment.

[1] "2019 National Detention Standards for Non-Dedicated Facilities," available at: https://www.ice.gov/doclib/detention-standards/2019/nds2019.pdf.

www.ice.gov

ICE, however, does not fully understand why the OIG has insisted on including 11 recommendations in this report while acknowledging at the same time that all of the recommendations have been overcome by events. Specifically, on November 5, 2024, ICE removed all detainees from Nye and on November 18, 2024, terminated its contract with Nye. ICE has no plans to house any future detainees at Nye.

While the OIG represents it will administratively close these recommendations at report issuance, it also "reserve[s] the option to reopen all recommendations if ICE signs a new contract and begins housing detainees at Nye again." Not only is there no provision for such action in DHS Directive 077-01, "Follow-Up and Resolution for Office of Inspector General Report Recommendations," dated October 7, 2010, this would complicate "Good Accounting Obligation in Government Act" (GAO-IG Act)[2] reporting that requires each agency to include, in its annual budget justification submitted to Congress, a report that identifies each public recommendation issued by GAO and the agency's Inspector General which has remained unimplemented for one year or more from the annual budget justification submission date[3]/[4].

The draft report contained 11 recommendations (see attached), with which ICE neither concurs nor non-concurs as all have been overcome by events. ICE previously submitted technical comments addressing accuracy, contextual and other issues under a separate cover for OIG's consideration, as appropriate.

Again, thank you for the opportunity to review and comment on this draft report. Please feel free to contact me if you have any questions.

Attachment

[2] Pub. L. No. 115-414
[3] See 31 U.S.C. § 1105 note.
[4] Recommendations are considered either "open and resolved" (i.e., no disagreement) or "open and unresolved" (i.e., in disagreement) and "implemented" or "unimplemented" when closed. Neither DHS guidance nor statute include an option for the OIG to identify recommendations as on hold with an option to reopen them.

Attachment: Management Response to Recommendations Contained in OIG 24-002-ISP-ICE(c)

OIG recommended that the Executive Associate Director of Enforcement and Removal Operations direct the Salt Lake City Field Office, responsible for Nye to:

Recommendation 1: Inform medical staff in the event of detainee transfers so they can provide a health record to the accepting facility and medication to detainees.

Recommendation 2: Ensure detainees' comprehensive health assessments indicate necessary follow-up care for abnormal vital signs and other health complaints.

Recommendation 3: Ensure sharp instruments are properly counted and inventories are reconciled at least weekly.

Recommendation 4: Ensure Nye staff maintain a separate detainee grievance log to document grievances, responses, and timeliness.

Recommendation 5: Provide responses to detainee grievances within 5 days.

Recommendation 6: Ensure Nye staff forward all detainee grievances containing allegations of staff misconduct to ICE.

Recommendation 7: Provide responses to detainee requests within 5 days.

Recommendation 8: Maintain a separate detainee request log to document response and timeliness to ensure proper oversight of the detainee request process.

Recommendation 9: Ensure telephones in detainee dorms are operational.

Recommendation 10: Ensure that sinks are working, and shower water does not create potentially hazardous conditions in the facility.

Recommendation 11: Ensure that the medical isolation room is kept clean.

Appendix C:
Report Distribution

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