OCO INVESTIGATION OF
DELAYED CANCER DIAGNOSIS & MANAGEMENT
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SUMMARY OF CONCERN

The Office of the Corrections Ombuds (OCO) previously conducted two investigations highlighting delayed cancer management[1] at the Monroe Correctional Complex, revealing delays of three to five months from the time the patients reported their symptoms until the time of diagnosis. Since those reports were released, OCO has continued to receive complaints regarding cases where delays in cancer diagnosis reportedly occurred. The complaints involve different facilities across the state, and some have resulted in death.

Identifying and treating cancer at an early stage is important because it greatly increases the chances for successful treatment. The purpose of this investigation is to review the series of alleged delayed cancer diagnoses that have come to OCO's attention; to identify key issues that affected quality of care; to analyze for commonalities; and to identify opportunities for improvement.

OCO STATUTORY AUTHORITY

- Per RCW 43.06C.005, OCO was created to assist in strengthening procedures and practices that lessen the possibility of actions occurring within DOC that may adversely impact the health, safety, welfare, and rehabilitation of incarcerated individuals, and that will effectively reduce the exposure of DOC to litigation.
- Per RCW 43.06C.040, OCO has the authority to receive, investigate, and resolve complaints related to incarcerated individuals' health, safety, welfare, and rights.

[1] OCO MCC Deaths Report 1 and Report 2

OCO INVESTIGATIVE PROCESS

Notice of this investigation was provided to DOC in October 2020. In the course of the investigation, OCO reviewed the following documents:

- Medical charts
- DOC Policies 600.000 Health Services Management
- 610.010 Offender Consent for Health Care
- 610.040 Health Screenings and Assessments
- 610.650 Outpatient Services
- 890.620 Emergency Medical Treatment
- Washington DOC Health Plan (a.k.a. Offender Health Plan)

In addition, the OCO interviewed several of the patients involved in these cases. Unfortunately, not all could be interviewed because OCO encountered obstacles in scheduling patient interviews at one of the facilities. DOC staff was not interviewed due to concurrent COVID19 outbreaks at the involved facilities; in addition, in some cases the involved medical staff had already left DOC employment.

CASE SUMMARIES

Patient A

Patient A is a White male who was 37 years old when he sought treatment at a DOC prison clinic in May 2019 for a painful skin lesion on his back that was cracking and bleeding. His provider diagnosed a benign skin lesion and explained that it could not be removed based on DOC's Offender Health Plan.

Over the following months, Patient A sent three medical Kites and filed a grievance, requesting treatment for the growing skin lesion; his provider conferred with the Facility Medical Director and in June 2019 responded, "It is not authorized by DOC. [Facility Medical Director] is sticking

to that." Finally, in September 2019 he underwent excision of the "benign" lesion; a pathology report identified malignant melanoma.

After the malignancy was identified, a period of two months passed before he was sent for a surgical evaluation in November 2019. At that visit, the surgeon recommended "urgent" full body imaging, lymphatic mapping, and re-excision of the melanoma site along with sentinel lymph node biopsy to check for metastasis; these same recommendations were reiterated by the medical oncologist at a separate visit. However, the imaging studies were not scheduled, and Patient A sent medical Kites inquiring about when they would be performed. In January 2020, Patient A finally received the "urgent" full body imaging, but the lymphatic mapping did not occur until March 2020 after additional prompting from Patient A via medical Kites.

The melanoma diagnosed in September 2019 did not undergo re-excision and lymph node biopsy until April 2020; unfortunately, this found that the cancer had spread to a lymph node in his left axilla. He again had to send medical Kites expressing concern about an oncology follow-up for treatment; in mid-May 2020, one response to a Kite was that the provider was waiting for a referral to oncology by the surgeon, and that it had "only been 2 days" (it had actually been three weeks since his lymph node biopsy results were known). He was not sent to the oncologist until late May 2020.

Chemotherapy began in June 2020. Despite the treatment, the cancer spread quickly, and he died one month later.

Patient B

Patient B is a 56-year-old Black male with a history of intermittent blood in the urine since at least 2017. On interview, he stated that he had asked his providers for cancer screening in 2017, because of a DOC document he received on entry that included a "Special Addendum for Men" indicating that African-American men should be checked for prostate cancer every year if they are over 40 years of age.[2] However, his provider and the Facility Medical Director declined to provide the testing he requested.

[2] State of Washington Department of Corrections Health Information and Patient Education Self-Help Guide, P-17961, v. 11/2008, page 24.

In August 2018, Patient B declared a medical emergency for a three-day history of blood in his urine; he was treated with a two-week course of antibiotics and was to have a follow-up urinalysis in 30 days. He continued to have painful urination with associated urinary frequency; he sent his provider a medical kite on 8/24/2018, complaining of severe pain in abdomen and frequent urination. He received a response six days later, instructing him to sign up for urgent care. A month later, he filed a grievance complaining of ongoing symptoms, stating that "they never followed up or examined me for anything else." That same month (September), DOC Health Services updated its protocol regarding prostate cancer to indicate that screening should be discussed with high-risk populations such as African Americans age 45 and older; however, there is no indication that this discussion took place with Patient B.

After another month of continued symptoms, Patient B was evaluated by his provider in October 2018. He reported continued and constant lower abdominal pain. Urinalysis was negative; his provider did not prescribe any treatment or further evaluation for the left lower quadrant pain. He was told to kite as needed. Another urinalysis was performed in early December 2018 due to complaints of painful and frequent urination; the test was again normal.

Patient B was not seen until late February 2019, when he sought care for the evaluation of a neck mass which he discovered 1 ½ weeks earlier; an ultrasound was ordered. Five days later, he declared a medical emergency for blood in his urine, left flank pain, and difficulty walking / standing; he was treated for muscle pain. Three days later, he declared another medical emergency due to a three-day history of blood in his urine and left flank pain; moderate blood was noted on urine dipstick, and he was admitted to the IPU for treatment of possible kidney stone.

In March 2019, a CT of neck revealed a mass concerning for neoplasm. At an appointment to discuss the CT results, the provider noted urinary frequency, recurrent hematuria, a 13-pound weight loss in 7 months, and history of night sweats; Patient B stated that this information was previously reported to his former assigned primary provider. A biopsy of the neck mass on 3/13/2019 revealed metastatic Stage IV prostate cancer. A subsequent PET scan demonstrated that the cancer had spread to the abdomen, pelvis, and clavicles. At the time of this writing time, he has completed two rounds of chemotherapy, but has been told he will likely die within 9 to 18 months.

Patient C

Patient C is a 35-year-old White male who entered DOC's system in June 2019. At an intake history and physical, he reported difficulty swallowing for eight months; nevertheless, the nurse practitioner deemed him "healthy" and did not indicate any need for additional evaluation. In August 2019, he presented to the clinic complaining of severe acid reflux, abdominal pain, and difficulty swallowing; he described having to take small bites of food and making a slurry with his saliva to swallow it. He was given medication and told to follow-up in two weeks, but an appointment was not made for him. In addition, a referral was made to gastroenterology to occur "within one month" but that ultimately did not get scheduled until December. Lab studies were performed revealing a hemoglobin of 9.4[3]; this significant anemia was acknowledged by the provider, but no additional action was taken.

In September 2019 Patient C was transferred to a minimum-security facility. He again reported pain with swallowing and reflux symptoms. An upper endoscopy was ordered. Unfortunately, he was transferred to a county jail several days later for a court order and he did not return to the minimum-security facility until November 2019. He again reported symptoms at that intake screening, and a consultation for upper endoscopy was placed.

By December, Patient C still had not been seen for the upper endoscopy. At a provider visit, he reported pain and difficulty with swallowing solids and liquids, as well as nausea; he additionally complained that he needed dental work, and unfortunately the provider focused on the dental complaint. The plan was to contact the Chief of Dentistry to transfer him to a facility that could provide dental care; there was no intervention regarding the other symptoms. He returned a week later with worsening symptoms; he was vomiting, unable to eat, had increased abdominal pain, and difficulty swallowing. At this point, the provider reviewed his lab studies and noticed his significant anemia in August; he was sent to the ER, where he was found to have a hemoglobin of 7.8 and multiple abdominal masses. He was transferred to another facility and finally underwent his gastroenterology procedures, which identified a highly aggressive Stage IV gastroesophageal adenocarcinoma. He underwent chemotherapy before being released through DOC's Extraordinary Medical Placement Policy DOC 350.270.

[3] Normal hemoglobin in adult males is generally >14.

Patient D

Patient D is a 55-year-old Native American[4] male on long-term anticoagulation (blood thinners) for a chronic medical condition. Routine lab studies performed by a DOC provider in January 2018 revealed a low hemoglobin of 12.8[5], but there was no further workup for this abnormal finding.

Shortly afterward, Patient D was transferred to another facility; although he was seen frequently to monitor his anticoagulation therapy, his anemia was not acknowledged, and no workup occurred. In November 2018, additional laboratory studies were performed, and hemoglobin was markedly low at 6.8; other markers consistent with anemia were additionally noted. The test results were signed by the provider indicating acknowledgement, but no action was taken on the significantly abnormal findings.

Patient D continued to be seen on a regular basis for his anticoagulation therapy, with some dosage adjustments. Finally, in June 2019 he presented to the clinic complaining of shortness of breath, fatigue, and blood in his stools; he was sent to the emergency room, where his hemoglobin was found to be 3.2 and his blood over-anticoagulated. Multiple transfusions were required. Additional diagnostic studies revealed an invasive adenocarcinoma of the colon which was felt to be the source of his blood loss; enlarged lymph nodes in the area were also noted. He underwent surgical resection of the colon mass, which was subsequently identified as a high-grade, aggressive type of carcinoma with spread to area lymph nodes.

Patient D was seen by the oncologist less than two weeks after release from the hospital. Chemotherapy began at the end of July; radiation therapy followed in October. He was released in February 2020 to continue cancer care at a community hospital; it appears that an appointment was made for him post-release.

Patient E

Patient E is a 34-year-old Black male with a prior history of small bowel obstruction in 2008 who presented to a provider in June 2020 for the complaint of abdominal pain over the last few weeks,

[4] Listed as White per DOC but noted to be Native American in medical chart.
[5] See footnote 3.

along with fever, chills, and nausea/vomiting. He was treated for constipation. Subsequent records indicate persistent abdominal pain and ongoing bloating / nausea, and on interview he additionally reported an inability to eat, resulting in a dramatic weight loss of 40 pounds in six weeks. He sent several medical Kites reporting pain, nausea, and no relief with medications, and declared numerous medical emergencies for the worsening pain. His provider responded by encouraging him to take medications for constipation and acid reflux. By the end of July 2020, the pain had spread to a new location in the abdomen and included additional new symptoms of pain with inspiration and with urination.

In early August 2020, Patient E sent another medical Kite asking his provider to schedule a gastroenterology consultation due to ongoing symptoms. At that time, the pain had become so severe that he could not sleep. The on-call provider recommended that Patient E be brought to the infirmary for an evaluation the following day, but a shift lieutenant would not bring Patient E to the clinic because he was not on the call-out list. Although there is only one documentation of this in the medical chart, Patient E stated that this refusal by IMU staff occurred on several occasions.

Over the next two days, the pain became worse; Patient E was unable to eat and was having abnormal bowel movements. He told the nursing staff "I feel like I'm going to die;" he requested admission to the IPU or the hospital, but the provider added him to the sick call schedule for the following day. A DOC nurse told Patient E that he needed to go to the hospital, but the provider refused this recommendation. On 8/12/2020, x-rays demonstrated a possible developing obstruction, and he was sent to the ER. There, a CT scan found a large mass occluding the colon and creating a high-grade obstruction. He was admitted to the hospital and underwent abdominal surgery, which confirmed the presence of a large malignant-appearing mass in the colon nearly occluding the lumen; biopsies confirmed poorly differentiated invasive adenocarcinoma. He underwent surgery to remove the mass and is awaiting a follow-up with his surgical oncologist to determine when additional surgery can be performed.

Patient F

Patient F is a 55-year-old White male who reports a history of hematuria (blood in urine) since November 2017. The condition was first identified at the intake facility, and he was told that he would be further evaluated for the diagnosis when he arrived at his parent facility. However, once

he arrived there, he did not receive any treatment or evaluations other than an x-ray to look for kidney stones. He states that he only noticed blood in his urine once a week, lasting 2-3 days at a time, so he "didn't push the issue" and did not pursue treatment.

Patient F was then transferred to another facility. In January 2020 his hematuria worsened, and he describes his urine as being "solid red" on a daily basis. At that point, he sought treatment from a provider, reporting a history of hematuria which began five months earlier, had become progressively worse, and was now constant. At that visit, a routine urology consultation was requested "within 1 month." He was to follow-up within three weeks, but there is no record reflecting this follow-up.

The routine urology consultation did not take place, and Patient F was not seen until two months later, when he presented to a provider in March 2020 complaining of thick blood in his urine with associated urinary urgency. The provider decided to treat him for a urinary tract infection; the urology consultation had been approved, but the appointment was still pending at that time. He states that he was treated for five urinary tract infections, with no resolution of his symptoms. He reports filing "grievance after grievance" in order to receive medical care.

Patient F was finally seen by the urologist in May 2020, five months after the original consultation request. The consultant recommended a workup to ensure that there was no malignancy; several studies including CT urogram[6] were ordered. Unfortunately, the CT urogram was not performed until July 2020; this revealed a large soft tissue mass in the right renal pelvis consistent with a primary urothelial malignancy.

Despite these CT urogram results, there is no indication of any specialty referrals after that diagnostic test. Patient F declared a medical emergency for abdominal pain and inability to urinate two days after the CT urogram; bladder catheterization yielded very bloody urine with clots, and antibiotics were prescribed. There was no further treatment until he declared another medical emergency in early August 2020, this time for fever and chills; he was sent to the ER, where he was admitted. CT now revealed an enlarging mass, with some suspicious lymph nodes. He finally underwent cystoscopy on 8/26/2020, and the definitive diagnosis of urothelial carcinoma was made.

[6] A CT urogram is an imaging exam used to evaluate the urinary tract.

Patient F has since completed chemotherapy and will be seeing the oncologist to discuss next steps; he anticipates needing an extensive surgical procedure.

Patient G

Patient G is a 58-year-old White male who initially presented to his medical provider in October 2018 complaining of a lesion on his bottom lip. A viral infection was suspected, and he was tested. A month later, he saw a dental assistant and informed them of a recurring lesion on his lower lip; the dental assistant recommended that Patient G request an exam with the dentist via Kite.

In December 2018, Patient G returned to his medical provider and gave a history of a "cold sore" on his lip for the past twelve months; he was treated with antiviral medication. A dentist's evaluation the following day reflected the plan for lip biopsy at the next visit; however, no appointment was scheduled for this procedure.

Because the lesion would not heal, Patient G contacted his medical provider via Kite. The antiviral medication was renewed four times, with each treatment course ranging from 14 days to 180 days; each time, the medications were renewed without a medical evaluation. He was not physically examined until June 2019, when he returned to the dentist who noted the lip lesions and submitted an internal consult request to the medical provider; however, no appointment was made by the scheduler, and after 60 days that consult request was automatically deleted from the scheduling queue.

Patient G returned to his medical provider in August 2019. The medical provider now described the lip lesion as "worrisome," and he was scheduled for a biopsy. The biopsy was not performed until October 2019, a year after his initial presentation; at that visit, the surgeon described the lesion as involving 70% of his lower lip. The biopsy revealed invasive squamous cell carcinoma. He underwent wedge resection of the lip lesion in November 2019.

Patient H

Patient H is a 68-year-old White male who has been in DOC since 1974. On interview, he stated that he began noticing blood in his stool sometime in 2019; he was sent to a local hospital for an

evaluation, but eventually he says he was told to stop straining when having bowel movements. He then transferred to another facility in May 2019 and had some initial basic laboratory studies performed; part of that initial battery of tests was testing for the presence of blood in his stool. In June 2019, two of the three tests were indicative of a GI bleed, and a consultation with gastroenterology was submitted.

Two months passed without the gastroenterology consultation taking place; the records indicate multiple subsequent follow-up appointments for other issues, with no further mention of GI bleed. Patient H was not seen by the gastroenterologist until August 2019, at which time a colonoscopy was recommended. Unfortunately, that diagnostic study was not performed until more than six weeks later, at which time it revealed a large mass in the colon; the biopsy in September 2019 confirmed the presence of colon cancer. He initially declined treatment and wanted only comfort measures / palliative care, then changed his mind after transferring to another facility and coming under the care of a new provider, who explained his tissue diagnosis and helped him understand that it was a curable condition. He then underwent resection of the cancerous lesion; one lymph node was positive for metastasis, so he was subsequently treated with chemotherapy. At the time of this writing, he was about to begin his last round of chemotherapy.

Patient I

Patient I is a 37-year-old White male who declared a medical emergency for abdominal pain in January 2020. He was treated for constipation. There is no further treatment after that initial instance; from April 9 through April 24th he was in COVID-19 isolation. On May 18, 2020, he declared another medical emergency for abdominal pain and a "lump" in his right upper quadrant; the record indicates that he had been having pain in the region for the last three months – i.e. since February 2020 – and was told that he would be assessed by a provider once he was released from isolation, but that assessment did not happen. He was then scheduled to be seen in sick call on 5/20/2020 but was moved to another facility on that date.

At the new facility, Patient I was evaluated by a provider for the same complaints; x-rays reportedly showed air fluid levels and increased stool, and he was again treated for constipation. However, the formal x-ray report from the radiologist did not find constipation; instead, the report described a large soft tissue mass over the right upper quadrant of the abdomen and extending over

the right lower chest which was suspicious for malignancy, and recommended CT. Another provider submitted an urgent request for this CT scan. Four days later, he declared a medical emergency for abdominal pain rated 9/10; he was sent to the ER, where CT confirmed several large liver masses, with the largest invading the diaphragm and reaching into the right lower lobe of the lung. He is currently under the care of an oncologist.

Patient J

Patient J is a 53-year-old Asian/Pacific Islander male who arrived at a DOC facility on 10/15/2019. At his intake physical, he reported that he had fallen from his top bunk a few days earlier, landing on his outstretched right arm. X-rays showed a lesion in one of the bones of the distal forearm. The following week, the DOC orthopedic consultant reviewed the x-rays and noted an expansile lytic lesion in the right wrist, consistent with a locally aggressive tumor; the recommendation was for him to see an orthopedic surgeon due to the risk of pathologic fracture.

A consult to an outside orthopedic specialist was submitted on 10/28/2019 but did not take place until 12/31/2019. An MRI of the wrist was ordered on 11/1/2019 but did not occur until 12/26/2019.

At the 12/31/2019 orthopedic appointment, the provider recommended a STAT referral to the university's Hand Center; a handwritten note that accompanied Patient J when he returned to the facility reiterated this referral recommendation but did not include the STAT designation. By the time Patient J transferred to his parent facility in February 2020, he still had not received this referral; the evaluation finally took place in March 2020, and he underwent surgery in April 2020. Biopsy confirmed the diagnosis of giant cell tumor.[7] He is currently under the care of an orthopedic oncologist.

Patient K

Patient K is a 66-year-old White male with a history of chronic right upper quadrant pain since at least 2012. In May 2019, he underwent abdominal MRI which revealed a small focal area in the

[7] Giant cell tumors of the bone are non-cancerous, but they are highly aggressive, have the potential to metastasize (spread), and can result in considerable morbidity due to destruction of surrounding bone. In light of this pathology and the delay in confirmatory diagnosis, the case was included in this investigation.

liver which was felt to possibly be imaging artifact. Magnetic resonance cholangiopancreatography[8] (MRCP) later that same month revealed other findings including a lesion in the liver which the radiologist stated was probably not cancer.[9]

A CT on 11/23/2019 revealed a 2.2cm nodule felt to probably be hepatocellular carcinoma, and a dedicated liver MRI was recommended; the results of this scan were not reviewed by the nurse practitioner until 12/9/2019. Per DOC, an appointment was scheduled for 12/15/2019 with the nurse practitioner, but this appointment was cancelled for unknown reasons.[10] On 12/19/2019 – almost a month after the CT was performed – Patient K was reviewing his medical records and discovered the presence of cancer in his liver.

MRI was performed in December 2019, and the report specifically noted an absence of suspicious liver lesions. However, repeat MRI in April 2020 demonstrated a markedly enlarging mass which was consistent with hepatocellular carcinoma. He is currently under the care of an oncologist.

ANALYSIS

Patient	Tumor	Time to diagnosis (months)	5-year relative survival rate[11] at localized stage
A	Melanoma	4	91%
B	Prostate cancer	7	~100%
C	Gastroesophageal adenocarcinoma	6	47%
D	Colon cancer	17	91%
E	Colon cancer	2	91%
F	Urinary tract malignancy	6	69%

[8] Magnetic resonance cholangiopancreatography, or MRCP, is a special MRI focused on the biliary and pancreatic ducts.
[9] The American College of Radiology created the LI-RADS system to standardize the reporting of CT and MR imaging for hepatocellular carcinoma. Patient K's liver lesion at the time of the MRCP was assigned LI-RADS 2 by the radiologist, equivalent to "probably not cancer."
[10] Patient K also had a nursing appointment on 12/10/2019 to follow-up on a complaint of ear pain – not to review the CT results – but he declined this appointment and it was not rescheduled.
[11] A relative survival rate compares people with the same type and stage of cancer to people in the overall population; in this case, since the 5-year relative survival rate for melanoma is 99%, people with localized melanoma are 99% as likely as people who don't have cancer to live for at least 5 years after being diagnosed.

G	Squamous cell carcinoma (lip)	12	92-95%
H	Colon cancer	3	91%
I	Liver cancer	3	34%
J	Giant cell tumor (bone)	6	(See footnote 11)
K	Liver cancer	5	34%

Data regarding 5-year relative survival rate was obtained from the American Cancer Society, except for squamous cell carcinoma of the lip (Hollestein LM, de Vries E, Nijsten T. Eur J Cancer. 2012 Sep;48(13):2046-53).

The average time to diagnosis for these eleven cases was approximately 6.5 months, with a range of two to seventeen months between the time of initial presentation until the diagnosis was finally made:

- In six of the eleven cases, the delay was associated with the clinician reaching an incorrect diagnostic conclusion;
- In five of the eleven cases, there was delayed scheduling of consultations with external specialists, contributing to the delay in diagnosis and/or the initiation of treatment;
- In four of the eleven cases, delayed scheduling of diagnostic studies contributed to the delay in diagnosis and/or initiation of treatment;
- Three cases demonstrated a delayed evaluation by a DOC provider; in one case, the delay was caused by refusal of custody staff to bring a patient to the clinic;
- In two cases, abnormal lab results were overlooked or not recognized;
- In one case, delay occurred because of a negative MRI interpretation by an outside radiologist, after a previously positive CT scan.

DISCUSSION

Cancer treatment varies considerably depending on the type of cancer and the stage at diagnosis. While it may be acceptable to wait a few weeks before initiating cancer treatment in some cases, for more aggressive cancers the treatment must start very soon. Increasing time to treatment is

generally associated with higher all-cause mortality,[12] higher psychological distress,[13] and increased healthcare costs and utilization.[14] When identified early, the cancer is more likely to respond to effective treatment, resulting in a greater probability of surviving, lower morbidity, and lower costs for treatment. Therefore, early diagnosis is important since it improves outcomes.

The World Health Organization[15] and National Institute for Health and Care Excellence[16] have identified a target of **no more than one month from presentation to diagnosis** for cancer cases. The target to start treatment is also set to within one month of diagnosis. Overall, the time from symptom onset to the start of treatment **should be less than 90 days** to reduce delays in care, avoid loss to follow-up, and optimize the effectiveness of treatment.

Considering these best practice targets for cancer diagnosis, the cases highlight the following opportunities for improvement:

- Identifying system deficiencies and gaps in resources that are preventing the diagnosis of cancer in its earliest possible stage;
- Requiring better oversight by the Chief Medical Officer and other responsible physician(s) to monitor the care provided, assist with challenging or confusing medical cases, and ensure that abnormal diagnostic studies are not missed, given this system that relies heavily on physician assistants and nurse practitioners to provide initial care;
- Shifting to a medical home model of practice, to achieve coordinated, longitudinal care that can ensure patients with critical health needs do not get forgotten even when transferring between DOC facilities or to/from county jails;
- Elevating the scheduling system to one more reliable than the confusing and antiquated color-coded spreadsheets currently in place, until an Electronic Health Record can be implemented (a process which can unfortunately take years);

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[12] Cone EB, Marchese M, Paciotti M, et al. Assessment of Time-to-Treatment Initiation and Survival in a Cohort of Patients with Common Cancers. Jama Netw Open. 2020;3(12):e2030072

[13] Miles A, McClements PL, Steele RJC, Redeker C, Sevdalis N, Wardle J. Perceived diagnostic delay and cancer-related distress: a cross-sectional study of patients with colorectal cancer. Psycho-Oncology, Vol 26, Issue 1, January 2017, pages 29-36.

[14] Delisle M, Helewa R, Ward M, Hochman DJ, Park J, McKay A. The Association Between Wait Times for Colorectal Cancer Treatment and Health Care Costs: A Population-Based Analysis. Diseases of the Colon & Rectum: February 2020 – Volume 63 – Issue 2 – p 160-171.

[15] World Health Organization. Guide to cancer early diagnosis. 2017; rev Jun 2018.

[16] National Institute for Health and Care Excellence. NICE guideline NG12. June 2015; updated January 2021.

- Ensuring that delivery of health care in the correctional setting is a joint effort between custody and health services, and that custody staff support the implementation of clinical decisions[17] so as not to hinder – and potentially jeopardize – patient care.

OCO's recommendation is that DOC develop an action plan to address these needs, as well as others they may identify through its own internal investigations. OCO welcomes the opportunity to assist and collaborate with DOC in developing solutions to the diagnostic delays identified by this report.

CONCLUSION

OCO recognizes that providing health care services in the correctional setting presents numerous challenges, including the high level of need, increased demand due to the aging population, shortages in qualified health care staff, difficulties in recruiting and retaining health care professionals, and budgetary constraints. Nevertheless, DOC has a duty to provide timely access to necessary medical care, and to meet accepted care delivery standards. These cases demonstrate the need to improve several care delivery processes within DOC, to ensure the best possible outcomes for patients with a cancer diagnosis.

OCO appreciates the opportunity to work collaboratively with DOC to identify solutions and strategies to promote positive change.

[17] National Commission on Correctional Health Care. NCCHC Essential Standard P-A-03. Medical autonomy. Standards for Health Services in Prisons, 2018.