

Congress of the United States

Washington, DC 20515

January 15, 2026

The Honorable Kristi Noem
Secretary of Homeland Security
U.S. Department of Homeland Security
2707 Martin Luther King Jr. Avenue SE
Washington, D.C. 20528

Mr. Todd Lyons
Acting Director
U.S. Immigration and Customs Enforcement
500 12th Street SW, Mail Stop 5902
Washington, D.C. 20536

Re: Dangerous Conditions for People with Disabilities at California City ICE Processing Center

Dear Secretary Noem and Acting Director Lyons,

As California Members of Congress, we are alarmed by the reports of dangerous conditions at the California City Detention Facility and call for the Office for Civil Rights and Civil Liberties (CRCL) and the Office of Inspector General (OIG) to conduct a joint investigation into CoreCivic, the facility operator.

We call for corrective action to ensure detained individuals with disabilities receive uninterrupted access to medications, mobility aids, and medical treatment. We also call for public reporting by CRCL and OIG on their findings and the remedial steps taken for the enforcement of federal disability standards, including the Rehabilitation Act, the Americans with Disabilities Act, and the Immigration and Customs Enforcement (ICE) 2011 Performance Based National Detention Standards (PBNDS). The 2011 PBNDS constitute the most appropriate standards applicable to all California detention facilities and, accordingly, agencies must demonstrate full compliance and transparent accountability for adherence to these standards.

Overview

The California City Detention Facility (hereinafter “California City”) is a CoreCivic operated ICE detention facility recently opened in California.¹ On November 3, 2025, Disability Rights California (DRC) published the report, “Newly Opened California City ICE Detention Facility: Dangerous for Disabled People.”²

DRC is the designated protection and advocacy system for people with disabilities in California and is charged under federal and state laws with protecting and advocating for the rights of people with disabilities.³

On September 22 and 23, 2025, DRC conducted a comprehensive monitoring visit and toured all areas of California City accessible to the people detained there. DRC spoke with CoreCivic representatives, ICE officials, and California City staff, and interviewed 17 individuals detained at the facility.⁴ Through this monitoring, DRC found that people with disabilities who were detained at California City faced abuse and neglect.

¹ Melissa Montalvo, “Central ICE detainee population up by 164% since June, new data shows,” (Nov. 28, 2025), <https://www.fresnobee.com/news/california/article313137596.html>

² Disability Rights California, “Newly Opened California City ICE Detention Facility: Dangerous for Disabled People,” (Nov. 3, 2025), [Newly-opened California City ICE Detention Facility: Dangerous for Disabled People | Disability Rights California](#) (hereinafter DRC Report).

³ See 42 U.S.C. §§ 15001 et seq. (“Developmental Disabilities Assistance and Bill of Rights Act”); 29 U.S.C. §§ 794e et seq. (“Protection and Advocacy of Individual Rights Act”); 42 U.S.C. §§ 10801 et seq. (“Protection and Advocacy for Individuals with Mental Illness Act”); Cal. Welf. & Inst. Code §§ 4900 et seq. (“Protection and Advocacy Agency”).

⁴ DRC Report

Concerns regarding medical neglect and unsafe conditions at California City have also been raised by other independent authorities. In December 2025, the California Attorney General transmitted a letter to the Department of Homeland Security outlining preliminary findings from its inspection of the facility and identifying serious deficiencies in medical care and compliance with detention standards. Around the same time, public reporting described pending federal litigation in which attorneys sought emergency relief on behalf of detained individuals alleging life-threatening medical neglect.⁵

According to the DRC report, staff at California City abused and neglected people with disabilities in the following major ways:

- Failure to provide critical medical and mental health care
- Failure to process and address disability-related requests
- Failure to address people’s basic needs
- Harassment by staff
- Unnecessary use of solitary confinement

Failure to provide critical medical and mental health care

In violation of ICE’s National Detention Standards, DRC found that detained individuals faced disruptions in critical surgeries,⁶ inadequate medication management,⁷ lack of timely responses to sick call requests, and poor mental health crisis management.⁸

Nearly every person interviewed reported problems accessing medical care.⁹ Individuals reported extreme delays in critical surgeries after their transfer to California City, such as surgery to prevent blood clots and surgery for a large hernia.¹⁰

Individuals also reported inadequate medication management.¹¹ One person went days without seizure medication, while another went a week without diabetes medication.¹²

Several individuals interviewed reported a lack of response and follow-up to written requests for medical evaluations and care.

Additionally, in response to a mental health crisis, an individual reported that staff placed him in a mental health observation cell for four days without access to a working toilet, shower, blanket or toothpaste. While in the observation cell, the individual did not receive any psychological services and was only briefly checked on by

⁵ <https://www.latimes.com/california/story/2025-12-17/man-held-at-ice-detention-center-faces>

⁶ See U.S. Immigration & Customs Enf’t, National Detention Standards § 4.3.II.D., (2025), <https://www.ice.gov/doclib/detention-standards/2025/nds2025.pdf> (discussing medical screenings and continuity of care for new arrivals) (hereinafter NDS).

⁷ See id. § 4.3.II.L. (requiring medication be distributed in accordance with health care provider’s instructions and procedures).

⁸ See id. § 4.3.II.A. (requiring detainees be provided access to medically necessary and appropriate medical care).

⁹ See id. § 4.3.II.D. (discussing medical screenings and continuity of care for new arrivals).

¹⁰ DRC Report

¹¹ NDS § 4.3.II.L. (requiring medication be distributed in accordance with health care provider’s instructions and procedures).

¹² DRC Report

custodial staff. As a result, he reported withholding the severity of his mental health to avoid staying in the cell.¹³

Failure to process and address disability-related requests

In violation of National Detention Standards and the Rehabilitation Act, DRC found that California City does not employ a dedicated disability or accommodations specialist and did not respond timely to individuals' disability-related needs.¹⁴

People with disabilities reported prolonged delays or outright denials of necessary accommodations, including mobility aids. One individual with a hernia, for example, waited three weeks and made several requests before finally receiving a wheelchair, while others reported staff denied requests for supportive footwear, causing pain and limiting their ability to walk.¹⁵

Failure to address people's basic needs

The report also found people with disabilities were subjected to unsuitable and dirty housing units, unsanitary water, inadequate clothing supplies, and low-quality and insufficient food.¹⁶

When people first arrived at the facility, they slept on the floor of a cafeteria with no mattresses or pads. Once brought to the units, interviewees found no working sinks or toilets, dust, and flooding from rainwater.¹⁷

People detained at California City also reported insufficient portions of inedible and low-quality food. One person had lost a considerable amount of weight since their arrival at the facility, while another reported not receiving the special diet needed to manage a medical condition.¹⁸

Harassment by staff

Interviewees reported multiple harassing behaviors by staff. For example, staff wore gas masks and threatened to pepper-spray detained individuals; an individual had his head pushed into a wall by a staff member, while another saw a staff member spit in his food. Interviewees stated they did not ask for assistance from staff, such as for medical needs, for fear of retaliation.¹⁹

Unnecessary use of solitary confinement

DRC observed 27 individuals held in near-constant solitary confinement with little access to a caged outdoor area, including people placed there in retaliation for requesting medical care and without required written notice.²⁰

Individuals reported not receiving the written explanations for segregation placement required under detention standards, and DRC was further told by staff that the facility follows the NDS rather than the applicable PBNDS.²¹

¹³ DRC Report

¹⁴ See id. § 4.7.II.B. (requiring a facility to designate a Disability Compliance Coordinator); 6 C.F.R. § 15.30 (providing general prohibitions against discrimination in programs or activities conducted by the Department of Homeland Security).

¹⁵ DRC Report

¹⁶ *Id.*

¹⁷ *Id.*

¹⁸ *Id.*

¹⁹ *Id.*

²⁰ *Id.*

²¹ See id. § 2.9.II.B.2. (describing how a disciplinary segregation order detailing the reasons for placing the detainee in disciplinary segregation shall be provided to the detainee).

A month later, several people with disability-related concerns reported no change in conditions inside the solitary confinement units.²²

The unnecessary and retaliatory use of solitary confinement is concerning given studies showing its long-term detrimental effects on psychological, neurological, and physiological well-being.²³

Based on this report and visit, we have the following questions regarding conditions at the California City Detention Facility and the treatment of detained individuals with disabilities:

1. What written policies and procedures are currently in place at California City for identifying, documenting, and providing reasonable accommodations for detained individuals with disabilities? What is the average timeframe for fulfilling such requests?
2. Does the facility employ a dedicated disability or accommodations coordinator?
 - a. If not, why not, and who is currently responsible for processing disability-related requests?
3. What protocols are used during intake and transfer to ensure continuity of medical care, including verification and uninterrupted provision of prescribed medications, mobility aids, and post-surgical treatments?
4. How many individuals have experienced lapses or interruptions in prescribed medications over the past 12 months, and what were the causes and durations of these lapses?
5. What procedures are in place to ensure timely response to sick-call requests and medical emergencies, and what are the facility's current averages for response times?
6. Why did California City staff inform DRC that they apply NDS standards, used for "non-dedicated facilities" such as jails, rather than the PBNDS standards, used for facilities that only hold ICE detainees. Given Cal City only holds ICE detainees, what is the facility's rationale for using NDS standards?
7. How many individuals with disabilities have been placed in segregation or solitary confinement in the past 12 months, and what were the stated reasons for their placement?
8. What policies and procedures does ICE have in place to prevent retaliation against individuals who request medical care, file grievances, or seek disability accommodations?
9. How many staff-related misconduct, harassment, retaliation, or use-of-force complaints have been filed in the past year, and what actions were taken in response?
10. When will ICE and CoreCivic bring California City into full compliance with the 2011 PBNDS and other applicable disability-rights standards, such as the Rehabilitation Act, the Americans with Disabilities Act?

Conclusion

In response to these findings, we urge you to refer CoreCivic's violations to the Office for Civil Rights and Civil Liberties and the Office of Inspector General for an immediate joint investigation.

²² DRC Report

²³ See e.g., Kayla James & Elena Vanko, The Impacts of Solitary Confinement, Vera Inst. (April 2021), <https://vera-institute.files.svdcdn.com/production/downloads/publications/the-impacts-of-solitary-confinement.pdf?dm=1617381199>.

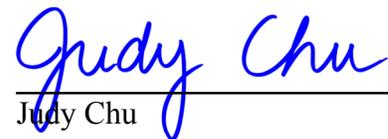
We call for corrective action to ensure detained people with disabilities receive uninterrupted access to medications, mobility aids, and medical treatment. We also call for public reporting by CRCL and OIG on findings and the remedial steps taken to enforce federal disability standards, including the Rehabilitation Act, the ADA, and ICE’s 2011 PBNDS, across all California detention facilities.

Please respond in writing by March 16, 2026, to our questions regarding current policies at California City and how DHS and ICE intend to remedy the violations identified in the DRC report.

Sincerely,



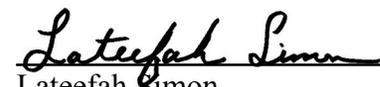
Nanette Diaz Barragán
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Raul Ruiz, M.D.
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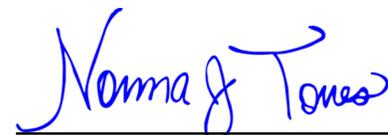
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