Decision 21HDC00722
15 December 2025

HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Inadequate care provision to disabled person in prison

1. This Office received a referral from the Office of the Ombudsman regarding the care provided to Ms A at Auckland Region Women's Corrections Facility (ARWCF) by Ara Poutama Aotearoa Department of Corrections (Corrections).

2. This report focuses on the care provided by Corrections and Health New Zealand | Te Whatu Ora (Health NZ) – Counties Manukau[1] between June 2019 and May 2023. The complaint concerns delays Ms A experienced in receiving therapeutic botulinum toxin A (Botox)[2] injections at Health NZ – Counties Manukau and the disability support offered to Ms A by Corrections, in particular the compromised disability support she received during a COVID-19 isolation period and the detrimental impact this had on her ongoing wellbeing.

Background

Botox injections

3. At the time of these events, Ms A was a prisoner at ARWCF. Ms A has sacral paraplegia,[3] a condition that affects bladder control and urinary function and management. As a result, Ms A requires regular Botox injections to her bladder to assist with urinary leakage (incontinence).[4]

4. In August 2018 (while she was a prisoner at Arohata Prison in Wellington), Ms A received a Botox injection for her bladder dysfunction at the urology clinic at Health NZ – Capital, Coast and Hutt Valley. A further injection was pre-emptively scheduled for July 2019 because, at that time, Ms A required an injection every 11 months.

5. In June 2019, Ms A was transferred from Arohata Prison to ARWCF. This meant that her care then fell under Health NZ – Counties Manukau. On 3 July 2019, ARWCF made a referral to the Health NZ – Counties Manukau urology service for a Botox injection, which was

[1] Formerly known as Counties Manukau District Health Board. On 1 July 2022, the Pae Ora (Healthy Futures) Act 2022 came into force, which disestablished all district health boards. Their functions and liabilities were merged into Health New Zealand | Te Whatu Ora. All references in this report to Counties Manukau District Health Board now refer to Health NZ – Counties Manukau.
[2] Used to treat a variety of muscle disorders, including muscular spasms and an overactive bladder. It is not a permanent solution and will gradually wear off, requiring the consumer to undergo further treatments.
[3] A type of paralysis affecting the legs and lower body due to spinal cord injury in the sacral region.
[4] Ms A required Pull-Ups/pads, catheters, incontinence products, extra bedding/clothes, and cleaning products.

prioritised as P2 (semi-urgent), and Ms A was placed on the Health NZ – Counties Manukau urology service waitlist.[5]

Removal from the urology waitlist

6. Between July 2019 and October 2019, ARWCF staff followed up on the referral with Health NZ – Counties Manukau.[6]

7. On 24 October 2019,[7] Health NZ – Counties Manukau called and advised ARWCF that their initial urology service referral (dated 3 July 2019) had been sent to the waiting list of the Auckland Regional Spinal Unit (spinal unit) for review because of Ms A's history of spinal cord injury.[8]

8. Health NZ – Counties Manukau advised that, after receiving the referral from Corrections, it attempted to contact ARWCF to book an appointment but did not receive a response, and a decision was made to remove the referral from the urology service waitlist and transfer it to the spinal unit for review.[9] Health NZ – Counties Manukau stated that administrative errors meant that this inter-department referral did not result in Ms A receiving an appointment with the spinal unit after the transfer. Corrections made a further referral, but delays were caused by the need for Ms A to undergo a urodynamic study[10] and the COVID-19-related lockdowns.

9. On 20 February 2020, some seven months after the initial referral to Health NZ – Counties Manukau, the ARWCF medical office sent a further referral to the spinal unit, noting that Ms A was overdue for a spinal unit review, required a Botox injection, and should be seen as soon as possible. However, Ms A did not receive the Botox injection until April 2021,[11] close to two years after the initial referral to Health NZ – Counties Manukau.

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[5] A referral letter from Health NZ – Capital, Coast and Hutt Valley to Health NZ – Counties Manukau recommending a further Botox injection 11 months from 3 August 2018 was completed on 3 July 2019. This was received by Health NZ – Counties Manukau on 17 July 2019.

[6] In response to the provisional opinion, Health NZ – Counties Manukau told HDC that it only received one follow-up request on 23 September 2019 from Corrections and that this was a generalised email covering multiple patients rather than a specific enquiry regarding Ms A. Records obtained from Corrections show that follow-up requests were sent on 6 September 2019 (addressed to the spinal unit) and on 23 September. Health NZ provided records from its patient management system (dated 23 September) recording that Ms A had been waitlisted for an appointment with the Auckland Regional Spinal Unit (spinal unit) team, which had been graded as semi-urgent.

[7] On 16 October 2019, Health NZ – Counties Manukau wrote to ARWCF asking them to book an appointment within the following two weeks. On 24 October 2019, this was followed up with a phone call to ARWCF, and a voice message was left. However, there is no evidence of return communication from ARWCF.

[8] Health NZ – Counties Manukau stated that all patients with a history of traumatic spinal injury who are referred to urology are declined and referred to the spinal urology team. Until October 2019, Ms A remained on the Urology wait list.

[9] In response to the provisional opinion, Health NZ – Counties Manukau told HDC that its communication with ARWCF could have been better. However, Health NZ advised that it is unable to communicate directly with prisoners and that all communication regarding appointments is sent through the prison health service.

[10] To assess how well the bladder, sphincters, and urethra hold and release urine.

[11] As Ms A's bladder leakage was the result of an ACC-covered injury, she was offered the option of having the Botox injection privately. Ms A elected for Botox treatment in the private sector, and this was undertaken by Dr B in April 2021.

10. A further injection was scheduled for March 2022, but Health NZ – Counties Manukau declined this referral because Ms A was scheduled to see a consultant (and receive a Botox injection) privately in April 2022. This appointment was subsequently cancelled because Ms A could no longer tolerate the administration of a Botox injection under local anaesthetic, so future Botox injections would require a general anaesthetic, which – in the circumstances – could only be performed at a public hospital.[12] Ms A attended an appointment at the Health NZ – Counties Manukau urology clinic on 2 June 2022, where the scheduling of a Botox injection was discussed.

11. On 8 March 2023, ARWCF made a referral to Health NZ – Counties Manukau. Health NZ – Counties Manukau advised that Ms A was on a waitlist because she required a general anaesthetic for administration of her next Botox injection; this meant a delay of up to a year.

12. On 22 May 2023, Ms A received a Botox injection at Middlemore Hospital, where it was noted that she needed to be rebooked in nine months.

13. Ms A stated that the delays in receiving the Botox injections meant she had frequent incontinence accidents and urinary tract infections, which had affected her mental health.

COVID-19 Isolation: 6–14 May 2022

14. Ms A tested positive for COVID-19 and was managed in quarantine. Ms A stated that, during this time, she was left with soiled bedding and clothing. Corrections acknowledged that Ms A did not receive the fresh laundry she required and apologised for this oversight.

15. As a result of this incident, Corrections conducted a health service event review and a custodial event review (concerning the period of COVID-19 isolation) and made the following findings:[13]

    a. No treatment care/plan was documented in Medtech[14];

    b. Ms A was not seen daily by health services while testing positive for COVID-19;

    c. Although an alert was in place on the Integrated Offender Management System (IOMS)[15] regarding Ms A's catheter allowance, the other required incontinence supplies were not documented, and there was no alert advising custodial officers to seek extra incontinence supplies from health services;

[12] In response to the provisional opinion, Health NZ – Counties Manukau told the Health and Disability Commissioner (HDC) that Ms A's care was transferred back to Health NZ – Counties Manukau as the practice at private hospitals is to not provide general anaesthesia to prisoners.

[13] Recommendations included that ARWCF create a joint health and custodial care plan outlining specific arrangements regarding laundry processes and supply, medical supplies, cleaning supplies and the process to obtain extra supplies; a practice reminder be sent to the ARWCF health team regarding the clinical management of people with COVID-19 in prison guidelines and daily assessment expectations; assessment and welfare check 'quick codes' be taught at the quality improvement meeting; IOMS alerts be updated by health services.

[14] Practice management system.

[15] This system holds information including offender details, prisoner movements, property registers, disciplinary events, incidents, and interactions between offenders and staff.

d. There is no documented record by health/custodial services that Ms A was given incontinence products.

Additional concerns

16. Ms A also raised concerns that it was difficult for her to access areas of ARWCF in her wheelchair; she reported that staff had to lift her and that she often had to wait to be supplied with incontinence products.

Corrections' response

17. Corrections accepts that aspects of Ms A's care did not meet the accepted standard of care and that areas could have been managed differently.

18. However, Corrections told HDC that a referral for Botox was made shortly after Ms A's transfer to ARWCF and that staff regularly followed up on the referral. Corrections told HDC that access to hospital services is governed and managed by Health NZ – Counties Manukau, that it is Health NZ – Counties Manukau's responsibility to ensure the appropriate referrals are in place to access those services, and that it does not have any control over waiting lists.[16] However, it acknowledged that, from March 2020, the impact of COVID-19 lockdowns significantly affected wait times and delayed the delivery of health services.

19. Corrections also stated that, during Ms A's time at ARWCF, the COVID-19 pandemic created challenges and delays that affected the provision of prison services, including when the mandatory isolation of prisoners was required.

Health NZ

20. Health NZ – Counties Manukau apologised for failing to provide appointments and treatments in the required time frame and accepted that communication with ARWCF should have been better. However, the delays in care were caused by resource constraints within the spinal unit and the impact of COVID-19 as opposed to lack of communication.

21. Health NZ – Counties Manukau also advised that these delays were the result of multiple factors that cannot be solely attributable to Health NZ – Counties Manukau. These include:

a. Ms A's referrals were not received by Health NZ – Counties Manukau until the time Ms A's treatment was due, which impeded its ability to carry out a pre-procedure assessment and allow time for appropriate scheduling before the due date of the procedure;

b. As Ms A had not been a patient in the Northern region previously, Health NZ – Counties Manukau were unable to access any information about her previous assessments. The only information available was the information in the referrals.[17]

[16] In response to the provisional opinion, Health NZ – Counties Manukau told HDC that this statement is incorrect. Health NZ – Counties Manukau assesses referrals when received and manages waitlists for publicly funded services, but it remains the responsibility of the patient's primary care clinician to initiate an appropriate referral with sufficient supporting information, consistent with the Health Pathways guidance.

[17] Health NZ explained that it does not operate a national NHI-linked system that provides clinicians with records held by other districts.

22. Health NZ – Counties Manukau told HDC that it is increasingly aware of, and concerned about, significant limitations on Corrections' ability to bring patients to their appointments. Health NZ – Counties Manukau told HDC that it is not unusual for Health NZ – Counties Manukau requests for contact to go unanswered or to be advised on the day of an appointment or surgery that Corrections is unable to bring the patient to the planned appointment/procedure because of their resource constraints. Health NZ – Counties Manukau is concerned that this is negatively affecting the health outcomes of prisoners. As a result, delays in follow-up surgical care can cause avoidable complications, and Health NZ – Counties Manukau stated that Ms A's case is one of many that highlight this.

Relevant legislation

23. The standard of health care that Ms A was entitled to while in prison is set out in section 75 of the Corrections Act 2004:

> 'Medical treatment and standard of health care:
>
> 1) A prisoner is entitled to receive medical treatment that is reasonably necessary.
>
> 2) The standard of health care that is available to prisoners in a prison must be reasonably equivalent to the standard of health care available to the public.'

Responses to provisional opinion

Ms A

24. Ms A was provided with an opportunity to comment on the 'information gathered' section of the provisional opinion. Ms A told HDC that she has experienced significant trauma and distress as a result of the lack of medical care she received while she was at ARWCF. During her time at ARWCF, Ms A said she had to do anything she could to get medical care, and no care plan was created for her.

Department of Corrections

25. The Department of Corrections was provided with an opportunity to comment on the provisional opinion and advised it did not have any comment to make on the provisional opinion.

Health NZ – Counties Manukau

26. Health NZ – Counties Manukau was provided with an opportunity to comment on the provisional opinion, and comments have been incorporated into the report, where relevant.

Independent clinical advice

27. Independent clinical advice was provided by disability advisor Ms Sandie Waddell (Appendix A), who noted the following departures from the accepted standard of care in relation to Corrections:

a. The standard of overall disability support provided to Ms A in relation to the management of her Botox injections: moderate to severe departure;

b. The standard of the disability support provided to Ms A in relation to provision of supplies and access to facilities:

   - Mild departure in regard to access around the facility;

   - Moderate departure if no solution had been found regarding access to toilets.

c. The standard of the disability support provided to Ms A during her COVID-19 isolation period in May 2022: severe departure;

d. The adequacy of the policies, processes, and procedures in place at the time of these events relating to the provision of disability support: mild departure.

28. Ms Waddell considered there were no departures from the accepted standard of care in relation to the supply of incontinence products.

29. In addition, independent clinical advice was provided by a medical officer, Dr Kelvin Billinghurst (Appendix B), who noted the following departures from the standard of care in relation to Health NZ – Counties Manukau:

a. The management of Ms A's referrals for Botox made between July 2019 and May 2023: mild departure;

b. The appropriateness of relevant policies, procedures, and systems in place at the time of the events: mild departure.

Decision: Department of Corrections – breach

30. Having undertaken a thorough assessment of the information gathered and guided by the clinical advice provided by Ms Sandie Waddell, I am critical of aspects of the care Ms A received from Corrections. I have set out my decision below.

Botox injections

31. From the outset, I acknowledge that other agencies were involved in the provision of Botox injections to Ms A and that poor communication between these agencies contributed to the delays in her treatment. However, as advised by Ms Waddell, Corrections were the lead agency and therefore responsible for coordinating activities, following up on referrals, and ultimately ensuring that both health services and disability supports were provided to Ms A in a timely and professional manner.

32. I accept that the COVID-19 pandemic did affect wait times and delayed the delivery of health services over this time, but I consider that there were missed opportunities for Corrections to follow up with Health NZ – Counties Manukau over this time, particularly as Ms A had flagged her concerns with Corrections. Ms Waddell's advice has highlighted a general lack of awareness of the detrimental impact the delays were having on her health and dignity, particularly in light of the issues Ms A raised about access to toilets (discussed further below) and that staff did not seem to be aware of the process that needed to be followed.

33. The Health Care Pathway Policy[18] requires that delays or deferments in the provision of health services are monitored appropriately and reported to the Prison Director monthly and tabled at Clinical Governance meetings. The documentation provided by Corrections contains no evidence that these requirements were completed, and Ms Waddell stated that if they had been documented and tabled, it may have resulted in timelier and more urgent follow-up.

34. I accept Ms Waddell's advice that the management of Ms A's Botox injections constituted a moderate to severe departure from the accepted standard of care, and the responsibility for this ultimately rests with Corrections.

Access to facilities

35. Access concerns around the facility and to the bathrooms were raised by Ms A on several occasions. Ms Waddell stated that access within the facility represented a mild departure, elevated to a moderate departure if no solution had been found to ensure Ms A had ongoing access to toilets.[19]

36. I accept this advice, and I am critical that Ms A was restricted in her access, particularly to toilets. I acknowledge that this would have had a significant impact on Ms A's dignity at the time, particularly in the context of the delay in receiving her Botox injections.

Policies and procedures

37. The Health Care Pathway Policy was the relevant policy in place at the time of these events, which included reference to the New Zealand Disability Strategy 2001 and the Health and Disability Sector Standards.[20]

38. As I have noted, it does not appear that there was a system in place to track delays in prisoners' access to health services, and in the context of Ms A, her delayed Botox procedures. While there may have been reference to relevant policies and legislation (set out above), Ms Waddell noted that staff were given little training or guidance that would have enabled them to be better informed. Ms Waddell also notes that the standards referred to in the policy documents did not specifically identify the processes needed to support individuals with a disability in any meaningful way.

39. Ms Waddell stated that it is accepted practice to have specific policy information and training available for staff so they can provide appropriate care. In this case, Ms Waddell concludes that the standard of care was compromised because of the lack of more specific policy guidance and concludes that this can be considered a mild departure from the accepted standard of care. I accept this advice. Corrections should have ensured that the Health Care Pathway Policy adequately addressed the needs of individuals with disabilities and that staff had adequate training in the application of this policy.

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[18] The relevant policy in place at the time was 'Health Care Pathway Policy, Corrections Health Services', April 2019.

[19] Corrections have not clarified whether a solution had been found to accessing toilets.

[20] NZS 8134:2008.

COVID-19 Isolation: 6–14 May 2022

40. Ms Waddell advised that the management of Ms A during her period of COVID isolation was not of an acceptable standard and that being left in soiled clothing and bedding was a severe departure from accepted practice.

41. I agree with Ms Waddell and am similarly concerned. I note that the event review undertaken by Corrections identified several shortcomings over this period. I acknowledge the issues arising from COVID-19 restrictions, but I remain highly critical of Ms A's treatment while she was in isolation and the impact of this on her wellbeing. The circumstances for Ms A during her period of isolation were unacceptable, and it is concerning that Corrections had not anticipated this type of scenario eventuating and planned accordingly.

Conclusion

42. Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code) states that every consumer has the right to have services provided with reasonable care and skill. Corrections did not ensure Ms A received the Botox injections she required to manage her condition; nor did it manage her support cares appropriately while she was in COVID-19 isolation. Accordingly, I consider Corrections breached Right 4(1) of the Code.

43. Right 3 of the Code states that every consumer has the right to have services provided in a manner that respects the dignity and independence of the individual. I consider that Corrections failed to provide services that respected Ms A's dignity as she was left with soiled bedding and clothing and with no ready access to the supports she required over a period of extended isolation. For this reason, I find that Corrections breached Right 3 of the Code.

Decision: Health NZ: educational comment

44. Although I have acknowledged that Corrections was the lead agency responsible for ensuring Ms A received her Botox injections, I have several comments about the care provided by Health NZ – Counties Manukau, which I have set out below.

45. My advisor, Dr Billinghurst, stated that Health NZ – Counties Manukau did make efforts to provide appropriate care for Ms A with respect to her Botox injection and spinal assessment needs and that adherence to the urological outpatient policies of the time was appropriate. However, Dr Billinghurst considered that the removal of Ms A from the urological outpatient waitlist and failure to communicate this to ARWCF was inappropriate and that the need for ongoing referrals for specialist opinions created delays in Ms A receiving treatment. Dr Billinghurst also stated there could be improvements to the Health NZ 'Patients under Prison/Police escort' policy[21] and the management of referrals between the urology service and the Regional Spinal Unit.

46. Health NZ – Counties Manukau accepted that communication with ARWCF could have been better. Health NZ – Counties Manukau maintains that it attempted to follow up with Corrections regarding Ms A's removal from the urology appointment waiting list but did not receive a response. Health NZ – Counties Manukau does not accept that ongoing referrals

[21] Version 4.1

for specialist opinions caused delays and maintains that patient safety requires that independent assessments take place before commencing a procedure.

47. I acknowledge that Health NZ – Counties Manukau did advise ARWCF of Ms A's removal from the urological outpatient waitlist in September and October 2019. However, Ms A's initial referral was made in July 2019, and I remain concerned about the delay in advising ARWCF of the transfer.

48. I accept that regular patient reviews are integral to the provision of quality care as a patient's condition is likely to evolve over time and it is important to check that a proposed treatment(s) is still appropriate in the circumstances. It goes without saying that clinicians should not rely solely on historic assessments, but I suggest that ready access to a patient's health record during a transfer of care is valuable as it will offer some indication of the currency of the information and the need for further assessment. In its response, Health NZ – Counties Manukau has said it was unable to access any information about Ms A's previous assessments and that the only information available was the information in the referrals, as it does not have access to clinical information held by other districts unless this is actively provided.

49. I acknowledge Health NZ – Counties Manukau's concerns and appreciate the delays caused by the COVID-19 pandemic during this time. Nevertheless, I have asked Health NZ – Counties Manukau to reflect on the recommendations for improvement outlined by Dr Billinghurst.

Changes made since events

Department of Corrections

50. Corrections advised that it has made the following changes:

a. Development of 'The Pathway Forward: Te Ara Whakamua,' a process of organisational change designed to grow capability, enhance delivery of services, and support a more effective and efficient system. As part of the organisational change, services were restructured to introduce a Pae Ora group to focus on and enhance health and rehabilitation outcomes.

b. Implemented the disability action plan and operating model and introduced a regional disability and older persons social worker.

c. Corrections advised that it is working to improve the way in which it cares for and manages people with disabilities and has reviewed accessibility guidelines. The Pae Ora team (discussed above) have focused on updating and reworking policies to align with a changing prison population.

d. Standards and guidelines will be used to support capital projects as they arise. However, changes to physical infrastructure will take time depending on the availability of funding.

Health NZ – Counties Manukau

51. Health NZ – Counties Manukau advised that it has made the following changes:

a. Introduced an electronic referral system.

b. Developed a system to improve referrals within the Auckland Regional Spinal Unit pathway.

c. In early 2023, the spinal unit service resumed its normal clinical capacity. In mid-2023, there was an uplift in urology service resourcing, which has had a positive impact on reducing overdue appointments.

d. Health NZ is in the process of developing a national appointment, booking, and choice (ABC) policy to standardise how it engages with consumers to provide them with input about when their outpatient appointments are offered. Currently, the draft ABC policy does not provide guidance on the management of appointments for prisoners. In light of this complaint, Health NZ – Counties Manukau advised that it will raise the question of whether a national approach to this should be included as part of the ABC policy.

Recommendations

Department of Corrections

52. I recommend that the Department of Corrections:

a. Provide a formal written apology to Ms A for the breach of Right 4(1) and Right 3 of the Code identified in this report. The apology is to be sent to HDC, for forwarding to Ms A, within three weeks of the date of the final report.

b. An update on Correction's implementation of new policy statements, including but not limited to its disability action plan. The update is to be provided to HDC within three months of the date of the final report.

c. Review training programmes and policies to ensure all Corrections staff have access to up-to-date and relevant information about working with prisoners with disabilities, along with disability-specific training. Evidence of this update, with corrective actions implemented, is to be provided to HDC within six months of the date of the final report.

d. Update relevant policy material to ensure all current legislation and procedures supporting those policies includes relevant disability information with a process to access disability-specific information as needed. The update is to be provided to HDC within six months of the date of this report.

e. Provide an update on what actions are being undertaken at ARWCF to improve access to facilities for prisoners with disabilities. The update is to be provided to HDC within three months of the date of the final report.

f. Consider Ms Waddell's recommendation of developing a pathway where contact with agencies is established as soon as a person with a disability comes under the care of Corrections and independent peer support is arranged.

Health NZ – Counties Manukau

53. I endorse the improvements Health NZ has made to its service since the time of these events. I support Health NZ – Counties Manukau raising with Health NZ National office whether a national approach to the management of appointments for people in custody should be included in the ABC policy.

54. I encourage Health NZ – Counties Manukau and Corrections to maintain regular communications to support continuity of care for people in custody, in line with Dr Billinghurst's recommendation.

Follow-up actions

55. A copy of this report with details identifying the parties removed, except Health NZ, the Department of Corrections and the advisors on this case, will be sent to the Office of the Ombudsman, Whaikaha – Ministry of Disabled People, and the Office of the Inspectorate, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent clinical advice to Health and Disability Commissioner

Complaint:	**[Ms A] / Auckland Region Women's Corrections Facility**
Our ref:	**21HDC00722**
Independent advisor:	**Ms Sandie Waddell**

I have been asked to provide clinical advice to HDC on case number 21HDC00722. I have read and agree to follow HDC's Guidelines for Independent Advisors.

I am not aware of any personal or professional conflicts of interest with any of the parties involved in this complaint.

I am aware that my report should use simple and clear language and explain complex or technical medical terms.

Qualifications, training and experience relevant to the area of expertise involved:	I have a Post Graduate Diploma in Health Service Management and a Certificate in Quality Systems and Auditing Principles. I have worked in the Health and Disability sector for over 30 years and have held senior management roles in community organisations, the Ministry of Health and ACC. I was the CEO of the New Zealand Disability Support Provider Network and worked as a lead auditor of Health and Disability Services nationwide from 2021 to 2022. This included auditing the development and implementation of policies, procedures and guidelines for compliance with the New Zealand Health and Disability Services Standards NZS 8134:2008 (the Standards). As a part of the audit process, I was involved in reviewing organisational policies and procedures, service planning, assessment and delivery and the evaluation of effectiveness of outcomes for clients. I have conducted assessments of business and community organisations' responsiveness to accessibility and the needs of people with impairment and provided advice on how this can be improved. I am currently a trustee on a Board of Trustees for a disability organisation that provides a range of support services to people with disability (tangata whaikaha) in my region. I have also lived with a disability for over 46 years as the result of an MVA and I am a full-time wheelchair user.
Documents provided by HDC:	1. Letter of complaint dated 12 February 2021 2. Auckland Region Women's Corrections Facility's response dated 15 June 2021 3. Supporting Advocacy report dated 4 April 2023

	4. Auckland Region Women's Corrections Facility's response dated 31 August 2023 5. Auckland Region Women's Corrections Facility's response dated 8 August 2023 6. Clinical records from Auckland Region Women's Corrections Facility covering the period June 2019 to August 2023. 7. Copies of Auckland Region Women's Corrections Facility policies.
Referral instructions from HDC:	Auckland Region Women's Corrections Facility 1. The standard of overall disability support provided to Ms [A]. 2. The standard of the disability support provided to Ms [A] in relation to provision of supplies and access to facilities (e.g. incontinence products, bathrooms and accessibility). 3. The standard of the disability support provided to Ms [A] during her COVID-19 isolation period in May 2022. 4. The adequacy of the policies, processes and procedures in place (at the time of these events) for providing disability support to inmates. 5. Any other matters in this case that you consider warrant comment.

Factual summary of clinical care provided complaint:

Brief summary of clinical events:	Ms [A] is a 33-year-old woman who sustained a spinal cord injury at the age of seven in a high-speed motor vehicle accident. This resulted in mobility issues initially requiring orthotic devices to support movement and then more permanent use of a wheelchair. In addition, the spinal cord injury resulted in bladder and bowel impairment requiring medical oversight and regular procedures, as well as the use of incontinence supplies to manage the subsequent issues. She became an inmate at Arohata Women's prison on 18 April 2018. In response to her request, she was transferred to Auckland Region Women's Correction Facility (ARWCF) on 28 June 2019. On 12 February 2021 she lodged a complaint with the Ombudsman regarding her access to a procedure to assist in managing her bladder control. This was well overdue despite her making regular requests for this to be carried out. The complaint was subsequently transferred to the Office of the

	Health and Disability Commissioner (HDC) as it was deemed to be the more appropriate office to address it. On 15 March 2023, the complainant was referred to the Nationwide Health and Disability Advocacy Service and was interviewed on 23 March 2023. Following discussions around her options for a way forward, she raised a number of other concerns relating to her disability supports in ARWFC over the previous 4 years. She requested the complaint and ongoing support issues be investigated by the HDC, rather than take up any of the options available to her through the Advocacy Service. Her concerns stem from the multiple delays in receiving botox procedures for bladder management, which led to multiple issues with her bladder causing anxiety, medical issues with recurrent UTIs, a lack of laundry and linen and clothing supplies when required and ongoing issues with personal cares. In addition, she had concerns about the humiliation and embarrassment with staff and other women she shared facilities with when she had issues with incontinence, the supply of incontinence products and her access around the facility due to her impaired mobility. A total of three responses from the Department of Corrections and the AWRCF dated June 2021, August 2023 and August 2024 were received by the HDC, which included medical and clinical records, complaints received from Ms [A] and subsequent responses. Copies of past and current policies including medical pathways and a Disability Action Plan 2023–2017. Plans for a disability advisory group, disability awareness training and relevant initiatives to address some of the concerns that have been raised and acknowledged over the course of the timeframe involved in the initial complaint and the subsequent investigations were also received.

Question 1: The standard of overall disability support provided to Ms [A].	
List any sources of information reviewed other than the documents provided by HDC:	ACC Injury Prevention, Rehabilitation, and Compensation (Code of ACC Claimants' Rights) Notice 2002 (Version current as at 28 October 2021)

	Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 (Version current as at 6 November 2021) https://communitylaw.org.nz/community-law-manual/prisoners-rights-chapter-7-health-and-disability/health-and-disability/ NZS:8143:2008 Health and Disability Services Standards
Advisor's opinion:	In the period reviewed (2019–2023), the standard of care provided to Ms [A] was variable. The specific disability support services in this instance, and in line with relevant standards at the time, that would be reasonably expected to be provided for residents with a disability were: 1. Timely access to disability-related medical care, medication, advice and procedures – including in this case, the botox procedures. 2. Supply of relevant continence products needed as required to ensure support and management of disability-related needs. 3. Suitable accommodation to meet specific disability-related needs, including bedding, laundry and toilet facilities. 4. Supply and maintenance of equipment to meet assessed disability support needs. 5. Access to all areas of her accommodation and work areas. More detailed responses will be discussed in the subsequent questions around the specifics of the provision of support relating to no's 2–5. The following is my overall opinion and assessment of the general support and standard of services received for Ms [A] during the period 2019–2023, with particular reference to no. 1. It needs to be noted here that there are multiple agencies that are generally involved in ensuring disability supports are provided in a timely and professional manner to support individuals with disabilities. In this case, the lead agency would be considered the Department of Corrections as the main provider, who then needed to liaise with the Accident Compensation Corporation (ACC), the Counties Manukau District Health Board (CMDHB) and latterly Te Whatu Ora (TWO). The period reviewed also covers the National COVID-

	19 emergency, which resulted in delays for treatment throughout the country. In relation to the timely access to disability-related medical care, medication, advice and procedures, the main concerns raised were the access to regular botox procedures to assist Ms [A] in her bladder management. These, in my opinion, were not provided in a timely way over the period reviewed, particularly from 2019 to 2021. These delays resulted in considerable anxiety, numerous 'accidents', frustration, embarrassment and a lack of dignity for Ms [A]. During her period of imprisonment, according to medical records provided, she received the procedure in August 2018 and then again in April 2021, a period of 2 years and 8 months, which was nearly two years overdue from the required 9- to 11-month intervals. There was an improvement in the 2021–2022 period, where the wait of 14 months was only 5 months overdue. The next procedure for the 2022–2023 period was not performed until February 2022, which was again a 15-month wait and at least 6 months overdue. These delays resulted in Ms [A] having frequent 'accidents', which were not always able to be managed in a timely and dignified way. This was due to a lack of adequate clothing and laundry being provided when needed and delays in access to toilet facilities if and when required. From the information provided, the initial delay between 2018 and 2021 was due to the referrals initially being made to CMDHB with a delay with the subsequent declining of that referral. The reason for the decline was that the referral needed to be through an ACC process to the Spinal Unit as Ms [A] was eligible under the ACC legislation, therefore treatment provision was managed by ACC. The initial referral from ARWCF to CMDHB was made in June 2019; however, this was not declined until October 2019. A referral was made on 24 October and then not followed up again by ARWCF until 20 February 2020. Ms [A] continued to follow up on the status of the request with the ARWCF. She was finally seen at the Spinal Unit on 7 August 2020. The botox request was again followed up on 20 February 2021. Her procedure was finally completed on 30 April 2021,

	by which time her continence issues had become extremely problematic for her. The next procedure was due in March 2022 but was not received until June 2022. The last procedure in the period reviewed was received in May 2023, by which time the correct process seemed to have been followed to ensure the assessed 11-month period between procedures occurred. From the documentation reviewed, which wasn't always specific around the actual reasons for requested follow-ups to agencies, the delays appeared to be the result of a combination of factors. Staff at ARWCF initially not being aware of the process that needed to be followed, then CMDHB delaying the 2019 decline note, which resulted in ongoing delays. In addition, poor communication on the part of all three agencies of Corrections, CMDHB with ACC, who were all needing to be involved in varying degrees during the referral processes. However, Corrections as the lead agency here must take primary responsibility. The COVID-19 emergency certainly impacted timeliness during the 2020–2022 period. The lack of awareness and relevant knowledge of the impact of the delays on Ms [A] in relation to her management of incontinence issues negatively impacted on her health, given the excessive number of UTIs she experienced over the period. Her mental health and self-esteem were also negatively impacted. It appears from the documentation provided that the delays were not adequately documented by Corrections in line with the Health Care Pathway Policy (April 2019) in place at the time. The policy required that delays or deferments were monitored appropriately and reported to the Prison Director monthly and tabled at Clinical Governance meetings. There is no evidence in the documentation that these requirements were completed. Had they been documented and tabled, this may have resulted in timelier and more urgent follow-up.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	It is my opinion that the standards of care for this specific issue were not acceptable and below what would be considered acceptable at the time of the events. This view was informed by the reference material cited at the beginning of this section, which outlines the standards of care and the rights of the individual receiving that care. In relation to other disability-related supports of appropriate medical care, medication, advice and procedures, the documentation provided evidence of a range of very regular

	interactions with the medical staff around other medical and disability concerns that Ms [A] presented with. She was seen by the medical staff at ARWCF on a very regular basis and was prescribed medication, advice specifically around ways to minimise UTIs as well as regular management of other conditions. Appropriate referrals for orthotics and subsequent surgery were all made as required, with Ms [A] receiving appropriate interventions on a regular basis. My opinion on the standard of care for all other areas of medical support is that this was all an acceptable standard and was timely and professional.
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	Due to the flow-on effect and resulting impact of the delay in the procedures for Ms [A], in my opinion, the departure from acceptable standards of care was moderate to severe in the timeliness of the Botox procedures. For the other disability-related support, including medical care, medication, advice and procedures, there was no departure from acceptable standards of care.
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	I believe the opinions above would be supported by my peers and my colleagues in the disability and health sector.
Please outline any factors that may limit your assessment of the events.	My assessments of events would be limited during the 2020 period and other relevant COVID-related timeframes, as I was not directly involved in the specific medical facilities and institutions during that time to fully appreciate the constraints and delays the lockdowns caused for patients and professionals who were working throughout those periods.
Recommendations for improvement that may help to prevent a similar occurrnce in future.	My recommendations for improvement, which may assist to prevent a similar occurrence in the future, would be: 1. The Department of Corrections to update training programmes and policy to ensure all staff have access to up-to-date and relevant information about disability in general and also disability-specific training. This would ensure there is a real understanding of the implications and issues around

	the particular disability of any prisoners who are in their care at any one time. 2. Clear communication channels between ACC and/or local health providers are established as soon as a person with a disability comes under the care of Department of Corrections staff. This would include relevant medical professionals contracted for regular interactions with the person. Eligibility criteria and relevant disciplines for disability supports need to be clarified at the outset with the appropriate agencies so staff are aware of who and when to contact as issues and concerns arise. The person themselves will usually be aware of who has been involved in their disability supports, so consultation with them will assist in ensuring the relevant agencies are contacted. 3. Outside peer support is arranged, if possible and/or reasonable for prisoners who have a disability, to enable them to share issues and concerns and to support them to advocate on their own behalf in a meaningful and positive way within the prison system. This will assist them to manage real issues and resulting frustrations before they impact on their personal wellbeing and health while they are within the prison system.

Question 2: The standard of the disability support provided to Ms [A] in relation to provision of supplies and access to facilities (e.g. incontinence products, bathrooms and accessibility).	
List any sources of information reviewed other than the documents provided by HDC:	https://www.legislation.govt.nz/act/public/2004/0072/latest/DLM306891.htm Also reference material as stated in question 1.
Advisor's opinion:	The documentation provided reflected that the provision of incontinence supplies to Ms [A] was usually regular and when requested. There was an instance in July of 2020 when supplies had not arrived, which was followed up a number of times by the prison staff. There was a delay before this was resolved; however, the records show staff did make a significant effort to resolve the issue. Another issue arose in February 2023 when there was a delay in the provision of urinary catheters, the reason for which seems to be unclear other than a mix-up with ACC and the supplier. There was just one other issue in July of 2020 recorded where the type of gloves supplied were unsuitable. This was also resolved, albeit

	with a small delay and alternative gloves supplied which were able to be used. Aside from those particular instances, the records provided by Corrections document each time additional supplies were requested and show that they were provided with minimal delay. There were occasions when Ms [A] needed to change the type or number of the supplies, but documentation showed these requests were also managed adequately. She was also permitted to keep some supplies in her cell, which would assist in her management of incontinence. Access concerns around the facility and to the bathrooms were raised by Ms [A] on a number of occasions. It appeared that some parts of the facility were not able to be accessed independently, which have been a cause of frustration for Ms [A], as well as staff on the ground who it appeared were having to physically lift her. Another access concern was raised by Ms [A] on 4 January 2020, about the ease of access to the toilet block. Due to the issues raised in the previous response around the delay in her botox procedure, her ability to 'hang on' until staff are available is compromised. It appeared from her complaint that the prison staff have to lock and unlock toilet facilities. If staff were unavailable, Ms [A] would not always be able to avoid having a bladder 'accident'. The resulting humiliation in front of both staff and fellow inmates understandably concerned her. A note added to some of the documentation, some ten days later, indicated there was no resolution to the issue. No further documentation was available to indicate if and when a solution was implemented. There were also concerns raised by Ms [A] in October of 2022 regarding the need for additional bedding due to her incontinence issues, which meant her cell was constantly smelling of urine. Over a period of the next two months, it was again recorded as a complaint from Ms [A] and subsequently a resolution was agreed.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	As the issues around supply of incontinence products were not a regular occurrence and were all followed up with the appropriate agency promptly, I would consider this to be an acceptable standard of care. The access concerns, especially around access to the toilet, would have resulted in significant issues and anxiety for Ms [A]. According to Community Law publications regarding

	prisoner rights "All prisons are supposed to have cells specifically designed for prisoners with disabilities." While Ms [A] was housed in a medical unit cell, which is reported as giving her adequate room to manage her wheelchair, no mention was made of access to toilet facilities. Little reference in the documentation provided is made to any response, or indeed any further reference to the complaint made by Ms [A] regarding toilet access, so I am unable to comment further on whether any solution was found for her. It was clear that if staff were able to be located then they would unlock the door for her. One entry did refer to Ms [A] being out at work and it was recommended she use the toilet facilities at her place of work before returning, to avoid immediate issues at that time. In my opinion, if a solution was not found and she continued to have difficulty accessing the toilet facility as needed, especially following delay in her botox procedures which would exacerbate her incontinence issues, that would be below the standard of care and accepted practice.
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	Regarding supply of incontinence products, I would consider this to be no departure from accepted practice. The access issues raised would be a mild departure in regard to access around the facility and a moderate departure if no solution had been found regarding access to toilets.
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	This opinion about lack of access to toilets as required would also be viewed by my peers, especially other wheelchair users, as concerning and not reflective of acceptable practice.
Please outline any factors that may limit your assessment of the events.	Factors limiting my assessment of the above issues, specifically around access to the toilet facilities, are my lack of experience and understanding as to the reasons for the toilets being locked and the factors Corrections staff would need to consider in providing unlimited access for inmates and/or only for inmates with disabilities. These factors are outside my

	areas of expertise and may affect any possible solutions to the problems. However, general access around the facility is not affected by these limits.
Recommendations for improvement that may help to prevent a similar occurrence in future.	Many of the issues raised in a number of complaints from Ms [A] and from medical records provided were concerning bladder and continence concerns. I would recommend that in similar situations with inmates presenting with disabling conditions and the resulting concerns from those be reviewed and that advice and guidance be sought from agencies with expertise in the relevant areas. In this instance management support and advice for staff could have been provided by the professionals at the Spinal Unit as well as their peer support service. While current legislation requires sleeping accommodation in prisons to be accessible, it is not clear whether access around the whole facility is included. The most recent information sent from Corrections includes several new policy statements, launched in February 2023, Ara Poutama – the Aotearoa Disability Action Plan 2023–2017. While this is definitely encouraging, it is recommended implementation of the plan is monitored to ensure the issues raised in this report are addressed in a way that ensures inmates with a disability receive appropriate access throughout the facility. Also, a process for the access to toilets needs to be available to those who need frequent and timely access.

Question 3: The standard of the disability support provided to Ms [A] during her COVID-19 isolation period in May 2022.	
List any sources of information reviewed other than the documents provided by HDC:	As in question 1.
Advisor's opinion:	Between 6 May 2022 and 14 May 2022, Ms [A] was managed in quarantine, having tested positive for COVID-19. On 14 May, she submitted a complaint about being left with soiled

	clothing and bedding while in quarantine, which she subsequently had to sleep in. According to a response by the Principal Corrections Officer (PCO), a request to complete laundry during the quarantine period had been 'misplaced'. Once she was out of quarantine, things returned to normal, and Ms [A] noted she was appreciative of the apology made. In my view, the fact that she was left to sleep in soiled clothes and linen, even if it was during a period of quarantine, is unacceptable.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	This was not an acceptable standard of care or in any way seen as acceptable practice.
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	This departure is, in my opinion, a severe departure from an accepted practice and standards of care.
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	This view would, I believe, be supported by my peers in the sector.
Please outline any factors that may limit your assessment of the events.	Nil
Recommendations for improvement that may help to prevent a similar occurrence in future.	That adequate documentation of individual needs be kept for all staff for those inmates with a disability, which is to be applied whatever the situation, whether it be isolation for any reason or during regular daily activity.

Question 4: The adequacy of the policies, processes and procedures in place (at the time of these events) for providing disability support to inmates.	
List any sources of information reviewed other than the documents provided by HDC:	Code of ACC Claimant Rights 2002. The Code of Health and Disability Services Consumers' Rights 2009.
Advisor's opinion:	The relevant policy that was in place over the reviewed period was the HealthCare Pathway Policy, which stated it had referenced various official documents, including Corrections regulations, The NZ Disability Strategy (2001), the 2008 Health and Disability Sector Standards and The Code of Health and Disability Services Consumers' Rights 2009. It is documented they are obliged to comply with legislation, including the Health and Disability Commissioner Act 1994, which is in place primarily to promote safe provision of health and disability services to the public, and enables standards to be established for this purpose. The relevant clauses relating to this advice are: **16.2** Patients receive assessments and/or planned care within the specified time frame and **16.3** There is a system to track delayed or deferred assessments/appointments. **16.5** The HCM is responsible for reporting the number of delayed or deferred assessments/appointments to the Prison Director monthly. The report will include the reasons for the delays or deferrals. These reports will be tabled at the quarterly site Clinical Governance meetings. **18.1** Patients in Corrections Health Services are referred to receive health care and treatment from external providers when they need it. **18.3** The HCM is responsible for ensuring there is a system for managing and monitoring referrals to external health providers. **26.4** Corrections Health Services will follow the **ACC Guidelines** for Providers. The documentation provided does not support that these policy directives were always followed or that a system was in

	place to track delays - specifically concerning the delayed botox procedures. There is little mention of disability and no information concerning appropriate responses to specific disabling conditions that would have provided more information and guidance for both medical and staff at the prison. Given the NZ Disability Strategy is one of the referenced documents, this is surprising. The staff were expected to incorporate the required legislative and regulatory requirements, but from the documentation provided, it was clear little training and guidance was provided that would have enabled them to be better informed and subsequently could have avoided some of the issues experienced by Ms [A]. With around 25% of any population being reported to have a disability of some kind, it can be assumed that a number of inmates at any one time would present with a disability. How many and the specific type would vary, and in my view, in the 2019–2022 period, it would have been accepted practice to have more specific policy information and training available for staff so they were able to provide more appropriate care. In this case, the appropriate policy and procedures that would have assisted staff to understand and respond to issues around lack of spinal cord injury – specifically bladder and bowel control, were not in place. It is my opinion that the standard of care provided to Ms [A] was compromised due to this lack of more specific policy guidance and knowledge.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	The policies in place for the period reviewed would be expected to be more responsive to facility requirements under the respective Building Code in place; and the standards referred to in the policy documents were not reflected in the actual policy document to specifically identify processes needed to support individuals with disability in any meaningful way.
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure;	I would view this [as] a mild departure, given it was generally adequate in the other areas of support provided to the complainant and that the support given by the other agencies was also a factor in the delays experienced.

• Moderate departure; or • Severe departure.	
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	I believe this view would be supported by my colleagues, specifically those who develop and/or audit policy documentation in government-contracted agencies and other support organisations.
Please outline any factors that may limit your assessment of the events.	Nil
Recommendations for improvement that may help to prevent a similar occurrence in future.	Ensure all policy material is updated and in line with all current legislation where required and procedures supporting those policies include relevant disability information with a process to access disability-specific information as needed.

Question 5: Any other matters in this case that you consider warrant comment.	
List any sources of information reviewed other than the documents provided by HDC:	
Advisor's opinion:	There are no outstanding issues that I think need further comment as the previous advice is comprehensive and addresses all issues raised by Ms [A].
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	

How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	
Please outline any factors that may limit your assessment of the events.	
Recommendations for improvement that may help to prevent a similar occurrence in future.	

By signing this report, I agree to HDC correcting any formatting, spelling, or grammar issues on the proviso that the substance of the report and any quoted material remains unchanged.
Signature: 
Name: Sandie Waddell
Date of Advice: 10 September 2024

Appendix B: Independent clinical advice to Health and Disability Commissioner

Complaint:	**[Ms A]**
Our ref:	**21HDC00722**
Independent advisor:	**Dr Kelvin Billinghurst**

I have been asked to provide clinical advice to HDC on case number 21HDC00722. I have read and agree to follow HDC's Guidelines for Independent Advisors.

I am not aware of any personal or professional conflicts of interest with any of the parties involved in this complaint.

I am aware that my report should use simple and clear language and explain complex or technical medical terms.

Qualifications, training and experience relevant to the area of expertise involved:	Dr Billinghurst holds an MBChB through the University of Otago, New Zealand. He has extensive international health experience in South Africa and Africa before specializing in Medical Administration through the Royal Australasian College of Medical Administration. He holds a Masters in Health Management and Public Health and has over 20 years' experience in health management roles in South Africa, the UAE, Australia and more recently in New Zealand.
Documents provided by HDC:	1. Letter of complaint dated 12 February 2021 2. Health NZ's response dated 30 November 2023. 3. Health NZ's response dated 20 September 2024. 4. Referral documentation from Health NZ covering the period July 2019 to May 2022. 5. Health NZ policies and processes.
Referral instructions from HDC:	Please comment on the following: 1. Health NZ's management of Ms [A]'s referrals for bladder botox injections made between July 2019 and May 2023. 2. The appropriateness of relevant policies, procedures and systems in place at the time of the events, including those relating to: a. Referrals of patient care between different health boards. b. Care provision for inmates, in particular managing referrals and booking appointments. c. Management of referrals between the Urology service and the Auckland Spinal Rehabilitation Unit (ASRU). 3. The systems that would be reasonably expected for a health board to have in place to identify delays in arranging, processing, triaging and actioning referrals and correcting administrative human errors.

	4. The adequacy of the remedial steps proposed and being implemented by Health NZ to address the issues identified from this complaint. 5. Any other relevant matters that you consider warrant comment, including any proposed recommendations for Health NZ.

Factual summary of clinical care provided complaint:

Summary of clinical events:	See Appendix One & Two to this advice
Question 1: Health NZ's management of Ms [A]'s referrals for Botox made between July 2019 and May 2023.	
List any sources of information reviewed other than the documents provided by HDC:	(Cooley and Kielb 2019) ACI-spinal-cord-injury-bladder-management-a-guide-for-clinicians-in-non-specialist-units.pdf Waiting List | Te Whatu Ora Counties Manukau Middlemore Hospital - Wikipedia
Advisor's opinion:	I believe Counties Manukau intentions were to provide appropriate care to Ms [A]. This was demonstrated with the initiating of the Spinal Unit review (recommended to occur every 2 to 5 years) in October 2019. As an overview from July 2019 to May 2023, Ms [A] received only half the number of Botox injections recommended from Burwood that should have been administered (based on an 11-month cycle). This caused significant inconvenience to her and her ability to manage urinary incontinence, particularly as she was constrained for complete independent care in the prison environment. There were two main overall and controllable failings of Counties Manukau that affected the delivery of care to Ms [A]. 1. Some of the staff at Counties Manukau did not appreciate the complexity in communicating to an incarcerated patient. This was first seen with the unilateral decision to withdraw Ms [A] from the waitlist after she failed to respond to the request to book an appointment based on the letter of 16 October 2019. This removal occurred: - After Ms [A]'s appointment was reviewed, triaged and prioritised accordingly by a clinician from within the Urological Department. This clinician should have understood any local processes (such as referral to the

	Spinal Unit first for spinal injury-related bladder issues). - The procedure itself (the Botox injection) is normally administered by a urological specialist. Regardless of the Spinal Unit review, the Department would have been asked to undertake the intervention. - A specialist colleague had already undertaken the intervention, and a referral had been made from Capital, Coast and Hutt District to Counties Manukau. - There were limited options outside of the Botox injection for management of hyperactive bladder. In retrospect, further efforts to confirm the original appointment (through communication with the prison) rather than removing her from the urological waitlist, could have ensured the initial assessment was undertaken sooner. This could have avoided the subsequent and significant delays of care that then followed. In an environment where there is a loss of control by patients to respond to outpatient appointment requests (such as a person in the prison environment and in other environments), health services should make extra efforts to ensure appointments can be met. It is noted that communication back to the referrer and the making of the appointment for the Spinal Rehabilitation Unit waitlist in October 2019 did not occur. It is also noted that Counties Manukau has apologised to Ms [A] for the lack of communication regarding the removal from waitlist and her subsequent referral to the Spinal Unit in the first response to the HDC. 2. The ongoing referrals for specialist opinions created significant delays. The referral for the overdue Spinal Rehabilitation Unit could have occurred <u>concurrently</u> (for the reasons given above) with that to the urologist for the Botox injection. The sequential nature of the two processes (urological referral for Botox and Spinal Review) added substantial delays to Ms [A] receiving her first Botox injection. The Botox (as already) mentioned was one of the few treatment options available for Ms [A]. At what point do additional specialist reviews need to happen before regular procedures such as Botox injections can be repeated? The second referral was made by Dr [B], a specialist urologist, and

	after the detailed spinal assessment of 2020 where the 11-monthly Botox procedure was already supported. Ms [A] was seen by [another doctor] in June 2022 (a reasonable time after the initial referral back to Counties Manukau by Dr [B]). Ms [A] could have been put directly on the waitlist for the Botox under general anaesthesia when the referral from Dr [B] was received. It is also noted Dr [B]'s efforts in advocating for Ms [A]'s second Botox injection 12 months from the earlier Botox administration.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	All health services aim to deliver specialist appointments within appropriate or given timeframes. Outpatient services cannot function unless effectively communicating to patients for mutually agreeable times. Counties Manukau now publishes updated outpatient wait times on the internet (see link above).
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	Mild departure from accepted practice or care. This is rated 'mild' because, in my opinion, Correctional Services contributed to the initial delayed outpatient appointment. There was no response to both the written and phone contact requesting uptake for the first appointment in October 2019.
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	I discussed this case with Dr […], previous Chief Medical Officer of […] Hospital, and Dr […], CMO for Primary Care […]. Extra efforts are sometimes needed by the health services to ensure some groups of patients are able to access the care they are entitled to. These are not necessarily written in policy. Dr […] met regularly with Correctional Services and commented that Hutt had been developing a policy around the care of prisoners. He also commented that if an issue was escalated to him (complaints, delays etc) he would work with the clinical and administrative teams to find a solution that would benefit the patient. Both considered the care less than ideal. The case needs to be considered in the context of the high number of yearly outpatient appointments that occur at

	Middlemore Hospital per year (at least 350,000 (2007[22])) versus the less than 1% of Correctional Service referrals that occur and the significantly lower number where problems occurred.
Please outline any factors that may limit your assessment of the events.	Additional information that would have been useful during the given time was / is – - Policy or principles that Counties Manukau uses when removing patients from waitlist. - Actual review or audit material of patients who have been removed from the waitlist (numbers, reasons, percentages and repeat appointments post waitlist removal, health outcomes and quality of care, complaints related to process), including those who come from Correctional Services. - Specific policies that relate to the management of prisoners. - The overall number of complaints from prisoners because of the lack of services or delays in outpatient appointments over a set period of time against the total number of outpatient appointments. - Was the Capital, Coast & Hutt Botox injection administered under local or general anaesthetic? - Was there any difference in the timeframes between prisoners being booked for outpatients versus non-prisoners?
Recommendations for improvement that may help to prevent a similar occurrence in future.	1. Meet regularly (suggesting annually) with Correctional Health Services to address issues of mutual concern in the delivery of patient care. 2. The term 'custom and practice' was used several times in the Counties Manukau response. From meetings with Correctional Services (such as (1) above), provide guidelines (or preferably 'principles') for administrative and clinical staff on how to more efficiently manage the outpatient booking process for patients with special circumstances (such as those coming from Correctional Health Services and other special needs) or where special management (patients with chronic conditions requiring regular procedures [Botox injection for example]) are required. This could include –

[22] Middlemore Hospital - Wikipedia

	- Appreciation of the complexities from both parties in organising the appointments and considerations for staff when the appointment happens (Correctional staff present in the consultation). - Reprioritising patients considering the time they may have already been waitlisted when there are unique circumstances which may limit a patient's response in confirming an outpatient appointment. - Pre-emptive bookings (in this case 11 monthly) at least 12 months in advance to minimise excessive wait times – note other groups of patients may have similar issues - Agree on the timeframe when additional specialist referrals may be required. - Ability to escalate issues for special considerations especially when the 'system' itself has contributed to delayed care. This could involve widening the 'Patients under prison/police escort' policy to include some of these concepts.

Question 2: The appropriateness of relevant policies, procedures and systems in place at the time of the events, including those relating to: a. Referrals of patient care between different health boards. b. Care provision for inmates, in particular managing referrals and booking appointments. c. Management of referrals between the Urology service and the Regional Spinal Unit.	
List any sources of information reviewed other than the documents provided by HDC:	Nil
Advisor's opinion:	The policies provided don't cover the issue at hand with Ms [A]'s delayed health management. Comments are as follows:

	1. Referrals of patient care between different health boards There were two inter-Health Board referrals referenced in the documentation – a. Burwood to Capital Coast – referenced in the Wellington Hospital to Counties referral (03/07/2019) b. Capital Coast to Counties Manukau – occurring concurrently as the one received from Auckland Regional Women's Corrections Facility (ARWCF). The referrals did get entered into the Manukau Counties 'system'. There is a measure of trust and collegial respect between specialists with such referrals. Potentially Ms [A] could have been waitlisted directly for the Botox injection without a detailed urological assessment based on the specialist referral from Capital Coast and by implication the specialist team from Burwood. As mentioned above, Ms [A] could have been waitlisted for both the Botox injection and a reassessment of her bladder function at the same time. Capital, Coast & Hutt should be commended for pre-emptively booking an appointment for Ms [A]'s Botox and then following up when that appointment couldn't be made. While the first Botox injection was undertaken privately, from the information provided Counties Manukau did not undertake a pre-emptive booking for a disabled patient who was having a regularly timed procedure as seen with Capital, Coast and Hutt. [The guideline, procedure and flow chart related to interhospital transfer were not available for review and no other comments can be made here.] 2. Care provision for inmates, in particular managing referrals and booking appointments. The Counties Manukau policy 'Patients under prison/police escort' does not deal with the unique issue of communication to prison services for the booking of appointments for prisoners. This (as per the Counties response) is based on 'custom and practice'. A contributing issue to the delay of care was the lack of communication from Counties Manukau back to ARWCF following the removal of the waitlist following the initial referral and subsequent (non) referral to the Spinal

	Rehabilitation Unit. An adequate explanation as to why this didn't happen was not provided. The outpatient booking, referrals and management process for the second Botox injection did occur effectively (albeit delayed because of COVID and the need for theatre space). Appropriate communications between Counties and ARWCF did occur at this time for the process to occur. 3. Management of referrals between the Urology service and the Regional Spinal Unit. The specialist urologist who initially assessed Ms [A] following the 3 July 2019 referral from ARWCF should have been aware of the referral process before triaging if the actual process was to refer to Auckland Spinal Rehabilitation Unit first. There is little evidence provided as to the actual value made concerning bladder management because of the overall spinal assessment. I was unable to access the Hospital Clinical Pathways described in the 20 September 2024 letter from Counties Manukau back to the HDC.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	Counties Manukau was following what was felt was to be appropriate management for Ms [A] (the urology and spinal reviews). Unfortunately, these efforts didn't take into account the daily and lived experience of Ms [A] in managing her bladder hyperactivity in the prison environment. The Botox injection was her priority and that kept on being subject to delays.
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	It is 'standard custom and practice' to communicate back to the primary referrer when there is a change in triage level or prioritisation or when a re-referral occurs.
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	
Please outline any factors that may limit your assessment of the events.	- The actual referral from Burwood to Wellington Hospital

	- Did Wellington Hospital undertake a complete urological evaluation before the 2018 administration of Botox based on the referral from Burwood Hospital? - Does Counties Manukau do 'pre-emptive' booking as seen with Capital, Coast and Hutt?
Recommendations for improvement that may help to prevent a similar occurrence in future.	See recommendations under Question 1. 1. Conduct regular reviews or audits of those patients being removed from waitlists (especially outpatients). Explore the reasons and subsequent health outcomes at a Departmental level. 2. Promote community and hospital pathways to have clear direction on the referral process for both internal and external health providers and when specialist evaluations need to occur before regular procedures such as Botox injections can be administered.

Question 3: The systems that would be reasonably expected for a health board to have in place to identify delays in arranging, processing, triaging and actioning referrals and correcting administrative human errors.	
List any sources of information reviewed other than the documents provided by HDC:	
Advisor's opinion:	It would have been very difficult to pick up the October 2019 waitlist removal and failure to make a new appointment until a new referral or complaint was received.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	
How would the care provided be viewed by	I discussed this case with Dr […] previous Chief Medical Officer (CMO) of […] Hospital. He is unaware of auditing that is

your peers? Please reference the views of any peers who were consulted.	undertaken to look at removal from waitlists. This should be viewed as a quality improvement outcome from this case.
Please outline any factors that may limit your assessment of the events.	It would have been helpful to know the numbers of patients booked for urology and their respective Clinical Priority Assessment Criteria (CPAC) scores
Recommendations for improvement that may help to prevent a similar occurrence in future.	As above.

Question 4: The adequacy of the remedial steps proposed and being implemented by Health NZ to address the issues identified from this complaint.	
List any sources of information reviewed other than the documents provided by HDC:	Nil
Advisor's opinion:	The key remedial steps will reduce some of the wait time that occurred with Ms [A] but doesn't address the root issues. The actions described and my comments are as follows– 1. Move from a paper-based to electronic system of booking. This will help in the management of the day-to-day running of outpatient clinics. It will assist in the overall efficiency of the outpatient process (from start to finish). It should make it easier for redirecting outpatient bookings when these have been inappropriate. This system should also allow for immediate booking for next routine procedures (such as Botox injections) and would align with the pre-emptive booking seen by Capital, Coast and Hutt. These are both conditional on staff actually making the necessary appointments. 2. ARSU & Urological Services refining of the referral process (now to the neuro-urology service). This would be effectual in reducing at least some of the wait time Ms [A] was subject to. This would require triaging doctors know what the appropriate referral pathway is. 3. Redirection to ARSU for individuals with Spinal Cord Injuries (SCI)

	This lacks clarity. 4. Education of the internal referral process to junior doctors This would not impact the issues at hand as the information was available to House Officers prior to Ms [A]'s delayed treatment. 5. Community referral mechanisms are being explored This lacks clarity. It is noted two referrals were provided to Counties initially (Capital, Coast & Hutt as well as ARWCF).
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	Not applicable
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	Not applicable
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	I discussed this case with Dr […], previous Chief Medical Officer (CMO) of […] Hospital. He did comment that if an issue was escalated through to him (such as Ms [A]'s case) he would have found ways to expedite her care. This of course would have been dependent on the issue being picked up early.
Please outline any factors that may limit your assessment of the events.	
Recommendations for improvement that may help to prevent a similar occurrence in future.	As above

Question 5: Any other relevant matters that you consider warrant comment, including any proposed recommendations for Health NZ.	
List any sources of information reviewed other than the documents provided by HDC:	

Advisor's opinion:	1. Private sector acceptance (or not) of prisoners for minor operative procedures 2. Role of the Correctional Services These comments are added in Appendix One.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	
Please outline any factors that may limit your assessment of the events.	
Recommendations for improvement that may help to prevent a similar occurrence in future.	

By signing this report, I agree to HDC correcting any formatting, spelling, or grammar issues on the proviso that the substance of the report and any quoted material remains unchanged.
Signature:
Name: Dr Kelvin Billinghurst
Date of Advice: 28 October 2025

Appendix One: Complaint and Clinical Care

Complaint: Delayed urological care

Background: ***From Referral to First Botox Injection***

Ms [A] was born […] and at the age of 7 years experienced a motor vehicle accident leaving her with L3 paraplegia (AIS A) and a T11 conus contusion. This resulted in a permanent disability including a saddle sensory loss, paraplegia in the lower limb, bowel and bladder incontinence and the need for a wheelchair for mobility. She was initially managed for rehabilitation at Burwood Spinal Unit which includes currently 11 monthly injections of Botox, to manage a hyperactive bladder and subsequent incontinence and sling surgery in 2010/2011. Ms [A] also had a past medical history of chronic depression with self-harm / suicidal tendencies, lower limb burns & pressure injuries (grafted) and a more recent lateral meniscus injury secondary to a fall (2019/2020). Bowel management involves medication and manual removal.

The first recorded Botox injection (from the notes provided) for the overactive bladder was on 3 August 2018 while within the Capital Coast & Hutt (CC&H) District Health Board. At that time she was incarcerated at the Arohata Prison in Wellington while partway into serving a five-year sentence. Her last documented referral to ACC, according to Ms [A] concerning Botox, was made four months earlier on 10 April 2018. Without the Botox, Ms [A] has limited bladder control and despite frequent intermittent catheterisation experiences urinary incontinence. There are challenges for bladder management within the prison environment, including the number of pull-ups available for her.

Ms [A] was transferred from Arohata Prison to Auckland Regional Women's Correctional Facility (ARWCF) sometime after this first recorded Botox injection (3 August 2018). The content of any medical communication including details of the timing of the Botox injection between Correctional Services (Arohata Prison & ARWCF) and Ms [A]'s arrival at ARWCF is unknown. She was scheduled to receive her next Botox injection in July 2019.

A referral was made by ARWCF to Counties for the Botox injection with an independent referral made from CC&H DHB to Counties around the scheduled time (July 2019) for her next injection. The two referrals resulted in Ms [A] prioritised as a P2 (up to three months' wait time) with an expected wait of seven weeks. This was communicated to ARWCF health services.

A letter was sent 13 weeks later (just outside the P2 timeframe, 16 October 2019) from Counties DHB to ARWCF / Ms [A] requesting for them to book an appointment within the next following two weeks. This was followed up by a phone call one week later to ARWCF (24 October 2019) with a voice message being left. No evidence of return communication from ARWCF is given or confirm a specific appointment time.

A decision was made then by the 'Charge Nurse Manager of Urology Module' and a scheduling team member to –

1. Remove Ms [A] from the Urology appointment waiting list (occurred)

2. Transfer to the waitlist of the Auckland Spinal Rehabilitation Unit (ASRU) (did not happen). If this had happened, it is likely this would have resulted in an additional P2 triage and at least a further three-month wait for an appointment with a further wait for the Botox. The reasons why this referral did not occur is not given by Counties Manukau.

It is noted that –

1. The removal from the 'system' regarding the Botox injection was not communicated back to ARWCF/Ms [A]
2. The intention to refer to the ARSU was not communicated to ARWCF/Ms [A]
3. It took a further 18 months (approximately) before the Botox injection was given (in the private sector) and followed the ARSU appointment
4. An apology to Ms [A] regarding these two issues is given by Counties in the communication to HDC of 23 November 2023 with the cause being an unspecified 'administration error'.

Ms [A] began advocating for her Botox injection from within ARWCF early 2020, some six months after the original request was made and three months after the original appointment at Counties Manukau should have occurred. The referral was made to ARSU and mentioned both the need for spinal review and the Botox injection in March 2020.

A comprehensive spinal review occurred 6 August 2020, three months outside of the original triage target because of staffing and the complexities of COVID lock downs at the time. The ASRU assessment at that time (as per the Integrated Patient Information Management System) notes that Ms [A] was on the waitlist for a urological evaluation (following from the ARWCF referral of March 2020). A form was provided for bladder ultrasound by the ASRU, and the bladder review occurred eight months (March 2021) later, with the first Botox injection occurring four weeks later (April 2021) privately and under local anaesthetic.

In summary, Ms [A] received the first Botox injection in Auckland just under two years past the scheduled date and 32 months from her earlier injection given in 2018. This first Auckland-based Botox injection occurred two months after her delayed treatment was escalated to the Ombudsman.

From First to Second Botox

The private urologist wrote to Counties Manukau, 12 months after the administration of the first Auckland-based Botox, requesting the procedure be undertaken under general anaesthetic and within the public sector. Ms [A]'s first urological appointment with Counties Manukau occurred four weeks later, 2 June 2022. From that appointment, she was placed on the waitlist for further cystoscopy and the Botox injection. Evidence of communication to ARWCF was not given in the materials provided by Counties Manukau. The second recorded Botox injection was administered 11 months after this at Middlemore Hospital on May 2023.

It is noted the impact of COVID and COVID lockdowns happening nationally and in Auckland during this period.

The time between the first and second Botox injection was just over two years or 24 months.

Opinion

There is a sense that Counties Manukau did make efforts to provide appropriate care for Ms [A] with respect to her Botox injection and spinal assessment needs. Adherence to urological outpatient policies that existed at the time appear appropriate.

The removal of Ms [A] from the urological outpatient waitlist and failure to communicate this to ARWCF in retrospect was inappropriate. It demonstrated a lack of appreciation with the complexity in managing and delivering health care to prisoners as well as the unique negative health outcomes. The removal from the urological waitlist occurred despite three clinical assessments (the referral from Capital, Coast and Hutt, the review of the SMO when triaging Ms [A]'s urological referral and the referral itself from ARWCF). The removal was not communicated back to ARWCF and Ms [A] and contributed to her anxiety and distress. Counties Manukau recognise this and in their letter of 30 November 2023 have offered an apology to Ms [A].

The referral to ASRU could have occurred concurrently with the urological appointment. The sequential nature of the referrals, while appropriate and in line with policy, contributed to significant delays to Ms [A] receiving her treatment. As noted above, multiple clinicians had assessed her and, as there are limited treatment options and harm from the Botox injection is low, this could have been provided while waiting for both the urological and/or spinal reviews to occur.

Counties Manukau should consider clear hospital pathways for chronic conditions. The triaging urologist made no reference to the need to refer Ms [A] to urology under the ASRU team. […]

The electronic referral system should minimise future missed referrals to ASRU as happened with Ms [A] in October 2019. The 2018 information to House Officers occurred prior to the described events. This intervention did not impact on the described events.

The detail spinal review by ASRU and the follow-up by the private urologist are to be commended.

Recommendations

1. Meet regularly (suggesting annually) with Correctional Health Services to address issues of mutual concern in the delivery of patient care.

   Such meetings occur with other districts across New Zealand (one large and one small hospital)

2. From this event and with meetings (such as (1) above), provide principles or guidelines for administrative and clinical staff on how to more efficiently manage the outpatient booking process for special circumstances (such as those coming from Correctional Health Services) or where special management (patients with chronic conditions requiring regular specialist management (Botox injection for example)) is required.

Considering Correctional Health Services, this should include –

a. Having a high level of communication between services when any clinical or administrative changes are made. While ARWCF did not respond to the appointment for a urological review, it would have been appropriate to formally communicate the cancellation of the urological appointment and the intention to refer through to ASRU.
b. Consider triaging higher CPAC scores or making special exemptions to get prisoners earlier for appointments (knowing that there are higher rates of mental health, limited self-determination with respect to their own health, and higher mortality rates on discharge[23]).
This was discussed with one other Chief Medical Officer (CMO) (similar hospital size to Counties). They do make provision where special circumstances such as administrative issues to fast-track appointments where appropriate. These are usually discussed directly with a senior manager and/or the CMO.

c. Consider pre-emptive booking appointments for repeating procedures such as Botox injections for patients with chronic conditions

3. Conduct regular reviews or audits of those patients being removed from waitlists (especially outpatients). Explore the reasons and subsequent health outcomes at a Departmental level.
4. Promote community and hospital pathways in order to have clear direction for the referral process for both internal and external health providers and when specialist evaluations need to happen for regular procedures such as Botox injections.

Observation: Correctional Services

The focus of the HDC review is primarily towards Counties Manukau. However, Correctional Services – in particular ARWCF – contributed to the delayed services for Ms [A] regarding her Botox injection. These comments are outside of the original review brief and made with limited information available from the ARWCF perspective.

These include –

1. The details of transferred medical notes are unclear between Arohata Prison in Wellington and ARWCF. However, as Ms [A] already had an appointment with Capital Coast for her 2019 Botox injection, it is not unreasonable to expect this to have been communicated between the respective health services.
2. With a patient having such a permanent disability and under ACC, the option for earlier and/or direct referral to the private sector should have been considered earlier. A conversation with Ms [A], follow-up on the clinical records, and a direct conversation with ACC or Burwood would have verified this information. It took one month from recognising that the procedure could be undertaken privately to the time of actual administration.
3. Advocacy for Ms [A]'s health needs (despite the various formal complaints made) appears ad hoc, piecemeal and lacked proactive follow-up after the initial referral for Botox. Having received formal communication that an appointment was scheduled (but

[23] Mortality after release from incarceration in New Zealand by gender: A national record linkage study - ScienceDirect accessed 13/01/2025 & chapter-15-prison-health-067754.pdf accessed 13/01/2025

unconfirmed) following the first referral, there was no evidence of active follow-up on why the appointment had not occurred until Ms [A] started enquiring again.

a. The message left by the booking team at Counties Manukau (October 2019) should have been picked up and communicated by ARWCF health services back to Counties Manukau and to Ms [A] directly. The past waitlist or possible appointment at Counties Manukau was not referenced in the referral to the Auckland Spinal Rehabilitation Unit referral of 20 February 2020. This could have resulted in lower triaging. There is no evidence that the possibility of an appointment in October 2019 with Counties Manukau was communicated to Ms [A] in the responses to her formal Personal Complaints.
b. It was seven months from the Auckland Spinal Rehabilitation Unit review (06/08/2020) until receiving the Botox injection in the private sector.
c. Although Ms [A] had submitted numerous complaints, initiation for the second Botox injection came from the private urologist who had undertaken the first Botox injection while in Auckland.

4. Rationing of the pads at ARWCF was noted by the assessment by the ASRU.

Private Health Services

Details on the refusal of a Private Health Services (Counties Response of 20 September 2024 3.v (para2)) to refuse care to prisoners should be explored further.

Appendix Two: Chronology

Date	Description	Cat	Source
[...]	**DOB**		
[...]1998	**MVA (aged 7)**		
2/11/2015	Last seen in spinal unit (Dx sacral paraplegia conus contusion from T11), suicide, chronic depression, L4 incomplete		
10/04/2018	Last referral received by ACC for Botox		
3/08/2018	CCDHB - Botox Injection provided while at Arohata Prison		
1/07/2019	Proposed Botox		
3/07/2019	Referral from ARWCF to Counties DHB, P2 - 7 week wait time, Expected appt date early Sept 2019	Ref1	
3/07/2019	Letter to Counties DHB from CCDHB - recommending further Botox injection 11 months from 3 Aug 2018 (due then on 3 July 2019), received by Counties on 17 July 2019.		
11/07/2019	Letter from Counties DHB to [...] re appt, not fixed but booked	1Admin	TWO Attach1
16/10/2019	TWO-Counties to [...] via Prison PO Box to book appt in next 14 days (to 31/10/2019)		
4/09/2019	Appt should have occurred before this date (based on 3/7/2019 letter)		
24/10/2019	TWO-Counties phone to ARWCF medical centre request to contact re appointment, message left.		
24/10/2019	TWO-Counties - transfer [...] to Auckland Regional Spinal Unit (ARSU) for review and removal from the urological waitlist		
13/01/2020	3 PC.01	2Admin	[...] Omb
10/02/2020	4 PC.01	2Admin	[...] Omb

20/02/2020	ARWCF - Letter to ARSU re appt for botox and spinal assessment (received 10/03/2020) (references in PC.01 of 13/02/2021 dates as of 17/02/2020)	Ref2	
17/03/2020	Interview with [...] by PCO at ARWCF - Verbal to [...] re referrals made to Hospital	2Admin	[...] Omb
10/03/2020	Received referral from ARWCF (20/02/2020) - P2 - 3 months, appt expected		
20/03/2020	Request by [...] for all ARWCF referrals to hospital by medical	2Admin	[...] Omb
20/04/2020	ASRU triage assessment as a P2	Letter	
1/05/2020	Due Procedure	Clin	
1/06/2020	Proposed Botox		
2/06/2020	7 PC.01	2Admin	[...] Omb
4/06/2020	? Telephonic consultation during COVID with the DHB alleged	Clin	
4/06/2020	PC.01 received and actioned - internal with ARWCF	2Admin	[...] Omb
10/06/2020	Appt from 10/03/2020 by this date expected - urodynamic studies		
6/08/2020	Spinal evaluation (SEAR)		
6/08/2020	Counties - Spinal Evaluation and Assessment Report - Outpatient Letter to ACC & ARWCF	Letter	
12/02/2021	Letter to Ombudsman from [...]	2Admin	
12/02/2021	PC.01 - three years overdue (missed two treatments, 2019 & 2020)	2Admin	[...] Omb
13/02/2021	ARWCF	2Admin	[...] Omb
15/03/2021	SRU appt with bladder assessment studies		
15/03/2021	Outpatient Clinic at Counties	Letter	
30/03/2021	Ombudsman to HDC letter	2Admin	
1/04/2021	Botox injection (pvt)		

1/05/2021	Proposed Botox		
1/03/2022	Next Botox injection due		
1/04/2022	Proposed Botox		
26/04/2022	Pvt urologist ([Dr B]) referred back to TWO-Counties urology (for GA with procedure)		
26/04/2022	Referral from [Dr B] to Counties - request GA (instead of LA)	Letter	
30/04/2022	Botox injection	Clin	
5/05/2022	Referral received by TWO-Counties		
2/06/2022	First appt at TWO-Counties Urology Dept (11 months, worse off after 9 months), appt made for cystoscopy and Botox.		
2/06/2022	Counties - Urological Outpatient Clinic letter		
9/06/2022	Placed on waitlist for procedure at Counties		
1/01/2023	Due Procedure	Clin	
1/03/2023	Proposed Botox		
8/03/2023	ARWCF referral to TWO-Counties for next Botox		
8/03/2023	Referral from ARWCF to TWO-Counties		
9/03/2023	Response from TWO-Counties to ARWCF re GA waitlist (sooner if under local)		
4/04/2023	Letter to HDC from Nationwide Health and Disability Advocacy Service, note the change to 9 months as recommended from Counties	2Admin	[...] Omb
6/04/2023	Request for information re blood in urine		
17/04/2023	Email re date for Botox injection (16/05/2023)	Letter	
23/05/2023	Botox at Middlemore Hospital under GA		
7/07/2023	HDC to Counties letter	Admin2	
19/07/2023	Request for information re blood in urine		

30/11/2023	Te Whatu Ora Counties - response to HDC	Admin2
1/02/2024	Proposed Botox	
1/01/2025	Proposed Botox	
1/07/2025	Complete prison sentence	

Appendix Three: References

Cooley, L. F. and S. Kielb (2019). "A Review of Botulinum Toxin A for the Treatment of Neurogenic Bladder." PM&R **11**(2): 192-200.

Prior to FDA approval of intradetrusor botulinum toxin (BoTA) injections for the treatment of neurogenic bladder, patients' treatment options were limited to use of pharmacotherapies such as antimuscarinics, alpha blockers, and more recently beta agonists (some off-label) or invasive interventions including bladder augmentation and urinary diversion procedures. Herein, we provide a comprehensive literature review detailing the salient clinical literature that led to FDA approval of intradetrusor BoTA for neurogenic bladder. Patients with neurogenic detrusor overactivity and detrusor sphincter dyssynergia have been shown in randomized studies to benefit significantly from intradetrusor BoTA injection with regard to the following parameters: improved voided volume, improved bladder pressure and urodynamic parameters, reduced incidence of urinary tract infection, and improved quality of life. Intradetrusor BoTA injection has revolutionized the treatment landscape for patients with neurogenic bladder by providing them with a safe, efficacious, and cost-effective means to reduce bladder dysfunction, preserve renal function, and reduce the need for invasive, surgical intervention. Level of Evidence I