United States Senate

WASHINGTON, DC 20510

September 23, 2025

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

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

Dear Secretary Noem and Acting Director Lyons:

We write with serious alarm regarding the rise in the number of deaths in U.S. Immigration and Customs Enforcement (ICE) custody nationwide. We are especially concerned by the deaths of two individuals in ICE custody in Georgia this year. We request that the Department of Homeland Security (DHS) and ICE immediately provide information about these individuals' deaths and about the Administration's plan to prevent further fatalities.

ICE has publicly confirmed that Abelardo Avellaneda-Delgado, a 68-year-old Mexican citizen, died in ICE custody during transport from a local jail to Stewart Detention Center ("Stewart") on May 5, 2025.[1] Media reports indicate that his death occurred while he was in the care of TransCor, a wholly owned subsidiary of CoreCivic, contracted by ICE to transport detainees. Mr. Avellaneda-Delgado's family has stated publicly that he had no known preexisting health conditions before being detained in local custody.[2]

ICE has also publicly confirmed that Jesus Molina-Veya, a 45-year-old Mexican citizen in the custody of ICE at Stewart, was pronounced dead by medical professionals at 6:42 p.m. on June 7, 2025.[3] Mr. Molina-Veya's death has been reported as a suicide.[4] His death marks the thirteenth death, and the third death by suicide, at Stewart since ICE began holding immigrants in the facility in 2006.[5]

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[1] U.S. IMMIGRATION & CUSTOMS ENF'T, *Mexican national in ICE custody passes away* (May 8, 2025), https://www.ice.gov/news/releases/mexican-national-ice-custody-passes-away.
[2] Timothy Pratt, *"Ticking time bomb": ICE detainee dies in transit as experts say more deaths likely*, THE GUARDIAN (June 22, 2025), https://www.theguardian.com/us-news/2025/jun/22/ice-detainee-death-georgia.
[3] U.S. IMMIGRATION & CUSTOMS ENF'T, *ICE Detainee death in Atlanta* (Jun. 11, 2025), https://www.ice.gov/news/releases/ice-detainee-death-atlanta.
[4] *Third Death By Suicide In Georgia's ICE Detention Center*, DETENTION WATCH NETWORK, (Jul. 12,2025) https://www.detentionwatchnetwork.org/pressroom/releases/2025/third-death-suicide-georgias-ice-detention-center-advocates-call-immediate.
[5] *Id.*

Stewart has faced numerous allegations of civil rights and civil liberties violations, including reports of sexual abuse,[6] medical neglect,[7] overuse of solitary confinement,[8] overcrowding,[9] barriers to accessing legal representation,[10] forced labor,[11] substandard food,[12] and issues with grievance reporting.[13]A 2017 Office of Civil Rights and Civil Liberties report assessing conditions at Stewart found the facility had an insufficient number of staff to manage the health needs of detainees, including highlighting a time when only one mental health provider would be available to serve a detainee population of 1,800.[14] Persistent deficiencies in medical care may contribute to preventable deaths and serious illnesses among detainees.

ICE has reported fourteen deaths in custody since January 2025.[15] There have been additional public reports of a fifteenth detainee death, which ICE has not yet confirmed.[16] Ten of these deaths occurred between January and June—the highest number of deaths in the first six months of any year listed in ICE's public records.[17] DHS must address safety and conditions within detention facilities in Georgia and across the country to prevent more deaths in its custody.

Additionally, ICE is failing to meet its own standards for reporting detainee deaths, thereby hindering Congressional oversight efforts and leaving families in the dark as to their loved ones' fates. ICE's own guidance requires the agency to post an interim notice of any detainee death to ICE's website "within 48 hours," and directs that "every effort should be made to post the interim notice" sooner ("as quickly as reasonably possible").[18] Yet, of the fifteen detainee deaths so far this year, ICE published notice within two days in only six cases. For example, according

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[6] Catherine E. Shoichet, *Four women are accusing a nurse at an ICE detention center of sexual assault*, CNN (Jul. 15, 2022), https://www.cnn.com/2022/07/14/us/ice-stewart-detention-center-nurse-assault-allegations.
[7] Kristin Kolenz & Amilcar Valencia, *Invisible Cruelty: Solitary Confinement and Medical Neglect at Stewart Detention Center*, El Refugio (Dec. 2024), https://static1.squarespace.com/static/5dedd42f60df274331bcd16b/t/675b6118a167665b0436d843/1734041892407/Invisible+Cruelty_Dic2024+FINAL.pdf.
[8] *Id.*
[9] Lautaro Grinspan, *People sleeping on floors in crowded Georgia ICE jail, former detainee says*, ATLANTA J.-CONST. (Jun. 24, 2025), https://www.ajc.com/news/2025/06/people-sleeping-on-floors-in-crowded-georgia-ice-jail-former-detainee-says/.
[10] Letter from Southern Poverty Law Center to U.S. Immigration and Customs Enforcement (Jul. 13, 2017), https://www.splcenter.org/wp-content/uploads/files/stewart_detention_center.pdf
[11] Lautaro Grinspan, *ICE detainees say they were forced into labor in GA., file lawsuit*, ATLANTA J.-CONST. (Aug. 26, 2022), https://www.ajc.com/news/georgia-news/ice-detainees-say-they-were-forced-into-labor-in-ga-file-lawsuit/ECLTIVQNMVE6LKOFKXQBWCCVUA/.
[12] *Id.*
[13] Dept. of Homeland Sec. Off. of Inspector Gen., OIG-23-38, *Results of an Unannounced Inspection of ICE's Stewart Detention Center in Lumpkin, Georgia* (2023).
[14] Freddy Martinez & Nick Schwellenbach, *DHS's Secret Reports on ICE Detention*, PROJECT ON GOV'T OVERSIGHT (Aug. 21, 2023), https://www.pogo.org/investigations/dhss-secret-reports-on-ice-detention.
[15] *Detainee Death Reporting*, U.S. IMMIGRATION & CUSTOMS ENF'T, https://www.ice.gov/detain/detainee-death-reporting; ICE *Detainee Passes away at Banner Desert Medical Center in Arizona*, U.S. IMMIGRATION & CUSTOMS ENF'T (Sept. 15, 2025), https://www.ice.gov/news/releases/ice-detainee-passes-away-banner-desert-medical-center-arizona.
[16] Bahar Ostadan, *ICE Detainee Dies in Nassau Jail, Officials Confirm*, NEWSDAY (Sept. 19, 2025), https://www.newsday.com/long-island/politics/nassau-detainee-ice-k3n3lavn.
[17] *See Detainee Death Reporting*, *supra* note 15.
[18] U.S. Immigration & Customs Enf't, *Directive 11003.6, Notification, Review, and Reporting Requirements for Detainee Deaths* (2025), https://www.ice.gov/doclib/foia/policy/11003-6.pdf.

to ICE reports, Mr. Avellaneda Delgado was pronounced dead on May 5.[19] ICE did not publicly post notification of his death until May 8.[20]

The delay was even more apparent in Mr. Molina-Veya's case: although he was pronounced dead on June 7, ICE did not publicly post notification of his death until June 11.[21] ICE's website and press statements indicate that agency practice is to report deaths within two business days, rather than 48 hours.[22] Even under this more lenient standard, ICE belatedly reported both Mr. Avellaneda-Delgado and Mr. Molina-Veya's deaths. Families, community members, and the public deserve the utmost transparency regarding these tragedies.

Given these issues, we ask that you provide both a briefing and written response to the following questions no later than October 31, 2025.

1. Public reporting indicates that, although he was apparently healthy when he was taken into local custody, Mr. Avellaneda-Delgado appeared ill the day before he died during transport.[23] What was his health status when he was taken into ICE custody for transport?
    a. What was the official cause of Mr. Avellaneda Delgado's death, as reported on his autopsy?
    b. Please provide a copy of the detainee death review, Healthcare and Security Compliance Analysis, Mortality Review, Root Cause Analysis, autopsy report, and psychological autopsy report for this death.
    c. Has ICE contacted local authorities to secure Mr. Avellaneda-Delgado's medical records and information about his medical history preceding his death?
    d. What corrective actions were recommended to the transportation provider by ICE Office of Professional Responsibility as a result of this death?
    e. What consequences or corrective actions have been levied on the transportation provider as a result of this death?
    f. When was Mr. Avellaneda-Delgado's family notified of his death? How were they notified? Who provided this notice?

2. What health assessments and medical care does ICE require transportation contractors to provide?
    a. What health assessments does ICE require transportation providers to administer prior to transport, pursuant to their contracts?
    b. Do ICE contracts require transportation contractors to be able to provide medical care? If so, what care? If not, why not?

3. What monitoring of detainees does ICE require during transport?

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[19] U.S. IMMIGRATION & CUSTOMS ENF'T, *Mexican national in ICE custody passes away* (May 8, 2025), https://www.ice.gov/news/releases/mexican-national-ice-custody-passes-away.
[20] *Id.*
[21] U.S. IMMIGRATION & CUSTOMS ENF'T, *ICE Detainee death in Atlanta* (June 11, 2025), https://www.ice.gov/news/releases/ice-detainee-death-atlanta.
[22] *E.g.*, *id.* ("ICE makes official notifications to Congress, nongovernmental organization stakeholders, and the media upon an official report of a detained illegal alien's death and posts a news release with relevant details on the ICE public website within two business days per agency policy.")
[23] Pratt, *supra* note 2.

a. How frequently must transportation providers check on detainees?
b. What video footage of transport is required to be captured? What measures are in place to ensure the protection of that video footage? How and when is it reviewed?

4. What protocols does ICE have in place to ensure that detainees receive their prescribed medications on the day of a transport or during a transfer of custody?

5. What oversight measures do DHS and ICE have in place for transportation contractors, such as TransCor?
    a. How often are transportation contractors audited?
    b. How often are contracts with transportation providers reviewed for compliance?
    c. Please provide a copy of ICE's contract with TransCor.

6. What were Mr. Molina-Veya's conditions of confinement at the time of his death? Please provide details regarding the conditions of his cell, access to support, and his interaction with detention staff members.
    a. Did Mr. Molina-Veya ever express thoughts of suicidal ideation to staff members or to other detainees?
    b. Was Mr. Molina-Veya held in segregation at any point during his confinement at Stewart? If so, why and for how long?
    c. What was the official cause of death, as reported on his autopsy?
    d. How long was Mr. Molina-Veya detained at Stewart?
    e. How many medical and mental health staff positions were vacant at the time of Mr. Molina-Veya's death? Which ones?
    f. How many mental health personnel were on staff at the time of Mr. Molina-Veya's death?
    g. How many detainees were held at the facility at the time of Mr. Molina-Veya's death?
    h. Please provide a copy of the detainee death review, Healthcare and Security Compliance Analysis, Mortality Review, Root Cause Analysis, autopsy report, and psychological autopsy report for this death.
    i. What corrective actions were recommended to the facility by ICE OPR as a result of this death?
    j. What consequences have been levied on the facility operator as a result of this death?
    k. When was Mr. Molina-Veya's family notified of his death? How were they notified? Who provided this notice?

7. What mental health screening, treatment, and suicide prevention protocols does ICE require to be in place at Stewart?
    a. How frequently does ICE audit Stewart for compliance with said protocols?
    b. Has Stewart ever failed to meet these requirements? If so, when and how?
    c. How many licensed mental health professionals are currently employed at Stewart?
    d. How many mental health staff positions are currently vacant at Stewart?

e. What steps is DHS taking to fill these workforce shortages?

8. An Office of Professional Responsibility inspection report on Stewart issued in May 2025 reported two deficiencies related to self-harm and suicide prevention and intervention—namely, that certain staff had failed to complete annual comprehensive suicide prevention training and due to deficiencies in continuous monitoring of detainees placed on suicide precaution.[24] Have these deficiencies been fully remedied? If not, when will they be fully remedied?

9. What additional steps are DHS and ICE taking to prevent further suicides in ICE custody?

10. ICE guidance on detainee death reporting requires it to publish an interim death notice within 48 hours. ICE's website and press releases note that agency practice is to publish the interim notice within two business days. Yet, as noted above, the death notifications for Mr. Avellaneda-Delgado and Mr. Molina-Veya were published later than two business days after their deaths. Why were these delayed?
    a. Please provide a copy of current ICE guidance governing detainee death reporting.

11. Have any third-party inspections been conducted at ICE detention facilities in Georgia this year? By whom? Please provide copies of those reports.

12. What is the average duration of detention in ICE detention facilities in Georgia? How is ICE ensuring individuals are not subjected to prolonged or indefinite detention?

13. Do detainees have adequate access to clean drinking water, healthy food, and medical care while detained, in compliance with national detention standards?[25]
    a. How does ICE ensure compliance with national detention standards regarding the availability of drinking water?
    b. How many reports have you received from detainees or their representatives registering issues with the safety or quality of drinking water?
    c. How many drinking water stations are available per detainee, and where are drinking water stations located?

14. Do detainees have access to healthy food while detained, in compliance with national detention standards?[26]
    a. How does ICE ensure compliance with national detention standards regarding the availability of healthy food?
    b. How does ICE ensure that the specific nutritional needs of detainees with chronic health challenges are met?

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[24] *Stewart Detention Center: Compliance Inspection 2025-001-126*, U.S. IMMIGRATION & CUSTOMS ENF'T OFF. OF PROF. RESPONSIBILITY (Mar. 2025), https://www.ice.gov/doclib/foia/odo-compliance-inspections/StewartDetCntr_LumpkinGA_Mar18-20_2025.pdf

[25] *National Detention Standards*, U.S. IMMIGRATION & CUSTOMS ENF'T (2025), https://www.ice.gov/doclib/detention-standards/2025/nds2025.pdf

[26] *Id.*

c. How many reports have you received from detainees or their representatives' registering issues with the safety, nutritional value, or quality of food?

15. Do detainees have access to appropriate medical, dental, and mental health care, including emergency services, in compliance with national detention standards?
    a. How does ICE ensure compliance with national detention standards regarding medical care?
    b. Do detainees have access to any and all prescribed medication that they took before being detained? If not, why not?
    c. How frequently is a detainee's medical state evaluated by a physician? What process does ICE follow to ensure detainees who require or request medical care are promptly evaluated by a physician?
    d. How many pregnant women are currently detained in Georgia? Do they have access to an obstetrics physician while detained? If so, how often?

Sincerely,

Jon Ossoff
United States Senator

Raphael Warnock
United States Senator