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"Can you please help me?": A Once Violent Town Regains its Deadly Reputation

by Judith Perera[1]

On October 13, 2004, the last Bush-Kerry presidential debate took place at Arizona State University in Tempe. The topic of the night was domestic affairs. Kerry said we absolutely must be safe and secure again. Bush replied we could if "we stay on the offense against the terrorists." On immigration, Bush wanted to increase border security with new equipment and a temporary worker card that allowed a "willing worker and a willing employer to mate up." And he obviously would not "reward illegal behavior." Kerry wanted to fix the "leaking" border, crack down on illegal hiring, and introduce an "earned-legalization program" for people who have "stayed out of trouble" (NA, 2004: Debate). Neither mentioned immigrant detention.

Yet, 60 miles southeast from the debate, José López-Lara sat in a cell inside an immigrant detention center. While not meant to be a prison, in it José was nevertheless surrounded by barbed wire fences and locked doors inside a 1,500-bed facility operated by the for-profit company, Corrections Corporation of America (CCA; today rebranded as CoreCivic). CCA had by then become an integral part of the small rural community where the facility was located. Just a few months before, CCA had teamed up with Home Depot and various community organizations to host the annual "Christmas in April" project to revitalize two homes in the town. As one CCA official noted, the event was "proof that a community can come together for the betterment of its citizens" (Staff Reports, 2004). But it appeared the betterment was intended for "citizens" in the most literal sense. Because even though the detention center provided revenue and jobs to the community and was not supposed to be a jail (despite locals referring to it as a "prison"), José remained incarcerated. Most certainly, few in this rural community thought about coming together for his betterment. Seven days after the presidential

Photo courtesy of U.S. Immigration and Customs Enforcement (ICE)

debate in which the plight of those like him were ignored by both candidates, José turned 56. He was probably anxious to get home. But four days after his birthday, José was dead (ICE, 2017).

The last place where José was alive has a history of violence. Nestled in the Arizona Sun Corridor, approximately half way between the Valley of the Sun and the Old Pueblo, lies the small community of Eloy. Legend has it that a railroad porter alighting from a train almost stepped on a coiled rattlesnake and exclaimed, "Eloi!" (translated "My God!"). The later misspelled name stuck. Eloy, a town which lingered and almost died in the early 1920s, developed a reputation by the mid-twentieth century as the "west's most western town" (Tarbox, 1952: 15). In the fall of 1948, for instance, a deputy sheriff, a postmaster, and at least two migrant workers were killed in gun battles within weeks. Deputy Charles Newsome pointed out that people parked along a major street waiting for the gun battles to start (Arline, 1977). In response to the violence, the governor considered martial law. In 1950, Deputy Jim Sloter wrote that Eloy was the Tombstone of that time and was known nationally as the West's last frontier town

(Sloter, c. 1950). Despite the violence, Eloy grew significantly after World War II as industrialized farming and the availability of labor enabled a cotton boom. King Cotton brought migrants and their families during the harvest season, business enterprises to attempt permanent residence, and millions of dollars to the Casa Grande Valley where the Cadillac became known as "an Eloy pickup" (Leach, 1952).

Against the backdrop of the majestic Sonoran Desert, the seasons changed, migrants came and went, cowboys played potshot, the Wild West took lives, and cotton became gold. Eloy came into its own at the start of WWII by producing cotton, along with carrots, potatoes, barley, and alfalfa. In 1951, a combination of an effective insect control program, the addition of fertilizer, the rotation of crops, and deep plowing all helped Eloy produce cotton yields greater than twice the national average. With millions of dollars coming in, Eloy boasted having no town tax and in 1952 paid more than half of a $65,000 city-county building project with cash (NA, 1950). The automated cotton picker brought change in the 1950s by keeping much of the so-called troublemaking laborers out and Eloy began to shed its Wild West, lawless past.

By the early 1960s, the city had adopted a uniform building code and begun a demolition program to tear down unwanted structures that lined the streets and reminded locals of its violent past (Kempton, 1963). By the mid-1970s, Eloy boasted of paved, clean streets, good housing, some twenty churches, a medical clinic, an eight-officer police department, and a well-equipped 26-man volunteer fire department. It no longer was the "toughest town in the West." Only on occasion did one see flashes of the past, like the Saturday night when a police officer shot and killed Angel Villalva Nunez after he had allegedly threatened his girlfriend and wounded the officer. Shedding the reputation of violence was so important that in the late 1970s the mayor wanted to change Eloy's name to Santa Cruz, but Eloyans preferred the name and the change never occurred.

In 1960, Robert C. Stone boldly predicted that Eloy's reputation paralleled that of Tombstone in the 1890's, and that if the parallel persisted, Eloy could be memorialized on TV programs as the final Western town symbolizing freedom and individualism (Stone, 1960). However, a tension within Eloy limited its ability to live up to the prediction, whatever the images the phrase "Western town" evoked. Perhaps the most appropriate image today is that of "Eloy, the prison town." In addition to the immigrant detention center, Eloy is also home to three other prisons that incarcerate people from Arizona, California, and Hawaii. While providing employment to area residents and embodying the expansion of the carceral landscape into rural areas eager for economic opportunities, Eloy provides a sense of freedom and individualism to a select few. For those employed in the carceral business and their

Photo courtesy of Judith Perera

families, there could be freedom in being able to live in a place that has long been home which negates the need to follow available jobs into more urban areas.

But their freedom has come at an incredible human cost magnified by the city's decades-long penchant for confinement. For those not trapped behind the barbed wire and prison cells far away from home, perhaps the imagery "Eloy" evokes remains ambiguous. For some, home. For others, family. For still others, memories of the past. However, for those experiencing incarceration and hearing and living with the stories from the immigrant detention center, there is little doubt that it is a prison town. Eloy's reputation within immigrant communities in Arizona today harkens back to its violent past. The city's immigrant detention center is the deadliest in the nation (González, 2016). Since 2003, the list of official deaths at Eloy Detention Center includes at least two persons who died of natural causes, seven of medical issues, and six of suicide. At least one of the suicides may have actually been a homicide. Western freedom and individualism is for a select few and at great human cost to many, which should compel us to reevaluate the entire enterprise of immigrant detention.

José died at the Maricopa Medical Center in Phoenix. His official cause of death is listed as cerebral infarction, an ischemic stroke caused by a reduction in the blood supply to an area of the brain (ICE, 2017). There is no way to know with certainty whether his death was preventable. Maybe better medical care could have made a difference. Maybe not. What is known with certainty is that José's death marked a grim beginning and brought notoriety to the former Wild West town in a way few could have anticipated. In the next thirteen years, fourteen others would lose their lives while held at the facility that would become a lifeblood of the town.

Deaths at Eloy

Maybe if José's death had remained isolated, the vastness of the Sonoran Desert and the remoteness of Eloy may have allied to conceal the human cost of the city's lucrative facility. But four days after the New Year, death came for another at the detention center. Elias Lopez Ruelas, 54 years old, died after being taken to the RTA Hospice in Casa Grande. The

official cause of death was cirrhosis of unclear etiology (ICE, 2017). While cirrhosis, or chronic liver damage, cannot be cured it can oftentimes be treated if diagnosed. Diagnosis often requires lab tests or imaging for detection. Like José, perhaps if Elias had received better care, he may not have died when he did.

The sons of Maya Nand are certain that would have been true of their father. Almost a month after Elias died, Maya suffered cardiac arrest while detained at the Eloy Detention Center. He was less than a month away from turning 57. Maya, a diabetic, had been frantically calling his family for more than 10 days after being abruptly arrested at the family home in Sacramento in mid-January. The last call Maya made to his family was the first time his sons ever heard their father cry. One son, Jay Ashis, later relayed that call: "He said, 'Son, if you don't get me out of here today, I'm going to die.'" Maya foretold his own fate. The day after the last call, Maya was taken to an emergency room in Casa Grande. After being diagnosed with congestive heart failure and later a heart attack, he was airlifted to St. Mary's Hospital in Tucson on life support. His family drove twelve hours to watch his heart fail. He died shackled to a hospital bed (Bernstein, 2008; ICE, 2017).

The lack of proper care inside immigrant detention centers has also had devastating consequences for those facing psychological symptoms. This is particularly true at Eloy Detention Center. Three days before Christmas 2005, *The Eloy Enterprise* ran a story titled "CCA death in cell" in the section "Of interest… In Brief." The story, totaling less than 60 words, told how guards at Eloy Detention Center had found a "detainee unresponsive in his cell." He was pronounced dead at 5:20 a.m. on December 14 of an "apparent suicide" (NA, 2005). No further details were provided. In a later investigation of 83 deaths of immigrant detainees between 2003 and 2008, *The Washington Post* found 30 "questionable." Juan Salazar-Gomez's death that December morning at Eloy was listed as one of them (NA, 2008, May 10). Juan, who was 29 at the time he was found in his cell, never anticipated the grim precedent his death would set (ICE, 2017). Juan's death marked the beginning of a string of suicides that have since followed.

In early 2006, the Bureau of Prisons (BOP) decided not to renew its contract with Eloy Detention Center due to budget issues. Nearly 500 BOP inmates were to be moved out of the Center (Kelley, 2006). Prison jobs were on the line. Eloy Mayor Byron Jackson, a former corrections officer, wrote to Immigration and Customs Enforcement (ICE),

> 'The city of Eloy has had discussions with CCA regarding the development of a Residential Services Agreement for the housing of detainees/inmates at the Eloy facility. Should [Immigration and Customs Enforcement] ICE have a need for detention space at this facility, the city would be happy to enter into discussions/negotiations with ICE.' CCA was attempting to find new jobs for its employees. In the meantime, employees at Eloy Detention Center were asked to sign non-disclosure agreements 'designed to limit their conversation with reporters and others' (Stark, 2006, February 2: 1).

While negotiations proceeded for the ICE contract, prison employees anxiously awaited their future. One corrections officer who went by "Mr. Ray" noted that 126 people had already been laid off. Ray argued that although cuts were by seniority, pay cuts would lead to the departure of senior officers (Stark, 2006, February 2). ICE eventually approved the intergovernmental service agreement with Eloy. The per diem rate per detainee was set at $68.45 (ICE, 2006). Meanwhile, Jackson had little concern about Eloy taking on the label of a prison town. He explained, "I think people are comfortable with the environment… Heck, it's been 10 years now with very little problems whatsoever" (Kelley, 2006: B2). Despite four deaths, Eloy Detention Center would stay open for business.

Conditions at Eloy Detention Center remained the same and deaths continued. On New Year's Day 2006, José López-Gregorio had turned 32. The husband and father likely spent his birthday and the coming of a new year worrying about how to care for his family. They were going hungry and he had to make a choice. In mid-August, he had left his family with a month's supply of food and headed north. By the end of September, he was held at Eloy Detention Center (NA, 2006, Suicide Autopsy). For twenty-one days after being incarcerated, José did not receive a physical examination. After he was finally examined, medical personnel ignored a sick call for seven days (Tovino, 2016). Guilt-ridden over leaving his family and unable to rejoin them, José contemplated ending his life.

On September 24, José was placed on suicide watch in isolation after fellow detainees reported he was voicing

Photo courtesy of U.S. Immigration and Customs Enforcement (ICE)

suicidal thoughts. A medical doctor met with him at 7 p.m. that night. The doctor reported his risk as low, discontinued suicide watch, and placed him on 15-minute checks. The next day, the doctor met with José. José was "very upset, sobbing, expressing much guilt." The doctor diagnosed José with Adjustment Disorder with Depressed Mood. As José was to leave the facility the next day, no further follow up was scheduled (NA, 2006, Suicide Autopsy). Four days later José, still at Eloy, was found in his cell with a bedsheet tied to the upper bunk. He was taken to Casa Grande Regional Medical Center and later pronounced dead (NA, 2006, Eloy Police Reports; ICE, 2017). ICE later stated after an investigation, "Medical care in this facility does not meet ICE standards" (Tovino, 2016: 174). Yet, the facility remained open.

As Eloy Detention Center continued to operate as if nothing was amiss, the death toll increased. In November 2006, a few months after José's death and less than a year after Juan's death, Mario Francisco Chavez-Torres turned 27. A month later he suffered headaches, dizziness, and vomiting at Eloy Detention Center while medical staff ignored his symptoms (Regan, 2016). Mario's sick call from solitary confinement was ignored for four days. When a nurse finally responded, it took her one hour to get to Mario, whose cell was a two-minute walk from the medical office. Once she got to his cell, she said she was not qualified to assess him and was "only a pill pusher." There is no evidence that a doctor ever saw Mario (Tovino, 2016).

A week later Mario collapsed in the shower. On December 13, 2006, he was found unconscious in an isolation cell after an "unwitnessed seizure" had left him brain dead. His official cause of death is listed as a ruptured arteriovenous malformation midbrain (ICE, 2017). An ICE memo investigating Mario's death concluded he "should have been referred for outside treatment and that Eloy failed to protect [Mario]'s health, safety, and welfare" (Tovino, 2016: 175). *Failed to protect*. A later Department of Homeland Security (DHS) investigation found that Eloy Detention Center had "failed on multiple levels to perform basic supervision and provide for the safety and welfare of ICE detainees" (Tovino, 2016: 175). *Failed on multiple levels*. Still, the facility stayed open.

Photo courtesy of U.S. Immigration and Customs Enforcement (ICE)

The brutality of immigrant detention at Eloy continued away from public scrutiny or legal remedy. Five days after Mario's death, Felix Franklin Rodriguez-Torres called his mother, Maria, in Queens, from Eloy Detention Center. Felix, a construction worker who loved to play soccer, told her that he had been sick from coughing and fever. He had developed swelling in his neck that his sister had noticed some time before, "most likely a sign that cancer was blocking his lymph system." Felix promised to call his mom again on Christmas. He never did. Two days after Christmas, Felix was taken to the emergency room at Maricopa Medical Center in Phoenix.

He had lain "pleading for medical help on the floor of his cell, unable to move." The mass in his neck had tripled in size and obstructed his breathing. He was too far gone for chemotherapy since his cancer had gone undiagnosed and untreated for too long. He was placed on life support. On January 12, 2007, the hospital gave notice to CCA that Felix had one week to live. The deportation officer refused to tell his family where he was hospitalized. The officer then offered to release Felix to his family if they paid for a plane ticket to New York. But Felix was too sick to travel. A nurse secretly lent Felix her phone so he could call his family. His parents finally came to his bedside once they heard from him. Felix's face lit up when he saw them. They spoke to him for a few hours before the visit was cut off by detention guards. The next morning, Felix was in a coma. On January 18, his family took him off life support. Felix died of a cancer treatable in a "vast majority of cases." He was 36. His mother later lamented, "I never want another immigrant to feel this pain" (Bernstein, 2009). Two months after Felix's death, Eloy underwent its annual review by DHS. It was assigned a final rating of "acceptable" (DHS, 2007).

It would be inaccurate to say that the detention center was completely inaccessible to public scrutiny. Four months after Felix's death and a month after the annual review, the then editor of *The Eloy Enterprise*, Lindsey Gemme, visited Eloy Detention Center for the first time. Maybe there was hope the town newspaper would finally shed light on the happenings inside the detention center for the community and the world to see. But Gemme would not be the journalist to do so. After thanking CCA for "their time and hospitality," Gemme detailed her introduction to the "prison system and its inner workings" (Gemme, 2007: 2). As she noted, prison is not just a place where "the rest of society hopes to lock away our undesirables and throw away the key" but also a place meant to "rehabilitate, teach, and maybe even heal people who have maybe made a few mistakes" (p. 2).

Someone should have informed Gemme that the detention center was not meant to be a prison since people are held there while their "administrative proceedings" are being adjudicated. But then again, considering the visual markers of

Photo courtesy of U.S. Immigration and Customs Enforcement (ICE)

barbed wire, locked doors, and armed security, she described what she saw. Regardless, such subtleties seem meaningless anyway in a "prison town." Gemme found that detainees "were friendly, talkative, and not scary at all," despite the barbed wire fencing. She highlighted that she believes "in forgiveness and second chances. Sometimes third and fourth chances." She ended by hoping that the women she met can "get 'back to a normal life'… as soon as they possibly can" (Gemme, 2007: 2). If only serving time at Eloy could have given hope to that possibility. A few months later, CCA's Anytown Scholarship funded three Pinal County high school students to attend a leadership development camp. As a CCA official noted, "As one of the largest employers in Pinal County, it is vital for us to invest in our host communities" (NA, 2007: 1). As detainees kept losing their lives at Eloy Detention Center, there was little indication the community would raise any objections.

This was particularly true as time passed and the incarcerating entity and job provider became even more embedded in the community. On Valentine's Day 2008, there was a company barbeque at Eloy Detention Center in celebration of CCA turning 25. John Ferguson, then president and CEO of CCA, attributed the company's success to their "dedication in providing a safe and secure environment for the inmates in our care, our employees and the communities we serve" (NA, 2008, Corrections: 7). At the annual inspection of the facility later that month, the detention center would again be given a rating of "acceptable." Five months later, Nail Yoursef Dawood, almost 42 years old, died at Eloy Detention Center. His official cause of death is listed as "natural/coronary artery vasculitis." Less than three months after his death, Emmanuel Owusu's life would end at the detention center. Emannuel, a 62-year-old barber, had lived as a permanent resident for 33 years, mostly in Chicago. He was a diabetic with high blood pressure. He had been detained for two years at Eloy. He was found hanging weeks after he had lost his last appeal (Bernstein, 2010). He died at Casa Grande Regional Hospital from "complications of acute cerebrovascular accident."

As the detention center continued to operate, the rural community continued to seemingly benefit despite the graveyard created at the edge of town. In its February 2010 annual review, Eloy Detention Center got a final rating of "superior." In July that year, representatives from the detention center donated "notebooks, pencils, paper, rulers, glue and much more" to the Eloy Elementary School District "just in time for the start of the new school year" (Gal, 2010: 5). In November, veterans employed at Eloy Detention Center received a "special commemorative pin that pays homage to their bravery and commitment to the country" (NA, 2010: 1). The annual review in February of 2011 stated that Eloy Detention Center met all standards.

Whatever guidelines this fictive narrative denoted, it did not mean an end to the reality of deaths. On October 5, 2011, Pablo Gracida-Conte submitted a call slip while held at Eloy that said, "Can you please help me?" Pablo had had no appetite for three weeks and threw up whenever he did manage to eat. A second call slip read, "my stomach hurts, unable to eat well, will vomit after eating. Pain in stomach" (DHS, 2012, Report: 6). Pablo only spoke his native dialect of Mixtec. He likely had someone write the call slips for him in English. At 3:30 p.m. three days later, a nurse at the clinic tried to use a Spanish interpreter but noted that "something was definitely lost when trying to communicate over a speaker phone." The nurse recorded that Pablo was a "thin male, appears older than stated age" (DHS, 2012, Report: 8). At 10 a.m. on October 14, Pablo stated he had "not felt well for two months." He had no appetite and a level of pain that did not "let him sleep" (DHS, 2012, Report: 10).

On October 22, Pablo was sent to the medical unit for shortness of breath. The nurse practitioner stated, "I'm not going to see him." Instead, instructions were given to "increase fluids, continue his medications and refer to the primary [midlevel practitioner] for follow-up next week" (DHS, 2012, Report: 11). The next day, Pablo submitted another sick call in English that he wanted to stop taking the medications because the pills made him feel bad, they gave him heartburn, and made him feel dizzy. On October 24, Pablo stated he had not "been eating for two months and was even unable to recall his last meal." He said he "was going to court tomorrow and just wanted to go home" (DHS Report, 2012: 12-13). At 7 p.m. the next day, Pablo was admitted to Casa Grande Regional Medical Center. Three days later, he was airlifted to the University Medical Center in Tucson. In likely one of his last words, at 12:57 a.m. on October 30, he noted that he "can't take a deep breath" (DHS Report, 2012: 16). At 4:42 a.m. Pablo passed away. The Medical Compliance Review later repeatedly noted that various individuals had "failed" to respond to his requests for medical care (DHS Report, 2012). A few months later in early 2012, DHS conducted a performance-based national detention standards inspection of the Eloy Detention Center. Eloy received a final rating of

"Meets Standards" (DHS, 2012, Performance: 99).

One might think that once deaths in a single detention center had risen to double digits, something would have been done. In a seemingly natural indication of how this nation has long cast off individuals deemed the "other," nothing was in fact done. A community had jobs, a company made money, the detention center stayed open, and tragic deaths continued. On January 12, 2012, Manuel Cota-Domingo turned 34 years of age. We can only guess whether he made plans then for his travels north. By early December of that year, he had made his way to Sasabe, Arizona (DHS, 2013, June 10). On December 12, he was held at Eloy Detention Center. Manuel had been carrying a "bag of meds" that was taken from him once he got to Eloy because it was "non-allowable property." The next day, Manuel signed a form indicating he wanted to tell the consulate he was detained. For the next 10 days, Manuel would suffer a series of medical symptoms. They started with congestion and a cough. Manuel verbally denied he had any serious medical conditions. As a registered nurse later explained, "some detainees are afraid to disclose medical conditions because they fear it will either cause them to be held in detention longer, or speed up their removal" (DHS, 2013, June 10: 12). His cellmate confirmed later that Manuel was "worried he would have to pay for medical care which he could not afford." So, Manuel suffered in silence.

A week after being at Eloy Detention Center, Manuel was medically cleared "to be removed" and scheduled for deportation via ICE Air the day after Christmas. At 11 p.m. on December 19, his cellmate heard Manuel having "very labored breathing." His cellmate banged on the cell door and yelled "CO" and "sick." A CO responded at 2 a.m. Manuel was evaluated by a registered nurse at 4:30 a.m. Manuel talked about "his family and seemed distressed about not being able to reach them." The nurse thought he was having "an anxiety attack" (DHS, 2013, June 10: 20). After 5 a.m. it was recommended that Manuel be taken to the hospital. But no ambulance was called. Instead, Manuel was restrained in irons and then driven to Florence Anthem Hospital in a van. On the way, one officer commented how bad Manuel's breath smelled. Officers noted that his "breathing became noticeably more labored during the trip" and he had "started out sitting upright, but gradually slouched down in his seat until he was laying [sic] down" (DHS, 2013, June 10: 23). Hours after arriving at the hospital, Manuel was shocked with a defibrillator. He remained unresponsive the next day. On December 22, he was transferred to St. Joséph's Hospital in Phoenix. Fifty-seven minutes after midnight on December 23, Manuel was declared dead. A later Medical Compliance Review found that Eloy Detention Center was not fully compliant with ICE standards for medical care (DHS, 2013, June 10). Yet, the detention center stayed open.

Photo courtesy of U.S. Immigration and Customs Enforcement (ICE)

It would be inaccurate to say nothing was ever done after lives were lost. In their final days, Elsa Guadalupe-Gonzales and Jorge Garcia-Maldanado lived almost parallel lives. Although by different means, they both found themselves at Eloy Detention Center in March 2013. Elsa was 24. Jorge had just turned 40. They both had significant others and children. After being booked, they were both allowed to take their shoes inside the facility as "allowable property." They were both deemed to be in good mental health during initial intakes. They were both given a pamphlet on managing stress (DHS, 2013, September 25; DHS, 2013, October 7). Three days apart, they both met with their assigned deportation officers. Elsa's officer later said that "he did not specifically remember" her. Jorge's officer later said that "he did not have any recollection" of him. They both went to Christian religious services several times although their paths did not cross. The Chaplain who was interviewed later said she did not "specifically remember" either of them.

Although the circumstances of their deaths were different their lives ended the same way. On April 28, Elsa waited for others in her unit to leave for dinner. She then "shut her cell door while still inside, and smiled through the window in her cell, at the detainees in the dayroom" (DHS, 2013, September 25: 11). She was found hanging from the top bunk with her shoelaces around her neck. Two days later, Jorge placed a towel to cover the cell door's window. He was found hanging from the top bunk with a shoestring around his neck (DHS, 2013, October 7). On May 10, 2013, Eloy Detention Center employees received an email stating that "all shoelaces have been taken from all detainees and are now considered contraband" (DHS, 2013, September 25: 22). Finally, something was done about the deaths at the detention center, although it cannot be said to be significant.

By this time, the City of Eloy had gained prominence among official detention circles and the summer of 2014 provided an opportunity for it to showcase itself as a well-connected prison city. Central American refugees were overwhelming border patrol. There was a need for a place to house mothers and children. All eyes were on CCA to take

the lead. CCA had a place in Dilley, Texas that they called the "South Texas Family Residential Center." If opened, it would be the largest immigrant detention facility in the country. But contracts had to be written and negotiated, a process that takes time. The City of Eloy stepped in to save the day and avoid bureaucratic delays. On September 25, 2014, the town newspaper ran the breaking story, "City takes on $290M deal with ICE." At CCA's request, the City agreed to modify the terms of its already-existing contract with ICE but only after the City Council sucessfully negotiated for twice the fee offered by CCA, which sought to pay 25 cents per day per detainee. The City Council wanted $1 a day per detainee. They settled for 50 cents. Eloy would net $438,000 per year from the family detention center in Dilley.

Money was the only point of contention. No efforts were made to address standards of care nor did the City reference the conditions inside its own detention center. As City Manager Harvey Krauss stated, "This is a business deal for the city – it is not about immigration" (Neu, 2014: 1). Before the vote was taken, Mayor Joseph Nagy stated, "It's the council's opinion that we should participate in some of the rewards of working with CCA and the government" (Neu, 2014: 1). After the vote, Nagy noted, "The citizens won" (Neu, 2014: 6). It would matter little who lost.

Of course, the money coming in to the City of Eloy had no impact on the rising death toll. In fiscal year 2015-16, the City adopted a tentative budget of more than $39 million, which included large sums of pass-through money that filled CCA coffers. Despite the large sums of money circulated, little changed inside the detention center. For Elisa Deniz this would mean unbearable heartache. Elisa last saw her son, José de Jesús Deniz-Sahagun, when they celebrated his birthday on May 13, 2015 at the family home in Jalisco, Mexico. The occasion was bittersweet as José was heading north to join his three young children in Las Vegas. Two days later, José encountered border patrol agents in Douglas, Arizona. He was "hysterical and visibly emotional" and "expressed fear that someone was going to kill him" (DHS, 2015: 1).

On May 17, José was taken to Banner University Medical Center in Tucson after "twice jumping from a concrete bench in a Border Patrol hold room and landing on his head." He was later discharged into Border Patrol custody and listed as "stable" (DHS, 2015: 2). After being booked at the Eloy Detention Center on May 18, José told a registered nurse during his intake that he had been taken to the hospital the day before after "throwing himself off a table to try to kill himself. He stated he wanted to break his neck and die because his life was threatened, and he would rather kill himself than allow someone else to do it" (DHS, 2015: 3-4). The registered nurse later said José at that time was not "suicidal, symptomatic, or urgent," and described him as appearing "stable" (DHS, 2015: 3-4). José spoke to his sister on the phone one time (Bishop, 2016). She never heard from him again.

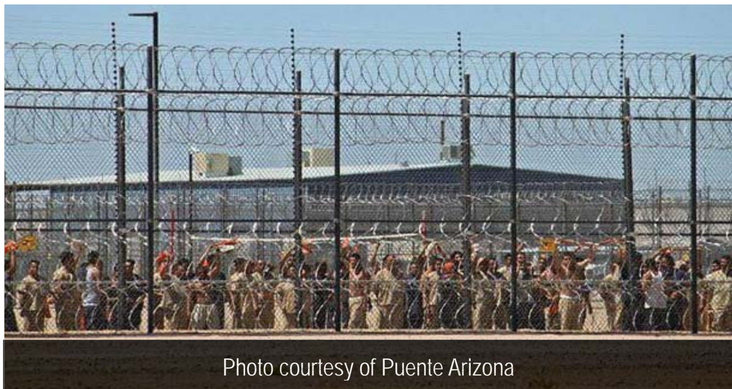


Photo courtesy of Puente Arizona

Records indicate José reacted to his incarceration on four separate occasions in a single day. Each time he was met with force. On May 19 around 9:30 a.m., two CCA employees attempted to interview him. José refused to answer any questions and insisted his attorney be present. When the employees gave up and returned him to his cell, José attempted to run out the main door. An officer pointed pepper spray at him and ordered him to face the wall and place his hands behind his back. José complied. After being handcuffed, José again attempted for the door. Two officers then took him down and one later described the take-down maneuver as "one of the easiest he has seen in his ten years in corrections" (DHS, 2015: 7). The officers described José as "completely uncompliant, uncooperative, and aggressive" during the incident (DHS, 2015: 7). Camera footage of the incident remains less than useful because "there was bright sunlight… obscuring clear view" and "some of the incident took place in a blind spot" (DHS, 2015: 8).

Incident #1. While José was on the floor, handheld video footage shows him surrounded by staff and "he is crying out and screaming." José refused to comply with the medical exam and repeatedly stated, "This is brutality. I need my lawyer." A registered nurse later recalled that he was "verbally combative, agitated, not making sense, and demanding his lawyer be called" (DHS, 2015: 9). She was only able to determine that he had "no visible signs of bleeding." José was again held face-down on the floor in the medical unit to "control his movements." José screamed in English and Spanish, "Help me," "Call my lawyer," "This is brutality" (DHS, 2015: 9).

Incident #2. After 14 minutes at the clinic, José was placed in a wheelchair to be taken back to his cell. José refused to cooperate and tried to slide out of the wheelchair. A CCA employee applied a pressure point technique to the base of his neck for five seconds and a second pressure point to his hypoglossal nerve for two seconds. Upon release of the pressure points, José stopped resisting. Four officers, one holding each of his limbs, carried him face down back to his cell. José was sobbing (DHS, 2015).

Incident #3. José was then placed on suicide watch and had to be moved to a different location. A "five-person cell extraction team was assembled" (DHS, 2015: 12-13). José was taken on a gurney. Once he got to the new cell, he refused to get off the stretcher and the staff had to carry him inside .

Incident #4. On May 20, José saw a doctor who wrote that José was "embarrassed about the events of yesterday" and that he has already written CCA staff a letter of apology. A later report found that because he was on suicide watch, José did not have access to "implements necessary to write an apology letter," there is no evidence they were given, and no apology letter was ever found (DHS, 2015: 16).

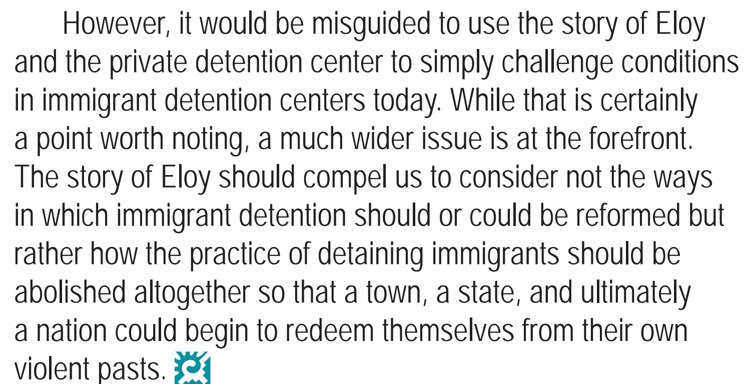
The doctor then changed José's status from suicide watch to mental health observation because "he believed the detainee was no longer a danger to himself" (DHS, 2015: 17). At 5:28 p.m. a medical emergency was called after an officer checked in on José. Ten minutes later 911 was called. Paramedics got to José at 5:52 p.m. José was pronounced dead at 6:09 p.m. The autopsy found that an orange sock stuck in his esophagus had caused him to asphyxiate (DHS, 2015). A later interview noted that the "nurses seemed preoccupied with taking the detainee's blood pressure instead of initiating the 'ABCs' of CPR: Airway, Breathing, and Circulation… the nurses seemed to have limited awareness of the contents of the emergency bag" (DHS, 2015: 25-26). The Security and Healthcare Review later found that Eloy Detention Center had not fully complied with ICE standards for medical care, significant self-harm and suicide prevention and intervention, special management units, and use of force and restraints (DHS, 2015). The Review further noted that even though there have been five suicides since 2005, Eloy Detention Center has not yet developed a suicide prevention plan (DHS, 2015). Clearly, the change of policy behind shoelaces did not amount to having a suicide prevention plan.

Thirty-six-year-old Raquel Calderon de Hildago, who had no criminal history, spent Thanksgiving 2016 incarcerated at Eloy Detention Center. She had been suffering a series of seizures that went untreated. That weekend, she was rushed by ambulance to the Banner Casa Grande Medical Center where she died (Planas, 2016). An autopsy later found that Raquel had died of blood clots in her right lung that had traveled from her leg upward after a leg injury. One story reported that it "remains unclear whether Calderon's death was preventable" (González, 2017). Perhaps clarity could come from accounts from inside the detention center. Those accounts seem to indicate that Raquel fell to the ground as she suffered seizures and was in great pain. The guards ignored her, thought she was faking it, and yelled at her to get back up. When she did not respond to their demands, they finally called for the medical cart. The medical cart was locked in a room some distance away. People held inside had repeatedly expressed concerns to the guards that the medical cart should not be locked in cases of emergencies. They had been ignored. The medical cart was finally brought and Raquel was transported to the hospital suffering continual seizures along the way. Whether she was "rushed" there does not seem as relevant. By then it was too late. The day after Raquel died, the room with the medical cart was apparently unlocked.

Conclusion

Outside the last place Raquel was alive, unpicked cotton was swaying in the fall breeze. A few weeks later, chilly winter nights set in and then a New Year. The next fall will bring harvest time. The cotton will bloom again. Many detainees will be "voluntarily" or forcibly deported. The winter will come. The unpicked cotton will wither away. Someone may end up dead and the sun will rise and set on Eloy. While home to the nation's deadliest detention center, the city has come to evoke fear in immigrant communities facing the violent threat of arbitrary arrest, detention, and deportation. If the detention center at Eloy expands to incarcerate more people, as indicated by many persons connected with the facility, more lives will be put at risk through a combination of inadequate medical care, arbitrary use of solitary confinement, and a record of violent deaths.

However, it would be misguided to use the story of Eloy and the private detention center to simply challenge conditions in immigrant detention centers today. While that is certainly a point worth noting, a much wider issue is at the forefront. The story of Eloy should compel us to consider not the ways in which immigrant detention should or could be reformed but rather how the practice of detaining immigrants should be abolished altogether so that a town, a state, and ultimately a nation could begin to redeem themselves from their own violent pasts.



Endnotes

[1]Judith Perera is a Ph.D. candidate in the School of Historical, Philosophical, and Religious Studies at Arizona State University focusing on immigration/migration.

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