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Department action related to April 5 inmate death

The Utah Department of Corrections has initiated employment actions involving five individuals based on the findings of two separate investigations into the death of an inmate who was receiving dialysis care at the Utah State Prison.

On Thursday, the Department gave termination notices to two employees — a physician assistant and a supervising nurse. A second supervising nurse has been given notice of a demotion, while a registered nurse has received notice of a 40-hour suspension.

All the employees had some responsibility for the care of seven dialysis patients who were receiving treatment at the prison's onsite Dialysis Center, operated by University of Utah Health Care, between April 3 and April 5.

In addition, the Clinical Services Bureau director will be returning to work in the capacity of a medical doctor.

Four of the employees had been on administrative leave. The Department is not releasing any of the employees' names.

The Department will now launch a national search for a medical administrator for its Clinical Services Bureau.

The Utah Department of Health is conducting an external review of our dialysis operation and has access to two additional, separate investigations: an internal investigation by the Department's Law Enforcement Bureau and an outside audit by the nationally recognized health care consulting firm WELLCON. The WELLCON audit looked at the prison's dialysis program, the prison's overall healthcare delivery system as it relates to dialysis patients and delivery of mental health services to these inmates.

That final review is expected to be finished within 90 days.

The Medical Examiner's Office has not yet completed its autopsy report on Ramon C. Estrada, 62, who died on April 5.

However, the Department's preliminary internal investigation indicates that the failure to provide Estrada with dialysis at the prison's on-site clinic could be a contributing factor in his death.

Technicians for South Valley Dialysis, the U.'s contracted provider, failed to show up at the prison clinic between April 3 and April 5 due to a scheduling error. As a result, the seven inmates, including Estrada, did not receive dialysis during that period.

The Department implemented several measures immediately following Estrada's death to improve communication with and oversight of the dialysis contract provider.

Since then, the Department and South Valley Dialysis have added additional measures to improve care and tracking of inmates receiving dialysis. These include provision of weekly summary sheets of inmate dialysis treatment; a procedure for monitoring and tracking inmates who refuse or stop scheduled dialysis treatment; sharing of treatment protocols and notes/orders between the Department and South Valley Dialysis; holding quality assurance protocol reviews every six months; and mandatory joint training of Department and South Valley Dialysis staff who work in the Olympus Facility (where the dialysis clinic is located).

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