

## Testimony of Belinda Maley

Before the Homeland Security and Governmental  
Affairs Committee (HSGAC) Permanent Subcommittee on Investigations (PSI)

Hearing on “U.S. Department of Justice’s (“DOJ”)  
Implementation of the Death in Custody Reporting Act”

Thank you, Chairman Ossoff and Ranking Member Johnson, for the opportunity to testify before you today. My name is Belinda Maley and I am the mother of Matthew Loflin. I am testifying today because in 2014 my son died because authorities in the Chatham County Detention Center (“CCDC”) denied basic medical care to him.

### **I. Introduction**

Matthew Loflin, whom we called Matt, was my only child. Every parent on this committee knows the love we have for our children. Imagine losing any of your children to the criminal legal system, especially to one of its jails where I was never able to hold him, never able to touch him. I am here today to ask you to put yourself in my shoes, to imagine the heartache of watching your only child suffer in a jail, be denied necessary medical care, and die after being transported to a hospital. Matt’s death highlights the importance of the Death in Custody Reporting Act (“DCRA”), and the need to count all deaths of people in our nation’s jails and prisons. Such data is a vital part of oversight of America’s criminal legal system.

On February 6, 2014, Matt was arrested for non-violent drug charges and booked into the CCDC, which serves as Savannah, Georgia’s jail. Within days he started losing consciousness in his cell. On February 21, 2014, the jail’s health care provider—Corizon Health, Inc. (“Corizon”)—collected medical information on Matt and performed a physical examination. They administered an electrocardiogram, which showed results consistent with congestive heart failure. In spite of the finding, Corizon staff took no action to have Matt evaluated further, and failed to treat him immediately for his heart condition.

As detailed in the attached Complaint, *Exhibit A*, for the next 5-6 weeks Matt suffered from congestive heart failure and was denied medical care by Corizon. On April 7, 2014—two months after he arrived in the CCDC—Matt was finally transported to a cardiologist, who immediately sent Matt to the emergency room of a local hospital. Although he finally received appropriate medical care, the lack of adequate medical care at the CCDC damaged his heart so much that Matt coded several times and suffered irreversible brain damage. On April 24, 2014, life support was withdrawn and Matt died that night. My testimony will focus on what happened to my son and the deadly perils of privatized medical care in Savannah’s jail.

### **II. Health Care That Prioritizes Profit Over Care**

Documents provided by the CCDC and Corizon show that many in the jail *knew* that Matt needed medical care for his heart condition, and some recommended that Matt be transported to a hospital for care, but Corizon leadership prohibited it. Why? Because medical

care for Matt would diminish Corizon's profits.

Matt's jail records show the following:

--February 6, 2014: Matt arrested for non-violent drug charges and jailed in the CCDC.

--February 21: Corizon staff collect a medical history, perform a physical exam, and administer an electrocardiogram ("ECG") of Matt's heart activity. The ECG indicated that his heart rate was elevated (125 bpm) and showed results consistent with congestive heart failure. Corizon staff took no further action.

--March 3: Matt complains to sheriff's deputies that his heart was racing and that he could not sleep. Corizon nurse V. Black responds, notes a heart rate of 140 bpm and that Matt had signs of syncope (i.e. fainting). Black merely marks the file to be reviewed later and took no further action.

--March 4: Matt again complains of passing out, anxiety, and a racing heart rate. Corizon nurse M. Stokes responds but makes no notation of Matt's elevated heart rate or signs of syncope. Instead, she schedules a mental health appointment for March 6, 2014.

--March 5: Sheriff's deputies call a Signal 55—code for a sick person—for Matt after finding him unconscious and appearing to have difficulty breathing. Nurse Stokes again responded, only to note that the mental health appointment she scheduled the day before was still on the calendar. She provided no further medical care and left Matt in his cell.

--March 6: Matt is seen by someone in Corizon's mental health department and prescribed medication for anxiety. Matt declined the medication, however, because he knew that he did not have a mental health problem.

--March 19: Matt is found unconscious in his cell. Sheriff's deputies called Signal 55 and Corizon Nurse D. Thrift responds. She takes no action except marking the file to be reviewed later and left Matt in his cell.

--March 20: Matt is found unconscious in his cell. Sheriff's deputies called Signal 55. Nurse K. Smith responds, scheduled Matt for an appointment with a doctor, gave him an additional blanket, and provided no further medical care. Later that day Matt had a chest x-ray which was read by Dr. Merrill Berman. The results showed that Matt had an enlarged heart (cardiomegaly) and pneumonia. The chart also notes that Matt was "coughing up blood," had a heart rate of 121, and had swelling of his feet.

--March 22: Matt complains to both security and Corizon that they were "covering up symptoms and not treating them."

--March 24: Matt is transferred to the medical unit of the CCDC and seen by Dr. Charles Pugh, the Corizon doctor at the CCDC. Dr. Pugh determined that Matt needed to be sent to the hospital. Corizon's policies, however, did not permit Dr. Pugh to send patients to

the hospital without the approval of the Regional Medical Director, Scott Kennedy. Dr. Kennedy works in the Corizon regional office located in Punta Gorda, Florida. Dr. Kennedy never personally observed, evaluated, or interacted with Matt. Kennedy overruled Dr. Pugh and refused to allow Matt to be sent to the hospital. Dr. Kennedy did approve, however, a referral for an outpatient echocardiogram for Matt.

--March 27: Matt is sent for an outpatient echocardiogram and testing. The test was performed, Matt was returned to the CCDC, and the results were sent to Dr. Pablo Elizalde, a cardiologist, for evaluation. In addition, Nurse Susan West wrote a progress note that indicated that Matt was faking his illness by "wretching (sic) neck all positions appearing to try to get himself to cough." Finally, she notes that Matt "stood up at the flap [and] yelled because he wants to know what we are gonna do for him that he can't breathe...observed yelling and stating that he has a heart condition."

--March 28: Dr. Elizalde informed Dr. Pugh that the results of the echocardiogram were consistent with the diagnosis of congestive heart failure. Matt had an Ejection Fraction of 10-15%, and his medical condition was acute. Dr. Pugh informed Dr. Kennedy of the results and requested authority to send Matt to the hospital. Dr. Kennedy again refused. At the end of the day, a 10:53 pm, Nurse Debra Thrift wrote a progress note indicating that Matt stated he was in constant pain, grabbed his chest, and rated his pain as a 10 on the 10 scale. Matt also said to the nurse, "[I am] not going to make it."

--March 29: Nurse Debra Thrift wrote another progress note indicating that Matt was "demanding to be taken to a hospital."

The documents show that each morning from March 28 through April 7, Dr. Pugh, Nurse Williams, and Nurse Riner informed their supervisor, Virginia O'Neill, that Matt needed hospitalization. Each day, Matt's medical condition declined. Each day, Ms. O'Neill refused to intervene and refused to send Matt to the hospital. Finally, on April 7, Dr. Pugh determined that he could send Matt to a cardiologist because Dr. Kennedy would only approve a cardiology consult, and he could get Matt to the hospital through the cardiology visit. The plan worked, and on April 7 Matt was sent to the Memorial Hospital Emergency Department. Treatment efforts failed, however, and on April 24 my husband and I said goodbye to my son.

The horror of what happened to Matt was knowing he was in such pain and knowing Corizon's supervisors did not care. On March 24 I was called by a stranger, a woman whose son was in the cell next to my Matt. The person in that cell relayed that Matt was not getting needed medical care, needed to go to the hospital, and was afraid he was going to die.

I called the jail to schedule a visit with my son and was informed that I could not see him until April 1 because his unit only allowed visitation on Tuesdays. When I finally saw Matt, I was shocked—it was clear that he was deathly ill, disoriented, pale, and bloated. Matt told me that he needed to be taken to the hospital, that he did not want to die in jail, and that he loved me.

My husband and I immediately started calling jail authorities to demand that Matt be taken to a hospital. We were told that we had to speak to the sheriff himself, and when we made

that call, he never responded. We called the jail over twenty times to have Matt sent to the hospital. We were ignored.

The perversity of this entire nightmare is that Corizon rewards staff for denying lifesaving medical care to people in the jails and prisons in which it operates. We discovered that the Regional Medical Director for Corizon, Dr. Kennedy, convened weekly conference calls with the Site Medical Directors who report to him what patients have been sent to outside medical providers. I understand that Kennedy uses these calls to pressure the Site Medical Directors about such patients and pushes the Site Medical Directors to work to release patients on bond or rush their return from the hospital to reduce costs and increase Corizon's profits. To make matters worse, Dr. Kennedy is compensated with both a base salary and performance incentives. That is, Dr. Kennedy's pay increases as Corizon's profits increase. In 2014, the year Matt died as a result of having the misfortune of being booked into Savannah's jail, Dr. Kennedy received performance incentives and casually joked that he would be able to "buy some fine scotch" with the increased pay he received.

### **Conclusion**

Thank you for the opportunity to testify before you today. I am here both because my son died in one of Georgia's jails and because I believe with all my heart that change is possible. Please continue to highlight the importance of the Death in Custody Reporting Act to identify deaths and develop solutions to avoid them in custody. Thank you.