



ANTHOLOGY OF ABUSE

A Legacy of Failed Oversight and Death at the
Eloy Detention Center



DETENTION
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Background

The Eloy Detention Center (Eloy), located in Eloy, Arizona, is a private immigration detention facility operated by CoreCivic. Opened in 1994, the center was designed to imprison people in criminal custody but has since evolved into one of the most controversial immigration detention facilities in the United States.

Today Eloy has the capacity to detain 1,550 individuals in the custody of U.S.

Immigration and Customs Enforcement (ICE)¹ and has gained notoriety as the "deadliest immigration detention center in the U.S.," with at least 16 reported deaths, including five suicides.²

Over the years Eloy has undergone several operational changes, reflecting broader shifts in U.S. immigration policy. For example, amid the Trump administration's zero-tolerance family separation policy in 2018, Eloy became one of the few locations detaining both mothers and fathers who had been separated from their children at the border.³ By January 2024, Eloy was among the 12 immigration detention facilities across the United States with an average population exceeding 1,000 people.⁴

Despite its grim history and ongoing issues, the Eloy Detention Center continues to detain over 1,000 people. Reports from people previously and currently detained, members of Congress, and advocates document a litany of abuses, including frequent suicide attempts, preventable deaths, excessive use of segregation, especially of people living with a serious mental illness, and inhumane living conditions. These accounts expose a disturbing pattern of negligence and mismanagement, with ICE repeatedly accused of complicity in concealing the mistreatment and suffering that occur

¹ Detained, Mapping Confinement. University of Arizona Digital Scholarship. <https://detained.digitalscholarship.library.arizona.edu/exhibits/show/clientart/map>.

² Monsy Alvarado, Ashley Balcerzak. "Deaths in custody. Sexual violence. Hunger strikes. What we uncovered inside ICE facilities across the US." USA Today. December 19, 2020. <https://www.usatoday.com/in-depth/news/nation/2019/12/19/ice-asylum-under-trump-exclusive-look-us-immigration-detention/4381404002/>

³ Concepcion de Leon. "'Split at the Root' Review: The Work of Sanctuary." The New York Times March 2, 2023. <https://www.nytimes.com/2023/03/02/movies/split-at-the-root-review.html>.

⁴ Felicia J. Persaud. "Twelve U.S. immigration detention centers each surpass 1,000 detainees," New York Amsterdam News, January 11, 2024. <https://amsterdamnews.com/news/2024/01/11/twelve-us-immigration-detention-center-each-surpass-1000-detainees/>.





TUCSON
Sentinel.com

More than 200 hunger strike at Eloy immigration detention center

Posted Jun 13, 2015

within the walls of Eloy. ICE's decision to continue operating the facility, despite its history of harm and controversy, raises serious questions about accountability and oversight in the U.S. immigration detention system.

Purpose

ICE insists through internal inspections that the Eloy is in compliance with "rigorous detention standards" despite years of evidence exposing failures. This brief presents evidence supporting the case for shutting down Eloy. For years, people detained, advocates, lawyers, government agencies, and journalists have documented and exposed rampant mistreatment and deaths at the facility, creating a substantial body of evidence of abuse.

The service contract for Eloy was set to expire in September 2024,⁵ offering an

opportunity for ICE to close this notorious facility. However, instead of seizing this moment to end the cycle of abuse, ICE extended the services contract to June 30th, 2028 and continues to detain people at Eloy, disregarding the facility's documented history of abuse and widespread community opposition.

We cannot accept empty promises to improve conditions at Eloy.

The evidence presented in this brief clearly demonstrates that the only viable solution is to permanently end its contract for Eloy, shut down the facility for good, and release people detained inside. The following sections provide a comprehensive summary of evidence and resources from

⁵ Detention Compliance and Removals. U.S. Immigration and Customs Enforcement. Office of Acquisition Management. Amendment of Solicitation/Modification of Contract. June 30 2023.





Why Are So Many Inmates Dying at the Eloy Immigration Center?

various perspectives, all supporting the urgent demand for closure.

The Paper Trail

Advocates and Directly Impacted Individuals

Over the past decade, the Florence Immigrant and Refugee Rights Project

(Florence Project) has documented and filed numerous complaints with oversight agencies regarding severe abuses at Eloy. These complaints document issues including severe medical deficiencies, abuse by guards, lack of legal access, violations of disability rights, and egregious use of segregation, particularly for individuals with serious mental illness. They also report unsanitary and inhumane living conditions, inadequate diets for those with chronic illnesses like diabetes, and delays in accessing specialized medical care, underscoring a persistent disregard for the health and safety of individuals detained at Eloy.

From October 2022 to September 2024, the Florence Project has filed 53 complaints to the Office of Civil Rights and Civil Liberties (CRCL) and the Office of the Immigration





LGBT detainees describe harrowing life inside Eloy

AZMIRROR

Family, former detainee say fumes at Eloy ICE facility is 'poisoning' women

Detention Ombudsman (OIDO).⁶⁷ In a February 2024 submission, they detailed worsening conditions despite a recent investigation by CRCL. Their findings exposed significant issues, including poor medical care, unsanitary dining conditions,

inadequate laundry services, frequent lockdowns, improper use of suicide watch and segregation, violations of privacy for women, and verbal and physical abuse by staff.

In one recent example, A 59-year-old man was detained at Eloy in good health. In January 2024, six months into his detention, he developed severe hyperglycemia that went untreated for weeks, resulting in permanent health damage.⁸ He began reporting to medical staff symptoms such as excessive thirst, frequent urination, weight loss, swelling in his legs, and dry mouth. Despite reporting

⁶ "Florence Project Six Month Report: Ongoing Complaints and Systemic Issues in Arizona Adult Immigration Detention Center." The Florence Immigrant and Refugee Rights Project, April 18, 2024. [Florence Project Six Month Report: Ongoing Complaints and Systemic Issues in Arizona Adult Immigration Detention Centers | Florence Project \(firrp.org\)](#)

⁷ "Report on ICE Immigration Complaints, October 2022-March 2023." The Florence Immigrant and Refugee Rights Project." [2023-09-15_Florence-Project-Report-on-ICE-Detention-Complaints_Oct-2022-March-2023.pdf \(firrp.org\)](#)

⁸ Liz Casey, Letter to the Florence Project. February 29, 2024 (on file with the Florence Project.)





azcentral.

Eloy Detention Center: Why so many suicides?

these symptoms multiple times, he was told to just drink more water and his blood sugar was not tested for almost a month. When his blood sugar was finally checked he had a reading of 500 and was immediately sent to the emergency room. The hospital noted that he had severe hyperglycemia requiring the highest level of care and multiple doses of insulin, with the risk of organ failure. The ER doctor wrote, "this patient had a high probability of imminent or life-threatening deterioration."⁹ During that time, he experienced loss of feeling in his toes and severe vision loss, which likely will be permanent.

In another case from 2022, a man diagnosed with a serious mental illness was subjected to six months of inhumane segregation before finally being transferred to a psychiatric hospital for necessary treatment.¹⁰ During his segregation, he was

often confined to wearing a 'suicide mock' without socks or underwear, sometimes left naked, and forced to sleep on a thin mattress on the floor without a blanket. He had little to no access to basic hygiene items like a toothbrush or to recreational activities. His mental health deteriorated rapidly, causing him to miss meals, lose a significant amount of weight, and reach a point where he urinated and defecated on the floor, often sitting in the mess for extended periods. His condition worsened to the point of becoming unresponsive and catatonic, none of which had been present before his segregation.

The tragic failures of medical care and oversight at Eloy Detention Center have exposed a disturbing pattern of negligence that has led to multiple preventable deaths. Advocates and individuals formerly detained at Eloy have highlighted the facility's alarming lack of responsiveness and preparedness, particularly in medical emergencies. A recent report by Physicians

⁹ US Immigration and Customs Enforcement. Eloy Medical Records. Provided by the Florence Project

¹⁰ Florence Immigrant & Refugee Rights Project.

"Report on ICE Immigration Detention Complaints, October 2022-March 2023."

[2023-09-15 Florence-Project-Report-on-ICE-Detenti](#)

[on-Complaints_Oct-2022-March-2023.pdf \(firrp.org\)](#)





for Human Rights and the American Civil Liberties Union National Prison Project, titled *Deadly Failures: Preventable Deaths in U.S. Immigration Detention System*, points to Eloy as a prime example of these failures.¹¹ In June 2018, Huy Chi Tran, a Vietnamese national detained at Eloy, was found unresponsive in his unit after suffering a cardiac arrest. He was transported to Banner Casa Grande Medical Center, where he died after eight days of hospitalization. It was later discovered that medical staff had failed to correctly place automated external defibrillator pads on his chest and had no backup pads when the equipment failed to adhere to his body.¹²

This was not an isolated incident. Through a Freedom of Information Act (FOIA) lawsuit, the ACLU obtained official communications between ICE officials discussing the impending death of Felix Franklin Rodriguez-Torres, one of ten cases where deaths in immigration detention had been omitted from public records for years. These emails revealed that Mr. Rodriguez, who died in January 2007, went undiagnosed with testicular cancer for two months while detained at Eloy.¹³ His

¹¹ Eunice Hyunhye Cho & Tessa Wilson. "Deadly Failures: Preventable Deaths in U.S. Immigration Detention". Physicians for Human Rights, June 25, 2024.

<https://phr.org/our-work/resources/deadly-failures-preventable-deaths-in-u-s-immigration-detention/>

¹² Ibid.

¹³ Detainee deaths at Eloy Detention Center The New York Times



symptoms had gone unnoticed, even after he was taken to the hospital.

People detained at Eloy have long been subjected to a climate of fear, exacerbated by a series of mysterious and unacknowledged deaths that have sparked outrage and protest.

<https://www.nytimes.com/interactive/projects/documents/detainee-deaths-at-eloy-detention-center>





In 2015, following the suspicious deaths of two people, a group of 200 individuals at Eloy initiated a hunger strike to demand accountability.¹⁴ The strike was catalyzed by the death of José de Jesús Deniz-Sahagún, who was found dead in his unit without visible signs of injury. People detained alleged that guards had beaten him and placed him in solitary confinement shortly before his death. Soon after, another death was reported within the facility, but ICE allegedly refused to acknowledge it. In their demands, the hunger strikers called for investigations into the deaths, excessive use of force, improved medical and mental health care, access to legal resources, and an end to the criminalization, detention, and deportation of immigrants.¹⁵ This strike was supported by a rally outside the facility, amplifying the voices of those inside and bringing attention to the ongoing abuses at Eloy.

Government Oversight

Government oversight mechanisms have failed to hold ICE or CoreCivic accountable for this long history of failures. The culture of secrecy within ICE has permeated down to its contracted employees, fostering an environment where accountability is routinely evaded, often at the expense of the lives of those in custody. A congressional oversight committee

¹⁴ Roque Planas. Hunger Strike at Arizona Detention Center After Immigrant's Mysterious Death. Huff Post. June 13, 2015. https://www.huffpost.com/entry/eloy-hunger-strike_n_7577154

¹⁵ Ibid.

investigation in 2020 uncovered that an employee at Eloy failed to monitor a person in solitary confinement, resulting in the individual being found unresponsive in their unit.¹⁶ Among the seven cases highlighted in the hearing was that of Huy Chi Tran, who had been placed in solitary confinement. CoreCivic detention staff were required to check on Mr. Tran every 15 minutes, yet the employee on duty left him unsupervised for 51 minutes, just before he suffered the cardiac arrest that ultimately led to his death. Investigators discovered that the officer falsified observation logs to cover up the failure to follow protocol. The investigation also revealed a series of other lapses, including delays in medication, lack of proper equipment, and incorrect administration of prescribed medication.

To this day, the Eloy Detention Center has consistently failed to fully comply with detention standards. In a recent inspection conducted by ICE's own Office of Detention Oversight in 2024, inspectors uncovered 29 deficiencies across five of the 13 evaluated detention standards.¹⁷ Most notably, these

¹⁶ U.S. House Committee on Oversight and Reform. Staff Report on ICE Contractors: Examination of ICE's Detention Oversight and Contractor Performance. September 24, 2020.

<https://oversightdemocrats.house.gov/sites/evo-subsites/democrats-oversight.house.gov/files/2020-09-24.%20Staff%20Report%20on%20ICE%20Contractors.pdf>.

¹⁷ U.S. Immigration and Customs Enforcement Office of Detention Oversight. Follow-up Compliance Inspection of the Eloy Federal Contract Facility. May 21, 2024.

https://www.ice.gov/doclib/foia/odo-compliance-inspections/eloyFedContractFac_EloyAZ_May21-23_2024.pdf





failures included serious lapses in medical care. One particularly alarming case involved an individual who was not given an eye exam during the intake process at Eloy and, as a result, was unable to read any printed material throughout their detention. The inspection also revealed the facility's failure to comply with suicide prevention and self-harm intervention standards. Logs showed six instances where medical staff delayed monitoring individuals under suicide watch, a critical oversight given the facility's troubling history with self-harm incidents. These persistent gaps in care highlight the systemic neglect that continues to jeopardize the lives of people detained.

Recent complaints outlined above demonstrate the same types of issues continue in Eloy despite the government's own inspections and recommendations and show that ICE and CoreCivic are unwilling and/or unable to humanely care for anyone detained in Eloy. Eloy's ongoing non-compliance, and violations of the ICE National Detention Standards and Section 504 of the Rehabilitation Act, particularly in these key areas, demonstrates that the facility is beyond repair. The repeated deficiencies—especially in medical care and suicide prevention—pose an immediate and life-threatening risk to those held in custody. These failures are not isolated incidents but part of a larger, entrenched pattern of mismanagement. If left unaddressed, it is only a matter of time before more lives are lost, making the

closure of this facility not only necessary but urgent.

The Media

The media has been critical in exposing the harsh, inhumane conditions at Eloy, including the troubling pattern of deaths and particularly high number of suicides. From its opening, journalists have documented the facility's failures, often linking these tragic outcomes to medical negligence and the systemic disregard for protocol.

One such report brought to light the harrowing experience of Karolina Lopez, a transgender woman from Mexico who was transferred to Eloy. Upon her arrival, Karolina was strip-searched and, due to her lack of surgery, was forced to be detained with men for over three years. In an AZ Central story, Karolina described enduring verbal and physical abuse, and when she sought help, was placed in isolation, further exacerbating her mental health struggles.¹⁸ Karolina feared for her life, knowing that two transgender women had already died in nearby detention facilities, where negligence contributed to their deaths. The media's coverage of cases like Karolina's has been instrumental in shedding light on the brutal realities faced

¹⁸ Javier Arce. "Arizona activists call on President Joe Biden to end transgender migrant detention." The Arizona Republic. June 30, 2021. <https://www.azcentral.com/story/news/politics/immigration/2021/06/30/arizona-activists-call-president-joe-biden-end-trans-migrant-detention/7810811002/>.





by those detained at Eloy, particularly the vulnerable transgender population.

Eloy has not only been a site of COVID-19 mismanagement but has a long history of failing to control other major disease outbreaks with the impact felt beyond the detention center itself. In 2015, a report from Tucson Local Media exposed the largest measles outbreak in Arizona since 2000, with two-thirds of the cases traced back to Eloy.¹⁹ The Arizona Department of

¹⁹ Tucson Local Media. "2015 Measles Outbreak." Explorer News. December 7, 2022. https://www.tucsonlocalmedia.com/explorernews/columns/article_0e7a4882-75fc-11ed-bbc3-176f5cf7692b.html.

Health Services confirmed that the detention center was responsible for the biggest measles outbreak in the United States at the time.²⁰ Eloy's mismanagement continued to make headlines as the COVID-19 pandemic ravaged detention facilities across the country. Conditions in the facility during the pandemic were repeatedly challenged and various judges held that the continued detention of medically vulnerable detainees in these facilities violates the detainees' constitutional due process rights.²¹ The

²⁰ Ibid

²¹ Urdaneta v. Keeton, D. Arizona. Filed May 11, 2020. <https://casetext.com/case/urdaneta-v-keeton>





center experienced the second-largest outbreak of COVID-19 in any U.S. immigration facility, with over 41% of the detention staff testing positive.²² Tragically, one correctional officer died due to COVID-19 complications. At its peak, the facility reported 270 active cases, according to a warden at the facility.²³

In the aftermath of the employee's death, another staff member resigned, citing the facility's failure to adhere to safety protocols.²⁴ The former employee detailed substandard conditions, including a lack of personal protective equipment (PPE) and pressure to work despite high risks of contagion. These conditions not only contributed to the spread of the virus within the facility but also posed a serious

public health risk to the surrounding community.²⁵

Eloy's repeated failures in managing infectious diseases reflect deep structural deficiencies in health and safety protocols. The persistent negligence in addressing outbreaks, from measles to COVID-19, underscores ICE's inability to protect those detained at Eloy.

These recurring health crises are yet another indication that Eloy Detention Center is beyond repair and must be closed immediately for the sake of those detained inside as well as in the interest of public health.

The Solution

The only viable solution to address the deeply entrenched issues at Eloy Detention Center is its immediate closure. ICE has repeatedly demonstrated that it is incapable of addressing the deficiencies at Eloy, despite numerous inspections,

²² Daniel Gonzalez. "Over 40% of Staff at Eloy Detention Center Test Positive for COVID-19, CoreCivic Reports." USA Today. July 9, 2020. <https://www.usatoday.com/story/news/nation/2020/07/09/elyo-detention-center-staff-positive-covid-19-corecivic-reports/3287289001/>.

²³ Daniel Gonzalez. "Guard at Eloy Detention Center may have died of COVID-19 as coronavirus cases at facility soar." AZ Central. June 15, 2020. <https://www.azcentral.com/story/news/politics/immigration/2020/06/15/coronavirus-cases-arizona-elyo-detention-center-guard-covid-19-deaths/3193118001/>.

²⁴ IAS Services. "Eloy Detention Center: Conditions, Location, and Contact Information." US Immigration Advisory Service. <https://us.iasservices.org.uk/elyo-detention-center>

²⁵ Bob Libal & Gregory Hooks. "Hotbeds of Infection, How ICE Detention Contributed to the Spread of COVID-19 in the United States." Detention Watch Network. December 2020. https://www.detentionwatchnetwork.org/sites/default/files/reports/DWN_Hotbeds%20of%20Infection_2020_FOR%20WEB.pdf





investigations, and reports detailing widespread abuse, neglect, and mismanagement. The continued operation of this facility, with its deadly history, poses a significant threat to the health, safety, and dignity of people within its walls.

Given this legacy of harm, Eloy should not be repurposed for any other form of incarceration.

Instead, it must be shut down permanently, with those detained released to reunite with their families—not simply transferred to endure suffering elsewhere.

ICE's decision to extend the services contract for Eloy until 2028 was a grave mistake, but it is not an irreversible decision. Given the extensive body of evidence documenting the facility's failures—ranging from preventable deaths and rampant disease outbreaks to substandard medical care and repeated non-compliance with ICE's detention standards—any assurances to improve conditions lack credibility. Eloy's track record makes it clear that no amount of oversight, reform efforts, or changes in management will be sufficient to address

the deep-rooted problems within the facility.

We have only one recommendation for the Eloy Detention Center: the administration must immediately release everyone currently detained at the facility and shut it down.

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