U.S. Department of Homeland Security
U.S. Immigration and Customs Enforcement
Office of Professional Responsibility
Inspections and Detention Oversight Division
Washington, DC 20536-5501

Office of Detention Oversight
Follow-Up Compliance Inspection

Enforcement and Removal Operations
ERO Salt Lake City Field Office

Henderson Detention Center
Henderson, Nevada

September 14-16, 2021

FOLLOW-UP COMPLIANCE INSPECTION
of the
HENDERSON DETENTION CENTER
Henderson, Nevada

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FOLLOW-UP COMPLIANCE INSPECTION TEAM MEMBERS

[redacted]	Acting Team Lead	ODO
	Inspections and Compliance Specialist	ODO
	Inspections and Compliance Specialist	ODO
	Contractor	Creative Corrections
	Contractor	Creative Corrections
	Contractor	Creative Corrections
	Contractor	Creative Corrections

FACILITY OVERVIEW

The U.S. Immigration and Customs Enforcement (ICE) Office of Professional Responsibility (OPR) Office of Detention Oversight (ODO) conducted a follow-up compliance inspection of the Henderson Detention Center (HDC) in Henderson, Nevada, from September 14 to 16, 2021.[1] This inspection focused on the standards found deficient during ODO's last inspection of HDC from March 29 to April 1, 2021. The facility opened in 1994, is owned by the City of Henderson, and is operated by the Henderson Police Department. The ICE Office of Enforcement and Removal Operations (ERO) began housing detainees at HDC in 2009 under the oversight of ERO's Field Office Director in Salt Lake City (ERO Salt Lake City). The facility operates under the National Detention Standards (NDS) 2000.

ERO has assigned a detention services manager to the facility. An HDC captain handles daily facility operations and manages [redacted] support personnel. The City of Henderson provides food services, Naphcare provides medical care, and Keefe provides commissary services at the facility. The facility does not hold any accreditations from any outside entities.

Capacity and Population Statistics	Quantity
ICE Detainee Bed Capacity[2]	[redacted]
Average ICE Detainee Population[3]	[redacted]
Male Detainee Population (as of September 14, 2021)	[redacted]
Female Detainee Population (as of September 14, 2021)	[redacted]

During its last inspection, in March 2021, ODO found 18 deficiencies in the following areas: Access to Legal Material (1); Detainee Classification System (1); Detainee Grievance Procedures (1); Environmental Health and Safety (1); Food Service (3); Funds and Personal Property (3); Hunger Strike (1); Special Management Unit (2); Suicide Prevention and Intervention (2); and Telephone Access (3).

[1] This facility holds male and female detainees with low, medium-low, medium-high, and high security classification levels for periods longer than 72 hours.
[2] Data Source: ERO Facility List Report as of September 13, 2021.
[3] *Ibid.*

FOLLOW-UP COMPLIANCE INSPECTION PROCESS

ODO conducts oversight inspections of ICE detention facilities with an average daily population of 10 or more detainees, and where detainees are housed for longer than 72 hours, to assess compliance with ICE National Detention Standards. These inspections focus solely on facility compliance with detention standards that directly affect detainee life, health, safety, and/or well-being. In FY 2021, to meet congressional requirements, ODO began conducting follow-up inspections at all ICE ERO detention facilities, which ODO inspected earlier in the FY.

While follow-up inspections are intended to focus on previously identified deficiencies, ODO will conduct a complete review of several core standards, which include but are not limited to Medical Care, Hunger Strikes, Suicide Prevention, Food Service, Environmental Health and Safety, Emergency Plans, Use of Force and Restraints/Use of Physical Control Measures and Restraints, Admission and Release, Classification, and Funds and Personal Property. ODO may decide to conduct a second full inspection of a facility in the same FY based on additional information obtained prior to ODO's arrival on-site. Factors ODO will consider when deciding to conduct a second full inspection will include the total number of deficiencies cited during the first inspection, the number of deficient standards found during the first inspection, the completion status of the first inspection's Uniform Corrective Action Plan, and other information ODO obtains from internal and external sources ahead of the follow-up compliance inspection. Conditions found during the inspection may also lead ODO to assess new areas and identify new deficiencies or areas of concern should facility practices run contrary to ICE standards. Any areas found non-compliant during both inspections are annotated as "Repeat Deficiencies" in this report.

FINDINGS BY NATIONAL DETENTION STANDARDS 2000 MAJOR CATEGORIES

NDS 2000 Standards Inspected[4]	Deficiencies
Part 1 – Detainee Services	
Access to Legal Material	0
Admission and Release	3
Detainee Classification System	4
Detainee Grievance System	0
Food Service	0
Funds and Personal Property	2
Telephone Access	0
Sub-Total	**9**
Part 2 – Security and Control	
Emergency Plans	1
Environmental Health and Safety	1
Special Management Unit (Administrative Segregation)	0
Special Management Unit (Disciplinary Segregation)	0
Use of Force	1
Sub-Total	**3**
Part 3 – Health Services	
Hunger Strike	0
Medical Care	0
Suicide Prevention and Intervention	0
Sub-Total	**0**
Total Deficiencies	**12**

[4] For greater detail on ODO's findings, see the *Compliance Inspection Findings* section of this report.

DETAINEE RELATIONS

ODO interviewed 20 detainees, who each voluntarily agreed to participate. None of the detainees made allegations of discrimination, mistreatment, or abuse. One detainee exhibited signs of mental health issues during the interview and ODO immediately referred him to both ERO and facility medical staff for follow-up. Most detainees reported satisfaction with facility services except for the concerns listed below.

Admission and Release: Nine detainees stated they did not receive the ICE National Detainee Handbook nor the facility's detainee handbook upon their admission to the facility.

- Action Taken: ODO reviewed the detainees' movement cards and found signed acknowledgements from each detainee, which indicated they received a copy of each handbook upon the intake process. ODO requested the facility ensure each detainee received a copy of the handbooks, and on September 28, 2021, ODO confirmed the facility provided copies to all detainees.

Medical Care: One detainee stated he requested to have a hearing aid for partial deafness in his left ear. He stated the facility's medical staff declined his request because they determined the detainee did not need a hearing aid. However, the facility's medical staff provided him with earwax drops. In addition, he said he needed glasses. The detainee reported he completed a vision test, but never heard from the medical staff.

- Action Taken: ODO interviewed the facility's medical staff, who reviewed the detainee's electronic medical record. On July 30, 2021, the medical staff met with the detainee about his ear and eyes concerns. On the same day, the medical staff ordered earwax removal medication for the detainee, and he completed a visual acuity assessment. He did not meet the criteria for prescription eyeglasses, and so the provider denied his request. The facility's nurse educated the detainee and informed him to submit a medical request if needed. On September 16, 2021, the facility's medical staff informed ODO his family delivered eyeglasses to the detainee. On September 17, 2021, the provider met with the detainee and noted no drainage or earwax build up. The provider told the detainee to notify the medical staff of any further medical issues.

Medical Care: One detainee stated he experienced side effects from his anti-depression medication in the form of urination problems. He said he spoke with the facility's medical staff, but his problem had not been resolved.

- Action Taken: On September 12, 2021, the detainee complained to the facility's medical staff about a burning sensation while urinating. On September 14, 2021, the detainee completed a urinalysis, which showed blood in his urine. The provider informed the detainee to increase his fluid intake with Gatorade. On September 23, 2021, the detainee was scheduled to complete lab work with the medical staff, and he had a blood potassium level of 6.6 millimoles per liter (mmol/L), which is high since the normal range is 3.6 to 5.2 mmol/L. His electrocardiogram (EKG) showed a heart rate of 86 (normal range). The medical staff ordered lab work and an EKG of the detainee since blood showed up in his

urine, possibly from the cumulative effects of psychiatric medication. The detainee had been scheduled to complete repeat labs the next morning. The results were pending during the inspection.

On September 16, 2021, the detainee had an appointment with the facility's licensed clinical social worker (LCSW). The LCSW discontinued the detainee's anti-depression medication since they were causing urination problems. The LCSW told the detainee to notify mental health of any further issues. On September 30, 2021, ODO confirmed the detainee had submitted no additional medical requests following his mental health appointment.

Medical Care: One detainee stated he had been involved in a car accident before entering the facility, which caused a spinal injury and necessitated physical therapy. While at the facility, he said the medical staff provided him Tylenol. He also reported that his outside doctor stated he should receive epidural injections and to consider surgery if the epidurals didn't work. The detainee indicated he was experiencing spinal pain.

Action Taken: ODO spoke with the facility's medical staff, who reviewed the detainee's electronic medical record. The detainee met with the facility's medical staff multiple times between April 22, 2020, and August 2, 2021. During this period, the medical staff prescribed the detainee multiple pain medications. On June 26, 2020, the detainee completed an x-ray of the spine, and the results were normal. On September 9, 2021, the medical staff prescribed the detainee Tamsulosin for his enlarged prostate, educated him on his condition and informed him to submit a sick call request if the pain worsened. The detainee completed a renal and prostate ultrasound on September 24, 2021, which showed an enlarged prostate, but no evidence of urinary retention. In addition, the detainee completed a retroperitoneal ultrasound, which showed no evidence of renal or bladder abnormality.

Medical Care: One detainee stated he had a hernia, and the facility's medical staff provided him with a hernia belt since he reported the hernia was growing and he was in pain. The detainee said the medical staff told him to wait until they released him from the facility to receive the proper medical attention. In addition, he stated he had high blood pressure, and prescribed medication did not work.

- Action Taken: ODO interviewed the facility's health services administrator (HSA) who reviewed the detainee's electronic medical record. The facility's medical staff prescribed the detainee Tylenol from August 19, 2021, through September 12, 2021. On September 9, 2021, the medical staff provided him with a hernia belt. The HSA denied the detainee's allegation to wait to receive proper medical attention. She reported the detainee did not place a medical request for his constant pain. On September 14, 2021, the medical staff met with the detainee and determined his blood pressure to be 136/86, within high-normal range. The provider reported no change to his medication because of the detainee's stable condition. On September 19, 2021, the detainee met with the medical staff and reviewed his plan of care. The provider ordered Lisinopril (40 milligrams (mg) daily) and

hydrochlorothiazide (12.5 mg) for his blood pressure, Tylenol as needed, and stool softener daily. Additionally, the provider ordered the detainee to continue using the hernia belt.

Medical Care: One detainee stated he had a bad heart, suffered heart pain, and that his left arm had intermittently gone numb. He said the facility's medical staff prescribed him multiple anxiety, depression, and pain medications. The detainee also claimed to have neck and shoulder pain and stated an off-site doctor told him he had two bad vertebrae for which he did not receive treatment. He asked for medicine for his neck and shoulder pain and remarked that the medication prescribed did not help his injury nor heart pain. In addition, the medical staff prescribed him medication for his high blood pressure. Furthermore, the detainee expressed a desire to speak with an ICE officer about his sister's death.

- Action Taken: ODO interviewed the facility's medical staff who reviewed the detainee's electronic medical record. The detainee met with the medical provider about his hypertension, diagnosed coronary heart disease, and pain multiple times from July 11, 2021, through September 5, 2021. He completed lab work on July 16, 2021. On July 11, 2021; July 13, 2021; August 2, 2021; and August 20, 2021, he completed an EKG. On September 12, 2021, the medical staff educated the detainee on eating a heart-healthy diet because of his commissary habits and specifically, his tendency to purchase multiple packs of ramen noodles, known for containing high levels of sodium. The medical staff said he disregarded the information, laughed, and stated, "I don't eat many." The medical staff prescribed various heart and psychiatric medications; however, the provider said the detainee was not in any immediate danger. In addition, the detainee's non-compliant lifestyle and diet were noted to be a concern. Regarding the detainee's sister's death, ERO Salt Lake City visited the detainee on September 28, 2021, at ODO's request.

Medical Care: One detainee stated she had back, hip, and leg pain. On her last visit with the facility's medical staff, they provided her with a muscle relaxer. The detainee rated her pain to be an 8 out of 10 on the pain scale so the facility provided her with an extra mattress. The detainee requested compression socks and stated her family tried sending a couple of pairs previously.

- Action Taken: ODO interviewed the facility's medical staff who reviewed the detainee's electronic medical record. The detainee met with the medical staff for her back, hip, and leg pain several times from May 3, 2020, through July 2, 2021. During this time, the medical staff prescribed the detainee with different medications. On January 8, 2021, the detainee completed a spinal x-ray, and the results were normal, showing no arthritis or acute fracture. On September 19, 2021, the detainee met with the medical staff, and they prescribed her medication for muscle spasms and pain. Medical staff also provided her with compression socks for pain and swelling. Per the facility's medical policy, compression socks must be provided by medical staff. Additionally, the medical staff advised the detainee to let them know if the pain worsened and to follow-up with her primary care physician once released from the facility.

Medical Care: One detainee stated he had a history of kidney stones and reported feeling pain. The detainee stated he did not submit a medical request.

- Action Taken: ODO interviewed the facility's medical staff who reviewed the detainee's electronic medical record. The detainee had no medical complaints or any sick call requests found in his chart. On September 15, 2021, the detainee completed a urinalysis, which showed traces of protein and a moderate amount of blood. The medical staff encouraged the detainee to drink 6-8 cups of water daily and continually monitored his pain between his rib and the hip. The medical staff had scheduled the detainee for a follow-up to occur on September 21, 2021, but the facility released the detainee on September 20, 2021.

Medical Care: One detainee stated he had written a letter to his brother on or about August 14, 2021, and disclosed thoughts of self-harm. During the detainee interview, he reported no self-harm ideations when asked directly and stated he was feeling "great now."

- Action Taken: ODO immediately notified the facility and informed ERO Salt Lake City about the detainee's self-harm ideations. The facility's mental health staff immediately evaluated the detainee and cleared him to return to the general population. On September 15, 2021, the facility's mental health staff said the detainee inquired about anxiety and depression medication. On the same day, the mental health clinician prescribed him Trazadone and Prozac for his anxiety and depression.

FOLLOW-UP COMPLIANCE INSPECTION FINDINGS

DETAINEE SERVICES

ADMISSION AND RELEASE (AR)

ODO reviewed [redacted] detainee detention files and found in [redacted] files, the Order to Detain or Release Forms (Form I-203 or I-203a) did not bear the appropriate official signature of the newly arriving detainees to the facility **(Deficiency AR-34[5])**.

ODO reviewed the facility's policy, interviewed the booking officer and sergeant, and found the facility did not have any instances of missing property reported since the initial inspection nor did they have any policy and procedures in place to forward completed Report of Detainee Missing Property Form (Form I-387) to ERO Salt Lake City. ODO notes this as an **Area of Concern**.

ODO interviewed the accreditation officer and found ERO Salt Lake City did not approve the facility's orientation procedures **(Deficiency AR-54[6])**.

Corrective Action: ODO reviewed a memorandum from the Supervisory Detention and

[5] "An order to detain or release (Form I-203 or I-203a) bearing the appropriate official signature shall accompany the newly arriving detainee." *See* ICE NDS 2000, Standard, Admission and Release, Section (III)(H).
[6] "In IGSAs, the INS office of jurisdiction shall approve all orientation procedures." *See* ICE NDS 2000, Standard, Admission and Release, Section (III)(J).

Deportation Officer (SDDO), dated September 15, 2021, that approved the facility's orientation procedures **(C-1)**.

ODO interviewed the accreditation officer and found ERO Salt Lake City did not approve the facility's release procedures **(Deficiency AR-73[7])**.

Corrective Action: ODO reviewed a memorandum from the SDDO, dated September 15, 2021, that approved the facility's release procedures **(C-2)**.

DETAINEE CLASSIFICATION SYSTEM (DCS)

ODO reviewed the facility's policy, interviewed the classification technician, and found the first-line supervisor did not review nor approve each detainee's classification. The classification technician entered each detainee classification into the facility's electronic Jail Management System, and the detainee files did not contain classification documentation nor a review **(Deficiency DCS-10[8])**.

ODO reviewed the facility's policy, interviewed the facility's classification technician, and found a supervisor did not review the technician's classification files for accuracy and completeness **(Deficiency DCS-19[9])**.

ODO reviewed the facility's policy, interviewed the facility's classification technician, and found the facility does not have a reviewing officer to ensure each detainee has been assigned to the appropriate housing unit. Instead, the classification technician assigned housing to detainees based upon their initial classification, which lacked any supervisory review **(Deficiency DCS-20[10])**.

ODO reviewed the facility's policy, interviewed the facility's classification technician, and found the first-line supervisor did not recommend changes in the detainee's classification level nor were each detainee's classification level reviewed **(Deficiency DCS-21[11])**.

FUNDS AND PERSONAL PROPERTY (FPP)

ODO reviewed the facility's policy and found the facility did not have written policy and procedures for detainee property reported missing or damaged **(Deficiency FPP-70[12])**.

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[7] "INS will approve the IGSA release procedures." *See* ICE NDS 2000, Standard, Admission and Release, Section (III)([sic] J).

[8] "The first-line supervisor will review and approve each detainee's classification." *See* ICE NDS 2000, Standard, Detainee Classification System, Section (III)(A)(3).

[9] "In all detention facilities, a supervisor will review the intake/processing officer's classification files for accuracy and completeness." *See* ICE NDS 2000, Standard, Detainee Classification System, Section (III)(C).

[10] "High custody detainees: … are always monitored and escorted." *See* ICE NDS 2000, Standard, Detainee Classification System, Section (III)(F)(3).

[11] "In addition, the reviewing officer will recommend changes in classification due to:

1. incidents while in custody;
2. a classification appeal by a detainee or recognized representative (see below); or
3. specific, articulable facts that surface after the detainee's in-processing." *See* ICE NDS 2000, Standard, Detainee Classification System, Section (III)(C)(1-3).

[12] "Each facility shall have a written policy and procedures for detainee property reported missing or damaged." *See* ICE NDS 2011, Standard, Funds and Personal Property, Section (III)(H).

ODO reviewed the facility's policy and found the facility did not have policy for loss of or damage to properly receipted detainee property. Specifically, the policy did not contain the following required components: All procedures for investigating and reporting property loss or damage will be implemented as specified in this standard; supervisory staff will conduct the investigation; the senior facility contract officer will process all detainee claims for lost or damaged property promptly; the official deciding the claim will be at least one level higher in the chain of command than the official investigating the claim; the facility will promptly reimburse detainees for all validated property losses caused by facility negligence; the facility will not arbitrarily impose a ceiling on the amount to be reimbursed for a validated claim; and the senior contract officer will immediately notify the designated INS officer of all claims and outcomes **(Deficiency FPP-80[13])**.

SECURITY AND CONTROL

EMERGENCY PLANS (EP)

ODO reviewed the facility's EP program, interviewed the accreditation officer, and found the facility did not compile INS-approved individual contingency plans for Search (Internal) and Service Wide Lockdown **(Deficiency EP-93[14])**.

ENVIRONMENTAL HEALTH AND SAFETY (EHS)

ODO reviewed a waiver from ERO Salt Lake City, dated April 2, 2012, which granted HDC authority to test the generators monthly for 30 minutes. In addition, ODO reviewed the monthly test reports from April 2021 through August 2021 and found the external company that tests the generators only tested the generators for 12 minutes each time **(Deficiency EHS-78[15])**.

[13] "All CDFs and IGSA facilities will have and follow a policy for loss of or damage to properly receipted detainee property, as follows:

1. All procedures for investigating and reporting property loss or damage will be implemented as specified in this standard;
2. Supervisory staff will conduct the investigation;
3. The senior facility contract officer will process all detainee claims for lost or damaged property promptly;"
4. The official deciding the claim will be at lease one level higher in the chain of command than the official investigating the claim;
5. The will promptly reimburse detainees for all validated property loss caused by facility negligence;
6. The will arbitrarily impose a ceiling n the amount to be reimbursed for a validated claim; and
7. The senior contract officer will immediately notify the designated INS officer of all claims and outcomes.

See ICE NDS 2000, Standard, Funds and Personal Property, Section (III)(H)(1-7).

[14] "All facilities will compile INS approved individual contingency plans, as needed, in the following order:

6. Search (Internal)
13. Service Wide Lockdown

See ICE NDS 2000, Standard, Emergency Plans, Section (III)(D)(2).

[15] "The biweekly test of the emergency electrical generator will last one hour." *See* ICE NDS 2000, Standard, Environmental Health and Safety, Section (III)(O).

USE OF FORCE (UOF)

ODO interviewed the accreditation officer and found the facility did not incorporate the responsibility to check the video camera into one or more post orders **(Deficiency UOF-31[16])**.

CONCLUSION

During this inspection, ODO assessed the facility's compliance with 15 standards under NDS 2000 and found the facility in compliance with 9 of those standards. ODO found 12 deficiencies in the remaining 6 standards. ODO commends facility staff members for their responsiveness during this inspection and notes there were two instances where staff initiated immediate corrective action during the inspection. ODO recommends ERO work with the facility to resolve any deficiencies that remain outstanding in accordance with contractual obligations. ODO has not received the uniform corrective action plan for ODO's last inspection of HDC in March 2021.

Compliance Inspection Results Compared	First FY 2021 (NDS 2000)/ NDS 2019)/ (FPBDS)	Second FY 2021 (NDS 2000)
Standards Reviewed	15/1/1	15
Deficient Standards	10	6
Overall Number of Deficiencies	18	12
Repeat Deficiencies	2	0
Areas of Concern	20	1
Corrective Actions	0	2

[16] "This responsibility shall be incorporated into one or more post orders." *See* ICE NDS 2000, Standard, Use of Force, Section (III)(A)(4)(l).