# An investigation into the Office of the Public Advocate's role in notifying the families of Mrs Joyce Savage, Mr Robert Ayling and Mr Kenneth Hartley of the deaths of Mrs Savage, Mr Ayling and Mr Hartley

**Ombudsman Western Australia**

Serving Parliament – Serving Western Australians

## About this Report

This Report is available in print and electronic viewing format to optimise accessibility and ease of navigation. It can also be made available in alternative formats to meet the needs of people with disability. Requests should be directed to the Publications Manager.



## Contact Details

**Street Address**
Level 2, 469 Wellington Street
PERTH WA 6000

**Postal Address**
PO Box Z5386 St Georges Terrace
PERTH WA 6831

**Telephone:** (08) 9220 7555 or 1800 117 000 (free from landlines)

**Translating and Interpreting Service (TIS National):** 131 450
(for people who need an interpreter)

**National Relay Service Helpdesk:** 1800 555 660 (quote 08 9220 7555)
(for people with a voice or hearing impairment)

**Facsimile:** (08) 9220 7500

**Email:** mail@ombudsman.wa.gov.au

**Web:** www.ombudsman.wa.gov.au

**ISBN (Print):** 978-0-6450318-0-5
**ISBN (Online):** 978-0-6450318-1-2

First published by Ombudsman Western Australia in July 2021.

**The office of the Ombudsman acknowledges Aboriginal and Torres Strait Islander people of Australia as the traditional custodians of Australia. We recognise and respect the exceptionally long history and ongoing cultural connection Aboriginal and Torres Strait Islander people have to Australia, recognise the strength, resilience and capacity of Aboriginal and Torres Strait Islander people and pay respect to Elders past, present and future.**

**We acknowledge the Whadjuk Noongar people as the traditional custodians of the land on which the office of the Ombudsman is located.**

This page has intentionally been left blank.

# Contents

This page has intentionally been left blank.

# Ombudsman's Foreword

On 2 March 2021, the Honourable John Quigley MLA, Attorney General, wrote to me requesting an investigation into the Office of the Public Advocate's (**OPA**) role in notifying the family of Mrs Joyce Savage of the death of Mrs Savage. The Attorney General also requested that I include in my investigation the circumstances of OPA's notification to the families of Mr Robert Ayling and Mr Kenneth Hartley of the deaths of Mr Ayling and Mr Hartley.

On the same day, in accordance with section 16(1) of the *Parliamentary Commissioner Act 1971*, I initiated an investigation into OPA's role in notifying the families of Mrs Joyce Savage, Mr Robert Ayling and Mr Kenneth Hartley of the deaths of Mrs Savage, Mr Ayling and Mr Hartley (**the Investigation**).

Mrs Savage's daughter, Ms Kaye Davis, Mr Ayling's son, (also named) Mr Robert Ayling and Mr Hartley's brother, Mr Phillip Hartley, were contacted as part of the Investigation and each made themselves available during the Investigation to talk about their experiences and views. These experiences and views have informed this report of the Investigation (**the Report**) and it is my hope that the Report can, in turn, provide information to Ms Davis, Mr Ayling and Mr Hartley that is of assistance to them. I express my sincerest condolences to the families on the passing of Mrs Savage, Mr Ayling and Mr Hartley.

A person for whom OPA has been appointed as their guardian is a 'represented person'. This was the case for Mrs Savage, Mr Ayling and Mr Hartley. Each was a represented person. But Mrs Savage, Mr Ayling and Mr Hartley were more than represented people. Each led a long life, was a family member and a contributor to their communities. Any delay in notifying a family of the death of a family member will, of course, be upsetting for a family. Further, the delay does not give the dignity to the person's passing that they should, and must, be afforded.

As a result of the Investigation, I have formed a number of opinions regarding OPA's role in notifying the families of Mrs Joyce Savage, Mr Robert Ayling and Mr Kenneth Hartley of the deaths of Mrs Savage, Mr Ayling and Mr Hartley.

Arising from these opinions, I have made seven recommendations to OPA.

I am very pleased that OPA has agreed to all seven recommendations. I will actively monitor the steps taken by OPA to give effect to my recommendations.

In my view, these seven recommendations, when implemented, will be responsive to the families of Mrs Savage, Mr Ayling and Mr Hartley, but also ensure that in the future OPA does, without delay, notify family upon the death of a loved one.

Chris Field
**OMBUDSMAN**

# 1 Introduction

## 1.1 Scope of the Investigation

The scope of the Investigation is to determine the role of OPA in notifying the families of Mrs Savage, Mr Ayling and Mr Hartley of the deaths of Mrs Savage, Mr Ayling and Mr Hartley.

## 1.2 Summary of opinions

In accordance with section 25(1) of the *Parliamentary Commissioner Act 1971*, following an investigation the Ombudsman can, where she or he is of the opinion that the actions taken by an agency being investigated are wrong, make recommendations about steps to be taken to address the wrongful actions.

As a result of the Investigation, I am of the opinion that OPA's actions in not notifying the families of Mrs Savage, Mr Ayling and Mr Hartley of the death of Mrs Savage, Mr Ayling and Mr Hartley were wrong.

## 1.3 Office of the Public Advocate staff acted in accordance with the guidance provided to them

As a result of the Investigation, and in the Report, no comments have been made, nor have any opinions been formed, that are defamatory or adverse to any staff member of OPA. This is so because OPA staff acted in accordance with the guidance provided to them about how their delegated functions should be undertaken. It is the case, in a number of instances, the guidance provided by OPA to staff members was, in my opinion, wrong. In the Report, a reference to guidance includes OPA's policies, practice standards and templated letters.

## 1.4 Summary of Recommendations

Arising from my opinions, I have made six recommendations to OPA regarding the appropriate actions to be taken in the future by OPA to notify family upon the death of a represented person. A further recommendation has been made that OPA should apologise for not notifying the families of Mrs Savage, Mr Ayling and Mr Hartley of the deaths of Mrs Savage, Mr Ayling and Mr Hartley. The seven recommendations are set out in the next chapter of the Report.

This page has intentionally been left blank.

# 2 Table of Recommendations

**Recommendation 1**

OPA should, at the commencement of OPA's role as guardian with the authority to make treatment decisions, inform family of OPA's role in relation to making palliative care treatment decisions and the concomitant criticality of ensuring that OPA is informed of any change in phone number.

**Recommendation 2**

OPA should see it as part of their role to contact family following the death of a represented person.

**Recommendation 3**

OPA should make every reasonable endeavour to contact family on every occasion:

1. That OPA is making a palliative care treatment decision for a represented person given the fact that this will notify the family of the potential (and potentially imminent) death of the represented person;
2. After OPA has made a palliative care treatment decision for a represented person, where it has not been possible to contact family at the time of the palliative care treatment decision, given the fact that this will notify the family of the potential (and potentially imminent) death of the represented person; and
3. After the death of a represented person.

Without limiting the meaning of every reasonable endeavour that OPA should make, OPA must:

1. Utilise all phone numbers of which OPA are, or become, aware; and
2. Where a current and in service phone number is not available, contact the Public Trustee (during office hours and where they are also appointed) or any relevant agency or place of care, including the residence of the represented person, treating hospital and any other relevant care facility to obtain a contact number for family.

**Recommendation 4**

OPA should ensure that it:

1. Provides guidance to on-call delegated guardians and delegated guardians that the death of a represented person is a matter of high priority and thus urgent actions are required to be undertaken; and
2. Has procedures in place to ensure that urgent actions are undertaken upon the death of a represented person when delegated guardians are absent on leave or are part-time employees.

**Recommendation 5**

OPA should always keep a record of whether it has contacted family when making a palliative care treatment decision and the views of family are recorded.

**Recommendation 6**

OPA should amend all guidance to delegated guardians, including the *Notification to key parties on the death of a represented person* practice standard, the *After-hours calls* practice standard and the *Letter to Service Providers*, to ensure that OPA's guidance to delegated guardians is consistent and that all guidance is consistent with the recommendations of the Investigation.

**Recommendation 7**

OPA should apologise to the families of Mrs Savage, Mr Ayling and Mr Hartley for not notifying them of the deaths of Mrs Savage, Mr Ayling and Mr Hartley.

# 3 The Ombudsman

The Ombudsman is an officer of the Western Australian Parliament. The Ombudsman is independent of the government of the day and completely impartial. The Ombudsman has functions in relation to:

- The investigation of State government departments, statutory authorities, boards and corporations, local governments and universities;
- The review of child deaths and family and domestic violence fatalities; and
- A number of other investigatory, review and oversight functions provided for in a range of legislation.

The Ombudsman can undertake investigations regarding the decision making of public agencies by reference by Parliament, arising from a complaint or of her or his own motion.

In undertaking an investigation, the Ombudsman has the rights, privileges and responsibilities prescribed in the *Parliamentary Commissioner Act 1971* and of a standing Royal Commission (in accordance with the *Royal Commissions Act 1968*).

At the completion of an investigation, the Ombudsman can form opinions and make recommendations. The Ombudsman's report of an own motion investigation is tabled in Parliament and is publicly available.

The Ombudsman also actively monitors the implementation and effectiveness of recommendations arising from own motion investigations. More specifically, twelve months after the tabling of an own motion investigation, the Ombudsman tables a report in Parliament on the implementation of the recommendations arising from the own motion investigation. This is done for every own motion investigation.

This page has intentionally been left blank.

# 4 The Ombudsman's investigation

## 4.1 Meeting with the families of Mrs Savage, Mr Ayling and Mr Hartley

As an important part of the Investigation, the office of the Ombudsman contacted Mrs Savage's daughter, Ms Kaye Davis, Mr Ayling's son, (also named) Mr Robert Ayling and Mr Hartley's brother, Mr Phillip Hartley. Each met with the office of the Ombudsman (by phone) and shared their experiences and views. These experiences and views have informed the Investigation.

## 4.2 Consideration of legislation

The office of the Ombudsman examined the legislative basis of OPA's role, in particular, the *Guardianship and Administration Act 1990* (**the Act**), in notifying the families of Mrs Savage, Mr Ayling and Mr Hartley of the deaths of Mrs Savage, Mr Ayling and Mr Hartley.

## 4.3 Information collection and analysis

The office of the Ombudsman required information from OPA including case files, correspondence, relevant policies and procedures as well as answers to questions from the office of the Ombudsman and then carefully considered the information provided by OPA.

## 4.4 Preliminary report

The office of the Ombudsman provided OPA with the Report, with preliminary opinions and preliminary recommendations, for OPA's consideration and response.

## 4.5 Final report

The office of the Ombudsman tabled the Report in Parliament.

This page has intentionally been left blank.

# 5 Guardianship in Western Australia

## 5.1 What is a guardian?

A guardian makes decisions for another person who has both a problem in relation to making decisions for themselves and is in need of a guardian. In Western Australia, the appointment of a guardian for a person is a decision made by the State Administrative Tribunal (**SAT**). The appointment of a guardian is an important decision and is regulated by the Act. Section 4 of the Act sets out principles that shall be observed by SAT in dealing with proceedings under the Act. These principles focus on the presumption of the capability and reasonableness of individual decision making and ensuring that this decision making is only circumscribed where it is in the best interests of the person to do so, is the least restrictive of their freedom of decision making and reflects their decision making as expressed or ascertained from past decision making. The principles are as follows:

(1) In dealing with proceedings commenced under this Act the State Administrative Tribunal shall observe the principles set out in this section.

(2) The primary concern of the State Administrative Tribunal shall be the best interests of any represented person, or of a person in respect of whom an application is made.

(3) Every person shall be presumed to be capable of —

(a) looking after his own health and safety;

(b) making reasonable judgments in respect of matters relating to his person;

(c) managing his own affairs; and

(d) making reasonable judgments in respect of matters relating to his estate,

until the contrary is proved to the satisfaction of the State Administrative Tribunal.

(4) A guardianship or administration order shall not be made if the needs of the person in respect of whom an application for such an order is made could, in the opinion of the State Administrative Tribunal, be met by other means less restrictive of the person's freedom of decision and action.

(5) A plenary guardian shall not be appointed under section 43(1) or (2a) if the appointment of a limited guardian under that section would be sufficient, in the opinion of the State Administrative Tribunal, to meet the needs of the person in respect of whom the application is made.

(6) An order appointing a limited guardian or an administrator for a person shall be in terms that, in the opinion of the State Administrative Tribunal, impose the least restrictions possible in the circumstances on the person's freedom of decision and action.

(7) In considering any matter relating to a represented person or a person in respect of whom an application is made the State Administrative Tribunal shall, as far as possible, seek to ascertain the views and wishes of the person concerned as expressed, in whatever manner, at the time, or as gathered from the person's previous actions.[1]

[1] *Guardianship and Administration Act 1990*, s. 4.

In accordance with section 43 (and subject to section 4) of the Act, where SAT:

> is satisfied that a person in respect of whom an application for a guardianship order is made under section 40 —
>
> (a) has attained the age of 18 years;
>
> (b) is —
>
> (i) incapable of looking after his own health and safety;
>
> (ii) unable to make reasonable judgments in respect of matters relating to his person; or
>
> (iii) in need of oversight, care or control in the interests of his own health and safety or for the protection of others;
>
> and
>
> (c) is in need of a guardian,[2]

SAT can declare the person to be in need of a guardian, and if it does, appoint a guardian.

## 5.2 What decisions can a guardian make?

Section 45 of the Act lists the functions a guardian can undertake. In respect to a represented person, the guardian may:

> (a) decide where the represented person is to live, whether permanently or temporarily;
>
> (b) decide with whom the represented person is to live;
>
> (c) decide whether the represented person should work and, if so, the nature or type of work, for whom he is to work and matters related thereto;
>
> (d) subject to subsection (4A), make treatment decisions for the represented person;
>
> (e) decide what education and training the represented person is to receive;
>
> (f) decide with whom the represented person is to associate;
>
> (g) as the next friend of the represented person, commence, conduct or settle any legal proceedings on behalf of the represented person, except proceedings relating to the estate of the represented person;
>
> (h) as the guardian *ad litem* of the represented person, defend or settle any legal proceedings taken against the represented person, except proceedings relating to the estate of the represented person;
>
> (i) if the plenary guardian is a research decision-maker for the represented person — subject to subsection (4A)(a) and sections 110ZR and 110ZT, make research decisions in relation to the represented person.[3]

[2] *Guardianship and Administration Act 1990*, s. 43(1).
[3] *Guardianship and Administration Act 1990*, s. 45(2).

SAT can appoint a plenary guardian or a limited guardian. A plenary guardian is authorised to undertake any of the functions mentioned in section 45 of the Act. A limited guardian is authorised to undertake such of the functions mentioned in section 45 of the Act as SAT vests in the limited guardian.[4]

In making section 45 decisions, section 51 of the Act provides that the guardian must act in the best interests of the represented person as far as possible, including:

(a) as an advocate for the represented person;

(b) in such a way as to encourage the represented person to live in the general community and participate as much as possible in the life of the community;

(c) in such a way as to encourage and assist the represented person to become capable of caring for themself and of making reasonable judgments in respect of matters relating to their person;

(d) in such a way as to protect the represented person from neglect, abuse or exploitation;

(e) in consultation with the represented person, taking into account, as far as possible, the wishes of that person as expressed, in whatever manner, or as gathered from the person's previous actions;

(f) in the manner that is least restrictive of the rights, while consistent with the proper protection, of the represented person;

(g) in such a way as to maintain any supportive relationships the represented person has; and

(h) in such a way as to maintain the represented person's familiar cultural, linguistic and religious environment.[5]

## 5.3 The Office of the Public Advocate

The Long Title of the Act is:

> An Act to provide for the guardianship of adults who need assistance in their personal affairs, for the administration of the estates of persons who need assistance in their financial affairs, to confer on the State Administrative Tribunal jurisdiction in respect of guardianship and administration matters, to provide for the appointment of a public officer with certain functions relative thereto, to provide for enduring powers of attorney, enduring powers of guardianship and advance health directives and for connected purposes.[6]

Section 91(1) of the Act creates an office of Public Advocate, the holder of which shall be appointed by the Governor.

[4] *Guardianship and Administration Act 1990*, ss. 45 and 46.
[5] *Guardianship and Administration Act 1990*, s. 51(2).
[6] *Guardianship and Administration Act 1990*, Long Title.

Section 97 of the Act provides for the functions of the Public Advocate. In the Public Advocate of Western Australia, *Annual Report 2019/20*, OPA paraphrases section 97 of the Act as:

- investigation of concerns about the wellbeing of adults with a decision-making disability and whether there is a need for an application for a guardian or administrator to be appointed
- investigation of specified applications made to the State Administrative Tribunal to assist it to determine whether a guardian or administrator should be appointed
- guardianship (for personal, lifestyle and treatment related decisions) when the State Administrative Tribunal determines that there is no one else suitable, willing and available to act as the person's guardian
- information, advice and training on how to protect the human rights of adults with a decision-making disability.[7]

## 5.4 The State Administrative Tribunal can appoint the Office of the Public Advocate as guardian

SAT can appoint OPA as guardian, but SAT 'shall not appoint the Public Advocate as a guardian unless there is no other person who is suitable and willing to act.'[8]

OPA informed the Ombudsman during the Investigation that OPA was the guardian for approximately 2,600 adults.

A person for whom OPA is appointed guardian is a represented person. The Act defines represented person as follows:

> represented person means any person in respect of whom —
>
> (a) a guardianship order is in force;
>
> (b) an administration order is in force; or
>
> (c) both a guardianship order and an administration order are in force.[9]

[7] Public Advocate of Western Australia, *Annual Report 2019/20*, September 2020, p. 7.
[8] *Guardianship and Administration Act 1990*, s. 44(5). In accordance with the *Guardianship and Administration Act 1990*, section 44(5), SAT appoints the Public Advocate as guardian. For ease of reading, and to avoid confusion, throughout the Report, all relevant references are made to OPA, rather than the Public Advocate.
[9] *Guardianship and Administration Act 1990*, s. 3.

The Public Advocate can delegate her functions in accordance with section 95 of the Act. Section 95 relevantly provides:

> (1) The Public Advocate may either generally or as otherwise provided by the instrument of delegation, by writing signed by him, delegate to an officer appointed under section 94 any function of the Public Advocate other than —
>
> (a) this power of delegation; and
>
> (b) except as provided in subsection (2), his functions as a guardian or administrator.
>
> (2) Where the Public Advocate is a guardian or administrator, he may with the approval of the State Administrative Tribunal, either generally or as otherwise provided by the instrument of delegation, by writing signed by him, delegate any of his functions as guardian or administrator, including this power of delegation, to any person specified in the instrument of delegation.
>
> (3) The State Administrative Tribunal shall not approve a delegation by the Public Advocate under subsection (2) to a body corporate unless it is satisfied that there is no individual willing and suitable to act as delegate.[10]

OPA states that the '[f]ive principles set out in Section 4 of the [Act] guide [OPA] in the provision of all services'.[11]

OPA describes these guidance principles as OPA's values:[12]

- **Presumption of competence**
  Every person is presumed to be capable of managing their own affairs and making reasonable judgements about themselves, their safety and their finances unless this is proved to the contrary.
- **Best interests**
  The primary concern is the best interests of the person with the decision-making disability.
- **Least restrictive alternative**
  A guardian or administrator is only appointed when a person's needs can no longer be met in a less restrictive way, without impacting on their freedom of decision and action.
- **Limited versus plenary**
  The authority of an appointed guardian or administrator will be limited to those areas in which the person with a decision-making disability needs decision-making support.
- **Current wishes and previous actions**
  The views and wishes of the person concerned are sought to the extent possible and expressed in whatever manner, either at the time or gathered from the person's previous actions.[13]

[10] *Guardianship and Administration Act 1990*, s. 95.
[11] Public Advocate of Western Australia, *Annual Report 2019/20*, September 2020, p. 8.
[12] Public Advocate of Western Australia, *Annual Report 2019/20*, September 2020, p. 8.
[13] Public Advocate of Western Australia, *Annual Report 2019/20*, September 2020, p. 8.

This page has intentionally been left blank.

# 6 The Office of the Public Advocate's role in notifying the family of Mrs Savage of her death

## 6.1 Mrs Joyce Savage

At the time of her death, Mrs Savage was an 89 year old woman and a resident at Acacia Living Group's Menora Gardens. During her life, Mrs Savage had worked as a nurse and taught at the (then) Western Australian Institute of Technology (now Curtin University). She was also a mother, a grandmother and a great-grandmother.[14]

## 6.2 The Office of the Public Advocate was limited guardian for Mrs Savage

As set out in Chapter 5 of the Report, SAT, in accordance with section 43 of the Act (and subject to the principles in section 4 of the Act), can declare a person to be in need of a guardian and appoint OPA as the person's guardian.[15] In accordance with section 45 of the Act, OPA can be authorised to do any of the things set out in section 45(2) of the Act. SAT can appoint a plenary guardian or a limited guardian. A plenary guardian is authorised to undertake any of the functions mentioned in section 45 of the Act. A limited guardian is authorised to undertake such of the functions mentioned in section 45 of the Act as SAT vests in the limited guardian.

In 2019, OPA was appointed as a limited guardian for Mrs Savage with functions relating to accommodation, treatment and the provision of services.[16] Accordingly, as Mrs Savage's limited guardian, one of the functions that OPA was authorised to undertake related to treatment for Mrs Savage. The Act defines treatment as including "medical or surgical treatment, including a life sustaining measure or palliative care".[17] A treatment decision is defined as meaning "a decision to consent or refuse consent to the commencement or continuation of any treatment of the person".[18] The Act defines palliative care as meaning "a medical, surgical or nursing procedure directed at relieving a person's pain, discomfort or distress, but does not include a life sustaining measure".[19] OPA contacts the family of a represented person to seek their views about a treatment decision for palliative care (**palliative care treatment decision**).

---

[14] Caitlyn Rintoul, 'Error for the ages', *The West Australian*, 1 March 2021, p. 1 and 'Nobody told us mum was dead', *The West Australian*, 1 March 2021, pp. 4-5.

[15] As previously noted, in accordance with the *Guardianship and Administration Act 1990*, section 44(5), SAT appoints the Public Advocate as guardian. For ease of reading, and to avoid confusion, throughout the Report, all relevant references are made to OPA, rather than the Public Advocate.

[16] *Guardianship and Administration Act 1990,* Schedule 1, cl.12 limits the publication of SAT guardianship proceedings. The material provided in the Report regarding OPA's guardianship for Mrs Savage is publicly available information.

[17] *Guardianship and Administration Act 1990*, s. 3.

[18] *Guardianship and Administration Act 1990*, s. 3.

[19] *Guardianship and Administration Act 1990*, s. 3.

As set out at 1.1 of the Report, the scope of the Investigation is the role of OPA in notifying the families of Mrs Savage, Mr Ayling and Mr Hartley of the deaths of Mrs Savage, Mr Ayling and Mr Hartley. However, OPA's role in notifying Mrs Savage's daughter, Ms Davis, of the death of Mrs Savage cannot be understood without first considering OPA's attempts to contact Ms Davis to seek her views about a palliative care treatment decision for Mrs Savage.

## 6.3 The Office of the Public Advocate's contact with Mrs Savage's daughter

On Saturday 13 February 2021 at 7:48am, OPA was informed by Acacia Living Group's Menora Gardens that Mrs Savage needed to be transferred from Acacia Living Group's Menora Gardens, where she was a resident, to Sir Charles Gairdner Hospital. At 11:00am on that same morning, OPA was informed that the Sir Charles Gairdner Hospital Emergency Department was seeking to speak with OPA, indicating it was very urgent. Again on that same morning OPA called the Sir Charles Gairdner Hospital Emergency Department and discussed a palliative care treatment decision for Mrs Savage. At this stage, OPA attempted to contact Ms Davis on the mobile phone number contained in OPA's records to seek her views about the palliative care treatment decision,[20] but "the mobile phone number was no longer connected".[21] OPA then attempted one phone call to Acacia Living Group's Menora Gardens to ascertain a phone number for Ms Davis but the call was not answered.[22]

Following the two phone calls, OPA made the palliative care treatment decision for Mrs Savage on the morning of Saturday 13 February 2021. The decision was that Mrs Savage was to be treated as 'Not for Resuscitation', 'Not for Intubation' and 'Not for Intensive Care', but to be treated for comfort care.[23] OPA contacted Sir Charles Gairdner Hospital to inform the hospital of OPA's decision. OPA indicated that Sir Charles Gairdner Hospital "confirmed with [OPA] that they had the phone number for Mrs Savage's daughter but it was not being answered and that [Sir Charles Gairdner Hospital] would keep trying" to

[20] As a matter of completeness, the on-call delegated guardian (see section 6.5.1 of the Report for a discussion of the role of on-call delegated guardians and delegated guardians) did not have immediate access to a laptop computer to view Mrs Savage's records in the OPA case management system to obtain a mobile phone number for Ms Davis. This did not cause delay as Mrs Savage's records were able to be viewed immediately by an OPA manager with access to the OPA case management system. This comment is not adverse to the on-call delegated guardian and occurred because OPA's guidance to on-call delegated guardians is, in my view, wrong. Following the commencement of the Investigation, OPA has instituted changes to its guidance to on-call delegated guardians in relation to access to laptops (see Chapter 9 of the Report).

[21] OPA provided this information to the Ombudsman in response to information required, and questions asked, by the Ombudsman during the Investigation.

[22] This comment is not adverse to Acacia Living Group's Menora Gardens. This comment is not adverse to delegated staff of OPA.

[23] Under OPA's instrument of delegation, only the Public Advocate herself can make 'end of life decision-making including palliative care', Public Advocate of Western Australia, *Practice Standard: Delegated Authority for Delegated Guardians and Administrators*, Version 4, p. 4. This is what occurred in relation to the treatment decisions for Mrs Savage.

call the phone number.[24] OPA was not aware of the phone number that was held by Sir Charles Gairdner Hospital and did not consider seeking to obtain the phone number held by Sir Charles Gairdner Hospital (when to do so may have been reasonable on the basis that the phone number contained in OPA's records "was no longer connected", but the phone number held by Sir Charles Gairdner Hospital "was not being answered", suggesting it was connected, but not answering). OPA subsequently become aware during the course of the Investigation that the phone number held by Sir Charles Gairdner Hospital was, indeed, a different phone number than that contained in OPA's records and that the phone number held by Sir Charles Gairdner Hospital was also incorrect, but OPA did not know this at the time of the phone conversation with Sir Charles Gairdner Hospital on Saturday 13 February 2021.[25] Mrs Savage died at Sir Charles Gairdner Hospital on Sunday 14 February 2021.

### 6.3.1 Opinion

The reason why Mrs Savage's daughter, Ms Davis, was not contacted by OPA at the time of making the palliative care treatment decision for Mrs Savage was because OPA had an incorrect phone number for Ms Davis. The importance of having a correct phone number for the family of a represented person cannot be overstated. It is not necessarily the case that family will be aware of the criticality of ensuring that OPA has a current phone number, given that this phone number will be used to seek family views regarding a palliative care treatment decision. I am of the opinion that OPA's guidance to delegated staff regarding the templated letter sent to the family of a represented person at the commencement of OPA's guardianship function is wrong as it does not specify for the family of a represented person the criticality of ensuring that OPA has a current phone number.[26]

### 6.3.2 Recommendation

**Recommendation 1**

OPA should, at the commencement of OPA's role as guardian with the authority to make treatment decisions, inform family of OPA's role in relation to making palliative care treatment decisions and the concomitant criticality of ensuring that OPA is informed of any change in phone number.

[24] OPA provided this information to the Ombudsman in response to information required, and questions asked, by the Ombudsman during the Investigation. This comment is not adverse to Sir Charles Gairdner Hospital.
[25] This comment is not adverse to Sir Charles Gairdner Hospital.
[26] In the Report, the present tense is used to refer to OPA's guidance. However, it is important to note that, following the commencement of the Investigation, OPA has instituted changes to its guidance to delegated guardians in relation to notifying family of the death of a represented person (see Chapter 9 of the Report for further discussion).

## 6.4 Why did the Office of the Public Advocate not notify Mrs Savage's daughter of the death of Mrs Savage?

Mrs Savage died at Sir Charles Gairdner Hospital on Sunday 14 February 2021. OPA was informed of the death of Mrs Savage on Sunday 14 February 2021 at 5:17am.

Ms Davis was notified of the death of Mrs Savage on Monday 22 February 2021, but she was not notified by OPA.

Why did OPA not notify Ms Davis of the death of Mrs Savage? The Investigation has determined that there are three reasons why OPA did not notify Ms Davis.

### 6.4.1 The Office of the Public Advocate had an incorrect mobile phone number for Mrs Savage's daughter

The first reason, as discussed at 6.3 of the Report, was that OPA had an incorrect mobile phone number for Ms Davis. OPA is of the view that contacting family to seek their views regarding a palliative care treatment decision will ensure that family are then notified of the potential death of the represented person. OPA informed the Ombudsman during the Investigation that:

> had Ms Davis been contacted as part of the palliative care decision-making process, she presumably would have attended the hospital and there would not have been a subsequent delay in her knowing that her mother had passed away.[27]

It may be correct that if OPA does successfully contact family to seek their views about a palliative care treatment decision for a represented person, and OPA as guardian makes a palliative care treatment decision, then family will be aware of the potential (and potentially imminent) death of the represented person. But, and critically, contact regarding a palliative care treatment decision in no way prevents OPA from contacting family upon the death of the represented person. This matter is explored further in section 6.4.3 of the Report.

Before leaving this matter, it is important to observe that even if OPA's view that contacting family as part of the palliative care treatment decision leads to family being aware of the potential death of the represented person, this contact never occurred with Ms Davis. If OPA's view is that contact with family to seek their views on a palliative care treatment decision is the basis of family becoming aware of the potential death of a represented person, then this contact was never going to be an effective way of notifying Ms Davis of the death of Mrs Savage.[28]

[27] OPA provided this information to the Ombudsman in response to information required, and questions asked, by the Ombudsman during the Investigation.
[28] This comment is not adverse to delegated staff of OPA.

### 6.4.2 The Office of the Public Advocate did not consider seeking to obtain the phone number held by Sir Charles Gairdner Hospital for Mrs Savage's daughter

The second reason why Ms Davis was not contacted by OPA, also as discussed at 6.3 of the Report, was that OPA did not consider seeking to obtain the phone number held by Sir Charles Gairdner Hospital (when to do so may have been reasonable on the basis that the phone number contained in OPA's records "was no longer connected", but the phone number held by Sir Charles Gairdner Hospital "was not being answered", suggesting it was connected, but not answering). OPA subsequently become aware during the course of the Investigation that the phone number held by Sir Charles Gairdner Hospital was, indeed, a different phone number than that contained in OPA's records and that the phone number held by Sir Charles Gairdner Hospital was also incorrect, but OPA did not know this at the time of the phone conversation with Sir Charles Gairdner Hospital on Saturday 13 February 2021.[29] The reason why OPA did not attempt to obtain the phone number held by Sir Charles Gairdner Hospital for Ms Davis, nor enquire into the phone numbers used by each party, was due to OPA's view that OPA had already exercised its functions as limited guardian when OPA made the palliative care treatment decision. OPA was of the view that from the point of making a palliative care treatment decision, and informing the hospital of that decision, the family of a represented person is not contacted by OPA. During the Investigation, OPA explained that this was OPA's 'standard approach' as 'the treating [hospital] team are best placed to speak to family members about their patient's condition.'[30]

### 6.4.3 The Office of the Public Advocate does not believe it has a statutory function to notify family of the death of represented person

Beyond the first two reasons, there is third and important reason that has been identified by the Investigation as to why Ms Davis was not notified of the death of Mrs Savage - OPA does not believe it has a statutory function to notify family of the death of a person represented by OPA. During the Investigation, OPA submitted that:

> [t]he Public Advocate's authority as guardian ends upon the death of a represented person. The Public Advocate does not have a statutory function to notify family of the death of a represented person.[31]

OPA's view that its authority as guardian ends upon the death of a represented person and that OPA does not have a statutory function to notify family of the death of a represented person had a very strong bearing on its actions following the death of Mrs Savage. Indeed, it is not the case that there was delay in OPA notifying Ms Davis of the death of Mrs Savage, rather, from the point of OPA being informed of the death of Mrs Savage on Sunday 14 February 2021, OPA at no stage attempted to contact Ms Davis.[32]

---

[29] This comment is not adverse to Sir Charles Gairdner Hospital.

[30] OPA provided this information to the Ombudsman in response to information required, and questions asked, by the Ombudsman during the Investigation.

[31] OPA provided this information to the Ombudsman in response to information required, and questions asked, by the Ombudsman during the Investigation.

[32] This comment is not adverse to delegated staff of OPA.

It is not required as part of the Investigation to determine whether OPA's view that it is not authorised to make decisions pursuant to section 45 of the Act for a represented person following their death is correct. This is so for a simple reason – if OPA was to notify family of the death of a represented person, it would not be making a decision pursuant to section 45 of the Act. OPA would be notifying, not deciding. Put another way, contacting family to notify them of the death of a represented person is not an action for which OPA needs statutory authority.

It is certainly correct that the Act does not provide a specific statutory function for OPA to notify family of the death of a represented person. However, there is nothing in the Act that prevents OPA from notifying family of the death of a represented person. When asked during the Investigation, OPA confirmed that:

> There is not anything in the [Act] which prevents the Public Advocate from notifying family of the death of a represented person.[33]

OPA's view can lead to a situation where OPA will attempt to contact family at the time of making a palliative care treatment decision, but potentially only a matter of a few hours later, does not attempt to contact the very same family to notify them of the death of the represented person.[34]

OPA's view that its authority as guardian ends upon the death of a represented person is also inconsistently applied. OPA does currently notify SAT of the death of a represented person. Indeed, OPA provides guidance to its delegated staff to do so. OPA's *Guideline for closing a file for a represented person under the guardianship of the Public Advocate*, includes the following step in the case file closure process:

> 3. … Guardians are to inform the State Administrative Tribunal of a represented person's deaths using the standard template letter in [the OPA case management system].[35]

This notification occurs, of course, after the death of a represented person. This notification is also undertaken despite the fact that the Act does not provide a statutory function to notify SAT of the death of a represented person (although it is very clearly the right thing for OPA to do).[36] OPA notified SAT of the death of Mrs Savage on Tuesday 23 February 2021 and on the same day, OPA notified the Public Trustee of the death of Mrs Savage.

---

[33] OPA provided this information to the Ombudsman in response to information required, and questions asked, by the Ombudsman during the Investigation.

[34] This comment is not adverse to delegated staff of OPA.

[35] Office of the Public Advocate, *Guideline for closing a file for a represented person under the guardianship of the Public Advocate*, 5 April 2011, p. 1.

[36] OPA noted that: "As the SAT retains a supervisory role after making a guardianship order and is required to periodically review the order, the Office notifies the SAT of the death of a represented person as the order is no longer required". OPA provided this information to the Ombudsman in response to information required, and questions asked, by the Ombudsman during the Investigation.

OPA also contacts relevant care facilities (residential care facilities, hospitals or other care facilities) to ask whether family has been notified of the death of the represented person. OPA informed the Ombudsman during the Investigation that:

> When a represented person who lives in a facility passes away, facilities routinely notify the resident's family of the person's death, where they have contact details. This is done as a practice aimed at enabling family to arrange for the resident's body to be transported (where the resident has died at the facility) and for the person's belongings to be collected to enable their bed to become available.
>
> If a represented person lives in a facility but was receiving treatment in hospital prior to their death, it would often be the case that the treating team are already in direct contact with family, communicating their patient's condition. The death notification therefore may be provided to family by the hospital.[37]

This results in a situation where OPA is aware of the death of a represented person, then attempts to check whether family have been notified of the death of the represented person by contacting a third party to contact family, rather than OPA (with potentially less delay and more appropriately) contacting family directly. OPA sent an email to Acacia Living Group's Menora Gardens on Tuesday 23 February 2021 asking whether Ms Davis had been notified of the death of Mrs Savage.

> I understand that Ms Savage passed away on 14 February 2021. Have you notified her daughter [Ms Davis] and are there any other family members?[38]

Finally, it is also unlikely that OPA's practice that it does not notify family of the death of a represented person is consistent with community expectations about how OPA should undertake its role.

#### *6.4.3.1 Opinion*

I am of the opinion that:

1. As contacting family to notify them of the death of a represented person should be, and should have been, the standard and usual practice for OPA, OPA is wrong not to notify family of the death of a represented person;
2. OPA's guidance to delegated guardians is wrong as it does not specify that every reasonable endeavour to contact family should be made by OPA during, and, where it has not been possible to contact family at the time of the palliative care treatment decision following, a palliative care treatment decision, given the fact that this will notify family of the potential (and potentially imminent) death of the represented person; and

[37] OPA provided this information to the Ombudsman in response to information required, and questions asked, by the Ombudsman during the Investigation.

[38] OPA provided this information to the Ombudsman in response to information required, and questions asked, by the Ombudsman during the Investigation. This comment is not adverse to delegated staff of OPA. This comment is not adverse to Acacia Living Group's Menora Gardens.

3. OPA's guidance to delegated guardians is wrong as it does not specify that every reasonable endeavour to contact family should be made by OPA upon the death of a represented person.

#### *6.4.3.2 Recommendations*

**Recommendation 2**

OPA should see it as part of their role to contact family following the death of a represented person.

**Recommendation 3**

OPA should make every reasonable endeavour to contact family on every occasion:

1. That OPA is making a palliative care treatment decision for a represented person given the fact that this will notify the family of the potential (and potentially imminent) death of the represented person;
2. After OPA has made a palliative care treatment decision for a represented person, where it has not been possible to contact family at the time of the palliative care treatment decision, given the fact that this will notify the family of the potential (and potentially imminent) death of the represented person; and
3. After the death of a represented person.

Without limiting the meaning of every reasonable endeavour that OPA should make, OPA must:

1. Utilise all phone numbers of which OPA are, or become, aware; and
2. Where a current and in service phone number is not available, contact the Public Trustee (during office hours and where they are also appointed) or any relevant agency or place of care, including the residence of the represented person, treating hospital and any other relevant care facility to obtain a contact number for family.

## 6.5 The nine-day delay between the Office of the Public Advocate being informed of the death of Mrs Savage and the Office of the Public Advocate contacting the care facility and other relevant bodies

Despite the fact that OPA did not notify Ms Davis of the death of Mrs Savage, OPA would typically after the death of a represented person contact the care facility and other relevant bodies such as SAT and the Public Trustee. However, OPA did not do so for the nine-day period between being informed of the death of Mrs Savage on Sunday 14 February 2021 and contacting Acacia Living Group's Menora Gardens, SAT and the Public Trustee on 23 February 2021.

What was the cause of the delay in OPA notifying the care facility and other relevant bodies? The Investigation has found that there were two reasons for the nine-day delay.

### 6.5.1 OPA's guidance to on-call delegated guardians and delegated guardians

OPA must be available to make decisions for represented persons twenty-four hours a day, seven days a week. In practice, OPA ensures that this can be done by allocating responsibilities for work done:

1. After business hours (including weekends), to a roster of OPA staff to whom the Public Advocate delegates powers of guardianship under section 95 of the Act (**on-call delegated guardians**); and
2. During business hours, to delegated guardians to whom the Public Advocate delegates powers of guardianship (**delegated guardians**).

Decisions made by on-call delegated guardians on weekends are notified to delegated guardians in an email sent at the end of the weekend by the on-call delegated guardian to be read on the Monday by delegated guardians. Such an email was sent regarding sixteen represented persons (of which Mrs Savage was one) on the evening of Sunday 14 February 2021 (the day on which Mrs Savage had died) (**the decisions-made email**).[39]

OPA does not provide guidance to delegated on-call guardians and delegated guardians, including for the purposes of the decisions-made email, that the death of a represented person is a matter of high priority and urgent actions are required to be undertaken.

### 6.5.2 OPA's arrangements for notifying the family of a represented person of the death of a represented person when a delegated guardian is absent

The delegated guardian that was responsible for Mrs Savage is a part-time employee (employed four days a week). Further, in the week beginning Monday 15 February 2021, the delegated guardian was on personal leave for three days. This resulted in the delegated guardian only being available on Monday 15 February 2021 of the week Monday 15 February 2021 to Friday 19 February 2021. The delegated guardian returned on Monday 22 February 2021.[40] On Monday 22 February 2021, OPA's records indicated that Acacia Living Group's Menora Gardens had already been notified of the death of Mrs Savage and so actions in relation to the death of Mrs Savage was not seen by OPA as a high priority:

> the 'on-call' record of Sunday 21 February 2021 identified that Acacia Living Group's Menora Gardens Aged Care Facility was already aware of Mrs Savage's death, it was not seen as a high priority...[41]

[39] This comment is not adverse to delegated staff of OPA.
[40] This comment is not adverse to delegated staff of OPA.
[41] OPA provided this information to the Ombudsman in response to information required, and questions asked, by the Ombudsman during the Investigation. This comment is not adverse to Acacia Living Group's Menora Gardens. This comment is not adverse to delegated staff of OPA.

On Tuesday 23 February 2021, OPA contacted Acacia Living Group's Menora Gardens, SAT and the Public Trustee.[42]

#### *6.5.2.1 Opinion*

I am of the opinion that OPA:

1. Is wrong not to provide guidance to on-call delegated guardians and delegated guardians that the death of a represented person is a matter of high priority and requires urgent actions to be undertaken; and
2. Is wrong not to have a procedure in place to ensure that urgent actions are undertaken upon the deaths of represented persons when delegated guardians are (completely lawfully and appropriately) absent on leave or are part-time employees.

#### *6.5.2.2 Recommendation*

**Recommendation 4**

OPA should ensure that it:

1. Provides guidance to on-call delegated guardians and delegated guardians that the death of a represented person is a matter of high priority and thus urgent actions are required to be undertaken; and
2. Has procedures in place to ensure that urgent actions are undertaken upon the death of a represented person when delegated guardians are absent on leave or are part-time employees.

[42] OPA provided this information to the Ombudsman in response to information required, and questions asked, by the Ombudsman during the Investigation.

# 7 The Office of the Public Advocate's role in notifying the family of Mr Ayling of his death

## 7.1 Mr Robert Ayling

At the time of his death, Mr Ayling was an 89 year old man and a resident at Bethanie Peel Lodge. During his life, Mr Ayling had worked in a variety of jobs, including working in local government, and was a naval veteran from the Second World War. He was also a father and grandfather.[43]

## 7.2 The Office of the Public Advocate was limited guardian for Mr Ayling

As set out in Chapter 5 of the Report, SAT, in accordance with section 43 of the Act (and subject to the principles in section 4 of the Act), can declare a person to be in need of a guardian and appoint OPA as the person's guardian. In accordance with section 45 of the Act, OPA can be authorised to do any of the things set out in section 45(2) of the Act. SAT can appoint a plenary guardian or a limited guardian. A plenary guardian is authorised to undertake any of the functions mentioned in section 45 of the Act. A limited guardian is authorised to undertake such of the functions mentioned in section 45 of the Act as SAT vests in the limited guardian.

OPA was appointed as a guardian of Mr Ayling with functions relating to accommodation and treatment.[44] Accordingly, as Mr Ayling's limited guardian, one of the functions that OPA was authorised to undertake related to treatment for Mr Ayling. As set out at section 6.2 of the Report, the Act defines treatment as meaning "medical or surgical treatment, including a life sustaining measure or palliative care".[45] A treatment decision is defined as meaning "a decision to consent or refuse consent to the commencement or continuation of any treatment of the person".[46] The Act defines palliative care as meaning "a medical, surgical or nursing procedure directed at relieving a person's pain, discomfort or distress, but does not include a life sustaining measure".[47] OPA contacts the family of a represented person to seek their views about a palliative care treatment decision.

[43] OPA provided this information to the Ombudsman in response to information required, and questions asked, by the Ombudsman during the Investigation.
[44] *Guardianship and Administration Act 1990,* Schedule 1, cl.12 limits the publication of SAT guardianship proceedings. The material provided in the Report regarding OPA's guardianship for Mr Ayling is publicly available information.
[45] *Guardianship and Administration Act 1990*, s. 3.
[46] *Guardianship and Administration Act 1990*, s. 3.
[47] *Guardianship and Administration Act 1990*, s. 3.

As set out at 1.1 of the Report, the scope of the Investigation is the role of OPA in notifying the families of Mrs Savage, Mr Ayling and Mr Hartley of the deaths of Mrs Savage, Mr Ayling and Mr Hartley. However, OPA's role in notifying Mr Ayling's son, (also named Mr Robert Ayling) of the death of Mr Ayling first requires consideration of OPA's attempts to contact Mr Ayling's son to seek his views about a palliative care treatment decision for Mr Ayling.

## 7.3 The Office of the Public Advocate's contact with Mr Ayling's son

On Thursday 2 October 2014, OPA was contacted by Bethanie Peel Lodge regarding Mr Ayling's medical condition. Mr Ayling was subsequently transferred by ambulance to Peel Health Campus on Thursday 2 October 2014.

OPA was contacted at 5.10pm on Thursday 2 October 2014 by Peel Health Campus regarding Mr Ayling's serious medical condition.

At approximately 6.37pm on Thursday 2 October 2014, OPA made a decision that Mr Ayling should be treated with intravenous antibiotics, moved to a palliative care bed, provided palliative treatment if Mr Ayling deteriorated or did not improve and to reassess the following morning, Friday 3 October 2014.

OPA sought an update at 8.05am on Friday 3 October 2014 regarding Mr Ayling's condition. OPA's records indicate that Mr Ayling was comfortable and stable, with no improvement or deterioration and that intravenous antibiotics continued.

Unfortunately, OPA's records do not indicate whether OPA made attempts to contact Mr Ayling's son to seek his views about the palliative care treatment decision.

As discussed at section 6.4.2 of the Report, OPA was of the view that from the point of making a palliative care treatment decision, and informing the hospital of that decision, the family of a represented person is not contacted by OPA. During the Investigation, OPA explained that this was OPA's 'standard approach' as 'the treating [hospital] team are best placed to speak to family members about their patient's condition.'[48]

### 7.3.1 Opinion

The keeping of records of decisions as to whether an attempt has been made to contact family to seek their views about treatment decisions, and to record the views given, is required by the *State Records Act 2000* and is an essential aspect of good governance, good administration and accountability.

[48] OPA provided this information to the Ombudsman in response to information required, and questions asked, by the Ombudsman during the Investigation.

I am of the opinion that OPA's guidance to delegated guardians, by not providing effectively for the keeping of a record of OPA's attempts to contact Mr Ayling's family to seek their views about the palliative care treatment decision, is wrong.

### 7.3.2 Recommendation

**Recommendation 5**

OPA should always keep a record of whether it has contacted family when making a palliative care treatment decision and the views of family are recorded.

## 7.4 Why did the Office of the Public Advocate not notify Mr Ayling's son of the death of Mr Ayling?

Mr Ayling died at Peel Health Campus on Saturday 4 October 2014. OPA was informed of the death of Mr Ayling on Saturday 4 October 2014.

Mr Ayling's son was notified of the death of Mr Ayling on Wednesday 8 October 2014, but he was not notified by OPA.

Why did OPA not notify Mr Ayling's son of the death of Mr Ayling? The Investigation has determined the reason why OPA did not notify Mr Ayling's son.

### 7.4.1 The Office of the Public Advocate does not believe it has a statutory function to notify family of the death of represented person

As discussed at section 6.4.3 of the Report, OPA does not believe it has a statutory function to notify family of the death of a person represented by OPA. During the Investigation, OPA submitted that:

> [t]he Public Advocate's authority as guardian ends upon the death of a represented person. The Public Advocate does not have a statutory function to notify family of the death of a represented person.[49]

OPA's view that its authority as guardian ends upon the death of a represented person and that OPA does not have a statutory function to notify family of the death of a represented person had a very strong bearing on its actions following the death of Mr Ayling. Indeed, it is not the case that there was delay in OPA notifying Mr Ayling's son of the death of Mr Ayling, rather, from the point of OPA being informed of the death of Mr Ayling on Saturday 4 October 2014, OPA at no stage attempted to contact Mr Ayling's son.[50]

Further to this, as discussed at section 6.4.3 of the Report, OPA's view at the time of the death of Mr Ayling was that the notification of the death of a represented person was

[49] OPA provided this information to the Ombudsman in response to information required, and questions asked, by the Ombudsman during the Investigation.
[50] This comment is not adverse to delegated staff of OPA.

routinely undertaken by care facilities and hospitals. OPA informed the Ombudsman during the Investigation that:

> When a represented person who lives in a facility passes away, facilities routinely notify the resident's family of the person's death, where they have contact details. This is done as a practice aimed at enabling family to arrange for the resident's body to be transported (where the resident has died at the facility) and for the person's belongings to be collected to enable their bed to become available.
>
> If a represented person lives in a facility but was receiving treatment in hospital prior to their death, it would often be the case that the treating team are already in direct contact with family, communicating their patient's condition. The death notification therefore may be provided to family by the hospital.[51]

OPA further informed the Ombudsman during the Investigation in relation to Mr Ayling that '…the hospital had been asked to advise family and friends as this was not the role of [OPA].'[52]

## 7.5 The delay between the Office of the Public Advocate being informed of the death of Mr Ayling and the Office of the Public Advocate contacting other relevant bodies

The Investigation has determined there was a two-day delay in OPA notifying other relevant bodies that arose due to the fact that, in my opinion, OPA does not provide guidance to on-call delegated guardians that the death of a represented person is a matter of high priority and thus urgent actions are required to be undertaken.[53]

#### *7.5.1.1 Applicable Recommendations*

The following recommendations made in the Report to OPA arising from the investigation into the role of OPA in notifying Ms Davis of the death of Mrs Savage are also applicable to the role of OPA in notifying Mr Ayling's son of the death of Mr Ayling.

**Recommendation 2**

OPA should see it as part of their role to contact family following the death of a represented person.

[51] OPA provided this information to the Ombudsman in response to information required, and questions asked, by the Ombudsman during the Investigation.
[52] OPA provided this information to the Ombudsman in response to information required, and questions asked, by the Ombudsman during the Investigation. There is nothing in this comment that is adverse to Peel Health Campus.
[53] This comment is not adverse to delegated staff of OPA.

**Recommendation 3**

OPA should make every reasonable endeavour to contact family on every occasion:

1. That OPA is making a palliative care treatment decision for a represented person given the fact that this will notify the family of the potential (and potentially imminent) death of the represented person;
2. After OPA has made a palliative care treatment decision for a represented person, where it has not been possible to contact family at the time of the palliative care treatment decision, given the fact that this will notify the family of the potential (and potentially imminent) death of the represented person; and
3. After the death of a represented person.

Without limiting the meaning of every reasonable endeavour that OPA should make, OPA must:

1. Utilise all phone numbers of which OPA are, or become, aware; and
2. Where a current and in service phone number is not available, contact the Public Trustee (during office hours and where they are also appointed) or any relevant agency or place of care, including the residence of the represented person, treating hospital and any other relevant care facility to obtain a contact number for family.

**Recommendation 4**

OPA should ensure that it:

1. Provides guidance to on-call delegated guardians and delegated guardians that the death of a represented person is a matter of high priority and thus urgent actions are required to be undertaken; and
2. Has procedures in place to ensure that urgent actions are undertaken upon the death of a represented person when delegated guardians are absent on leave or are part-time employees.

This page has intentionally been left blank.

# 8 The Office of the Public Advocate's role in notifying the family of Mr Hartley of his death

## 8.1 Mr Kenneth Hartley

At the time of his death, Mr Hartley was an 80 year old man and a resident at Hamersley Aged Care Home. During his life, Mr Hartley had worked as a supply manager.[54]

## 8.2 The Office of the Public Advocate was limited guardian for Mr Hartley

As set out in Chapter 5 of the Report, SAT, in accordance with section 43 of the Act (and subject to the principles in section 4 of the Act), can declare a person to be in need of a guardian and appoint OPA as the person's guardian. In accordance with section 45 of the Act, OPA can be authorised to do any of the things set out in section 45(2) of the Act. SAT can appoint a plenary guardian or a limited guardian. A plenary guardian is authorised to undertake any of the functions mentioned in section 45 of the Act. A limited guardian is authorised to undertake such of the functions mentioned in section 45 of the Act as SAT vests in the limited guardian.

OPA was appointed as a guardian of Mr Hartley with functions relating to accommodation, treatment and the provision of services.[55]

## 8.3 The Office of the Public Advocate's contact with Mr Hartley's brother

On Saturday 7 November 2020, Hamersley Aged Care Home emailed OPA to advise Mr Hartley had been reviewed and treated by a General Practitioner as he had felt unwell. On Thursday 12 November 2020, Mr Hartley was transferred to hospital.

Mr Hartley returned from hospital to Hamersley Aged Care Home on Saturday 14 November 2020. On Thursday 17 December 2020, Mr Hartley was reviewed by a General Practitioner.

On Saturday 19 December 2020, Mr Hartley was transferred to hospital. Mr Hartley was discharged and returned to Hamersley Aged Care on Tuesday 22 December 2020. On Tuesday 29 December 2020, Mr Hartley was again reviewed by a General Practitioner.

[54] OPA provided this information to the Ombudsman in response to information required, and questions asked, by the Ombudsman during the Investigation.

[55] *Guardianship and Administration Act 1990,* Schedule 1, cl.12 limits the publication of SAT guardianship proceedings. The material provided in the Report regarding OPA's guardianship for Mr Hartley is publicly available information.

## 8.4 Why did the Office of the Public Advocate not notify Mr Hartley's brother of the death of Mr Hartley?

Mr Hartley died at Hamersley Aged Care Home on Thursday 31 December 2020 at 3:51am. OPA was informed of the death of Mr Hartley on Thursday 31 December 2020 at 5:03am.

Mr Hartley's brother was notified of the death of Mr Hartley on Tuesday 5 January 2021, but he was not notified by OPA.

Why did OPA not notify Mr Hartley's brother of the death of Mr Hartley? The Investigation has determined the reason why OPA did not notify Mr Hartley's brother.

### 8.4.1 The Office of the Public Advocate does not believe it has a statutory function to notify family of the death of represented person

As discussed at section 6.4.3 of the Report, OPA does not believe it has a statutory function to notify family of the death of a person represented by OPA. During the Investigation, OPA submitted that:

> [t]he Public Advocate's authority as guardian ends upon the death of a represented person. The Public Advocate does not have a statutory function to notify family of the death of a represented person.[56]

OPA's view that its authority as guardian ends upon the death of a represented person and that OPA does not have a statutory function to notify family of the death of a represented person had a very strong bearing on its actions following the death of Mr Hartley. Indeed, it is not the case that there was delay in OPA notifying Mr Hartley's brother of the death of Mr Hartley, rather, from the point of OPA being informed of the death of Mr Hartley on Thursday 31 December 2020, OPA at no stage attempted to contact Mr Hartley's brother.[57]

OPA did, however, contact Hamersley Aged Care Home, SAT and the Public Trustee regarding the death of Mr Hartley on Monday 4 January 2021.

Further to this, as discussed at section 6.4.3 of the Report, OPA's view at the time of the death of Mr Hartley was that the notification of the death of a represented person was routinely undertaken by care facilities and hospitals. OPA informed the Ombudsman during the Investigation that:

> When a represented person who lives in a facility passes away, facilities routinely notify the resident's family of the person's death, where they have contact details. This is done as a practice aimed at enabling family to arrange for the resident's body to be transported (where

[56] OPA provided this information to the Ombudsman in response to information required, and questions asked, by the Ombudsman during the Investigation.
[57] This comment is not adverse to delegated staff of OPA.

> the resident has died at the facility) and for the person's belongings to be collected to enable their bed to become available.
>
> If a represented person lives in a facility but was receiving treatment in hospital prior to their death, it would often be the case that the treating team are already in direct contact with family, communicating their patient's condition. The death notification therefore may be provided to family by the hospital.[58]

OPA further informed the Ombudsman during the Investigation in relation to Mr Hartley that OPA contacted Hamersley Aged Care Home 'requesting facility staff to advise Mr Hartley's two listed contacts…of Mr Hartley's passing'.[59]

## 8.5 The four-day delay between the Office of the Public Advocate being informed of the death of Mr Hartley and the Office of the Public Advocate contacting the care facility and other relevant bodies

Despite the fact that OPA did not notify Mr Hartley's brother of the death of Mr Hartley, OPA would typically after the death of a represented person contact the care facility and other relevant bodies such as SAT and the Public Trustee. However, OPA did not do so for the four-day period between being informed of the death of Mr Hartley on Thursday 31 December 2020 and contacting Hamersley Aged Care Home, SAT and the Public Trustee on Monday 4 January 2021.[60]

What was the cause of the delay in OPA notifying the care facility and other relevant bodies? The Investigation has determined the reason for the four-day delay.

### 8.5.1 OPA's arrangements for notifying the family of a represented person of the death of a represented person when a delegated guardian is absent

The delegated guardian that was responsible for Mr Hartley was on leave between Thursday 31 December 2020, when OPA was notified of the death of Mr Hartley, and Monday 4 January 2021.[61] As discussed at section 6.5.2 of the Report, this occurred as OPA does not have a procedure in place to ensure that, at those times when a delegated guardian is (completely lawfully and appropriately) absent on leave or are part-time employees, that actions are undertaken by another delegated guardian.

[58] OPA provided this information to the Ombudsman in response to information required, and questions asked, by the Ombudsman during the Investigation.
[59] OPA provided this information to the Ombudsman in response to information required, and questions asked, by the Ombudsman during the Investigation. This comment is not adverse to Hamersley Aged Care Home.
[60] This comment is not adverse to Hamersley Aged Care Home or the Public Trustee.
[61] This comment is not adverse to delegated staff of OPA.

#### *8.5.1.1 Applicable Recommendations*

The following recommendations made in the Report to OPA arising from the investigation into the role of OPA in notifying Ms Davis of the death of Mrs Savage are also applicable to the role of OPA in notifying Mr Hartley's brother of the death of Mr Hartley.[62]

**Recommendation 2**

OPA should see it as part of their role to contact family following the death of a represented person.

**Recommendation 3**

OPA should make every reasonable endeavour to contact family on every occasion:

1. That OPA is making a palliative care treatment decision for a represented person given the fact that this will notify the family of the potential (and potentially imminent) death of the represented person;
2. After OPA has made a palliative care treatment decision for a represented person, where it has not been possible to contact family at the time of the palliative care treatment decision, given the fact that this will notify the family of the potential (and potentially imminent) death of the represented person; and
3. After the death of a represented person.

Without limiting the meaning of every reasonable endeavour that OPA should make, OPA must:

1. Utilise all phone numbers of which OPA are, or become, aware; and
2. Where a current and in service phone number is not available, contact the Public Trustee (during office hours and where they are also appointed) or any relevant agency or place of care, including the residence of the represented person, treating hospital and any other relevant care facility to obtain a contact number for family.

**Recommendation 4**

OPA should ensure that it:

1. Provides guidance to on-call delegated guardians and delegated guardians that the death of a represented person is a matter of high priority and thus urgent actions are required to be undertaken; and
2. Has procedures in place to ensure that urgent actions are undertaken upon the death of a represented person when delegated guardians are absent on leave or are part-time employees.

[62] Recommendation 3 is reproduced in its entirety, however, those parts of the recommendation relating to notifying family regarding palliative care treatment decisions are not applicable to the role of OPA in not notifying Mr Hartley's family of the death of Mr Hartley.

# 9 Changes instituted by the Office of the Public Advocate following the commencement of the Investigation

## 9.1 The Office of the Public Advocate has instituted changes to its guidance to delegated guardians

As previously set out, as a result of the Investigation, I am of the opinion, that in a number of instances the guidance provided by OPA to delegated guardians is wrong. This guidance includes OPA's policies, practice standards and templated letters.

It is therefore pleasing that following the commencement of the Investigation, and directly as a result of OPA reflecting upon the fact that Ms Davis was not notified of the death of her mother, that OPA has instituted changes to its guidance to delegated guardians in relation to notifying family of the death of a represented person. OPA informed the Ombudsman during the Investigation that:

> As a result of Mrs Savage's family not having been notified of her death for a prolonged period, this Office, under my instruction, has taken a number of steps to guard against this occurring again.[63]

## 9.2 The Office of the Public Advocate has introduced a new practice standard: *Notification to key parties on the death of a represented person*

OPA has introduced a new practice standard, *Notification to key parties on the death of a represented person*, that commenced on 11 March 2021. The new practice standard is attached as Appendix 1 to the Report. OPA informed the Ombudsman during the investigation that it:

> … has introduced a new practice standard, 'Notification to key parties on the death of a represented person', coming into effect on Thursday 11 March 2021… A new notification of death form has also been developed…and is being uploaded into the Office's case management system. This will serve as a summary of actions taken.[64]

[63] OPA provided this information to the Ombudsman in response to information required, and questions asked, by the Ombudsman during the Investigation.
[64] OPA provided this information to the Ombudsman in response to information required, and questions asked, by the Ombudsman during the Investigation.

The *Notification to key parties on the death of a represented person* practice standard provides guidance to on-call delegated guardians and delegated guardians of the actions to be taken upon OPA being informed of the death of a represented person, particularly the actions to be taken to notify family of the death of the represented person. The *Notification to key parties on the death of a represented person*, includes the following actions:

- Obtain the full name and contact details of the person advising of the death, noting the time of the notice.
- Confirm with the person whether the key parties have been advised of the death; who was informed, when were they informed (date and time) and how were they informed (telephone call, in attendance, email)
- Confirm contact details for key interested parties with the caller – contact key interested parties if not already notified.
- Contact key family members if not already notified – record the time and date of contact and whether a message was left and enter into [the case management system].
- Contact aged care facilities and/or service providers if not already notified record the time and date and enter into [the case management system].
- If it is not possible to make contact with a key family member, after 3 attempts - record the date and time contact was attempted and notify Manager Guardianship and the Public Advocate promptly who will advise if follow-up action required.[65]

## 9.3 The Office of the Public Advocate has updated an existing practice standard: *After-hours calls*

OPA has updated an existing practice standard regarding the management of after hours calls in relation to the notification of key parties, including family, following the death of a represented person. The updated practice standard is attached as Appendix 2 to the Report. OPA informed the Ombudsman during the investigation that it:

> … has updated the practice standard, 'After-hours calls' … to incorporate the new procedures relating to notification of the death of a represented person to key parties.[66]

[65] Public Advocate of Western Australia, *Practice Standard: Notification to Key Parties on the Death of a Represented Person*, Version 1, 11 March 2021, p. 3.

[66] OPA provided this information to the Ombudsman in response to information required, and questions asked, by the Ombudsman during the Investigation.

## 9.4 The Office of the Public Advocate updated the letter that it sends to service providers at the time of the Office of the Public Advocate's appointment as guardian

OPA has updated the letter that it sends to service providers upon OPA's appointment as guardian regarding OPA's contact with the family of represented persons. The updated letter is attached as Appendix 3 to the Report. OPA informed the Ombudsman during the investigation that the:

> … standard letter sent by guardians to service providers, at the time of the Public Advocate's appointment … has been replaced with an updated letter ... Guardians will be instructed by the Acting Manager Guardianship … that this letter is to be sent to aged care facilities, disability accommodation facilities and other relevant service providers, on appointment of the Public Advocate, and at any time the represented person's accommodation changes.
>
> This replacement letter also makes clear to facilities, that contact with the represented person by family, is determined by the facility, unless the Public Advocate has been appointed with the function to make decisions about contact.[67]

## 9.5 The Office of the Public Advocate has informed staff about the actions to undertake upon the death of a represented person

Further to these changes, OPA informed the Ombudsman during the Investigation that an internal email was sent on 3 March 2021 directing delegated guardians to undertake certain actions following the death of a represented person to ensure that family is informed of the death of a represented person.[68]

### 9.5.1 Opinion

It is correct and commendable that OPA has reflected on its actions following the fact that Ms Davis was not notified by OPA of the death of Mrs Savage. Having undertaken this reflection, it is also correct and commendable that OPA has implemented new guidance to on-call delegated guardians and delegated guardians regarding family being notified by OPA of the death of a represented person.

It is particularly pleasing that OPA has addressed the root cause of the fact that the families of Mrs Savage, Mr Ayling and Mr Hartley were not notified of the deaths of Mrs Savage, Mr Ayling and Mr Hartley – OPA's guidance to on-call delegated guardians and delegated guardians is wrong.

[67] OPA provided this information to the Ombudsman in response to information required, and questions asked, by the Ombudsman during the Investigation.
[68] OPA provided this information to the Ombudsman in response to information required, and questions asked, by the Ombudsman during the Investigation.

The new guidance, in the form of new and updated practice standards and an updated template letter, are an important step taken by OPA. Nonetheless, I am of the opinion that there are three matters that must be addressed in relation to the new guidance:

1. First, the requirement contained in the new practice standard, *Notification to key parties on the death of a represented person*, to make three attempts to contact a family member on the available mobile phone number is arbitrary, and more critically, would not have resulted in OPA notifying Ms Davis of the death of Mrs Savage. If the new practice standard would not have remedied the very reason why the practice standard is being introduced in the first place it is, in my opinion, wrong;
2. Second, the updated *After-hours calls* practice standard, which sets out the actions to be taken by OPA upon being informed of the death of a represented person, is inconsistent with the instructions, in identical circumstances, in the *Notification to key parties on the death of a represented person* practice standard. Relevantly, the *After-hours calls* practice standard does not include the requirement to make three attempts to contact family member(s), but instead instructs OPA to confirm contact details with the care facility, treating team or service provider;[69] and
3. Third, although the new guidance has been introduced prior to the conclusion of the Investigation and its recommendations, upon OPA's acceptance of the recommendations, all of OPA's guidance to delegated guardians, including the new *Notification to key parties on the death of a represented person* practice standard, the updated *After-hours calls* practice standard and the updated *Letter to Service Providers*, will need to be updated to be consistent with the recommendations of the Investigation. This will result in, for example, the removal of 'three attempts' to contact family upon the death of a represented person with Recommendation 3 of the Investigation, namely that:

> OPA should make every reasonable endeavour to contact family on every occasion:
>
> 1. That OPA is making a palliative care treatment decision for a represented person given the fact that this will notify the family of the potential (and potentially imminent) death of the represented person;
> 2. After OPA has made a palliative care treatment decision for a represented person, where it has not been possible to contact family at the time of the palliative care treatment decision, given the fact that this will notify the family of the potential (and potentially imminent) death of the represented person; and
> 3. After the death of a represented person.

[69] Public Advocate of Western Australia, *Practice Standard: After Hours Calls*, Version 5, 11 March 2021, pp. 6-7.

Without limiting the meaning of every reasonable endeavour that OPA should make, OPA must:

1. Utilise all phone numbers of which OPA are, or become, aware; and
2. Where a current and in service phone number is not available, contact the Public Trustee (during office hours and where they are also appointed) or any relevant agency or place of care, including the residence of the represented person, treating hospital and any other relevant care facility to obtain a contact number for family.

### 9.5.2 Recommendation

**Recommendation 6**

OPA should amend all guidance to delegated guardians, including the *Notification to key parties on the death of a represented person* practice standard, the *After-hours calls* practice standard and the *Letter to Service Providers*, to ensure that OPA's guidance to delegated guardians is consistent and that all guidance is consistent with the recommendations of the Investigation.

This page has intentionally been left blank.

# 10 Apologies to the families of Mrs Savage, Mr Ayling and Mr Hartley

## 10.1 Recommendations have been made about what should be done in the future

As a result of the Investigation, I have made six recommendations regarding the appropriate actions to be taken in the future by OPA to notify family upon the death of a represented person.

## 10.2 The Investigation related to what had happened to three families of three people

The Investigation, however, was not undertaken in the abstract. The Investigation considered the role of OPA in notifying the families of Mrs Savage, Mr Ayling and Mr Hartley of the death of Mrs Savage, Mr Ayling and Mr Hartley. As a result of the Investigation, I am of the opinion that OPA's actions in not notifying the family of Mrs Savage, Mr Ayling and Mr Hartley of the death of Mrs Savage, Mr Ayling and Mr Hartley were wrong.

## 10.3 Expressing regret and sympathy when an organisation's actions are wrong

As noted in the Ombudsman's publication *Remedies and Redress*, expressing regret and sympathy for things that have gone wrong is a hallmark of a strong organisation:

> Apologising should not be seen as a sign of organisational weakness. To the contrary, it is a sign of organisational strength and maturity.[70]

This is equally so when an organisation has itself undertaken self-reflection and determined that its actions were wrong, or when the Ombudsman has formed an opinion following an investigation that the organisation's actions were wrong.

### 10.3.1 Opinion

In addition to implementing the recommendations of the Investigation regarding the appropriate actions to be taken in the future by OPA to notify family upon the death of a represented person, I am of the opinion that OPA should apologise to the families of Mrs Savage, Mr Ayling and Mr Hartley.

[70] Ombudsman Western Australia, *Remedies and Redress*, April 2010, p. 2. <www.ombudsman.wa.gov.au/Publications/Documents/guidelines/Remedies-and-Redress-Guidelines.pdf>

During the Investigation, OPA informed the Ombudsman that:

> The Public Advocate had planned to write to Ms Davis to inform her about the involvement of this Office in relation to her late mother and actions taken around the time of her death. However, given this matter was subsequently referred to the Ombudsman for investigation, the Public Advocate wrote to Ms Davis on Wednesday 3 March 2021 to offer her condolences and indicated that given the Ombudsman's investigation, it would not be appropriate to detail the Office's involvement at this time.[71]

Offering condolences and informing family about OPA's involvement with a person represented by OPA is correct. But it is insufficient. OPA should apologise for not notifying the families of Mrs Savage, Mr Ayling and Mr Hartley of the deaths of Mrs Savage, Mr Ayling and Mr Hartley.

### 10.3.2 Recommendation

**Recommendation 7**

OPA should apologise to the families of Mrs Savage, Mr Ayling and Mr Hartley for not notifying them of the deaths of Mrs Savage, Mr Ayling and Mr Hartley.

[71] OPA provided this information to the Ombudsman in response to information required, and questions asked, by the Ombudsman during the Investigation.

# 11 Appendix 1: Office of the Public Advocate Practice Standard – Notification to Key Parties on the Death of a Represented Person

Following the commencement of the Investigation, OPA introduced a new practice standard, *Notification to Key Parties on the Death of a Represented Person*, which came into effect on 11 March 2021.

# Office of the Public Advocate Practice Standard

| | | |
|---|---|---|
| **Notification to Key Parties on the Death of a Represented Person** | ***Version: 1***<br>11 March 2021 | ***Approved***:<br>Public Advocate |
| | ***Contact Officer***:<br>Managers Guardianship | ***1st Approval date:***<br>11 March 2021 |
| | ***Review Date:***<br>10 September 2021 | ***Last Amended:*** |
| | ***Distribution:***<br>Senior Guardians, Guardians | ***Distribution Date:***<br>11 March 2021 |

**Amendments**

| *Version* | *Date* | *Author* | *Section* | *Summary* |
|---|---|---|---|---|
| 1 | 11/03/2021 | | All | Original |

This practice standard details the specific actions a delegated guardian undertakes to notify key interested parties of the death of a represented person when the Public Advocate has been appointed either plenary guardian or limited guardian.

This practice standard should be read in conjunction with those practice standards and documents identified under **Relevant Legislation/Policy.**

## 1. Definitions

***"Delegated guardian":*** a person delegated by the Public Advocate pursuant to Section 95 of the *Guardianship and Administration Act (1990)* (the Act) to carry out the functions of a guardian.

***"Guardianship and Administration Act 1990":*** an Act to provide for the guardianship of adults who need assistance in their personal affairs … to provide for the appointment of a public officer with certain functions relative to thereto, to provide for enduring powers of attorney, enduring powers of guardianship and advance health directives, and for connected purposes.

***"Key Interested Parties":*** people who played a significant role in a represented person's life. This could include family members, including family members who have minimal contact, close personal contacts, aged care facilities and/or service providers.

***"Represented person":*** means any person in respect of whom:
- A guardianship order is in force;
- An administration order is in force; or
- Both a guardianship order and an administration order are in force.

## 2. Position Statement

The Public Advocate maintains a 24-hour 7-days per week contact service as decisions need to be made during office hours (Monday – Friday 8.30am – 4.30pm) and after-hours including at weekends and public holidays.

The Office of the Public Advocate is contacted to be advised of the death of the represented person for whom the Public Advocate was appointed as plenary or limited guardian during business hours and after hours.

## 3. Scope

When the State Administrative Tribunal appoints the Public Advocate as plenary guardian or limited guardian the guardian is responsible for ensuring key parties are advised of the death of the represented person.

This practice standard provides the steps that must be taken when a represented person dies.

A checklist forms part of the Practice Standard to assist guardians in completing this task. The Manager Guardianship and the Public Advocate are to be informed if is not possible to contact the represented person's family. The completed and signed checklist is to be provided to the guardian's line manager, the Manager Guardianship or the Senior Guardian, before the file is closed.

In preference the process outlined will be undertaken by the delegated guardian, however in their absence the Senior Guardian/ Manager Guardianship will allocate the task to the duty guardian or another guardian.

## 4. Process

### 4.1. Notification of Death Received

During business hours calls received advising of the death of a represented person are to be passed to the delegated guardian, or in their absence to the duty guardian.

Where the On-Call service is notified the on-call guardian undertakes action to notify key family members, either directly or through a lead family member, after contact has been made with the notifier and confirmation has been provided about whether key family members have been told of the death and, on the next business day, advise the delegated guardian of the actions taken.

Where the Public Advocate is not appointed to make treatment decisions the on-call guardian is to refer the notice of death to the delegated guardian for discussion with the Manager Guardianship and the Public Advocate on the next business day.

Emails received advising of the death of a represented person are to be emailed to the delegated guardian, or in their absence the duty guardian, and copied to their Senior Guardian or the Manager Guardianship where the case is allocated to a Senior Guardian.

| *Notification to Key Parties of the Death of a Represented Person.* | VERSION 1 |
|---|---|
| | Page 2 of 5 |

When notifications are received from medical practitioners, aged care facilities or service providers that a represented person has died, the guardian receiving the call is to confirm with the person giving the notice of death whether anyone has been notified of the death, and if so, who has been informed and when.

### 4.2 Mandatory Functions to be undertaken during office hours

#### 4.2.1 Inform Key Interested Parties

On receipt of the notice of death, by whatever means, the delegated guardian must:

- Obtain the full name and contact details of the person advising of the death, noting the time of the notice.
- Confirm with the person whether the key parties have been advised of the death; who was informed, when were they informed (date and time) and how were they informed (telephone call, in attendance, email)
- Confirm contact details for key interested parties with the caller – contact key interested parties if not already notified.
- Contact key family members if not already notified – record the time and date of contact and whether a message was left and enter into PACMAN.
- Contact aged care facilities and/or service providers if not already notified record the time and date and enter into PACMAN.
- If it is not possible to make contact with a key family member, after 3 attempts - record the date and time contact was attempted and notify Manager Guardianship and the Public Advocate promptly who will advise if follow-up action required.
- Send advice to the State Administrative Tribunal and the Public Trustee, if the appointed administrator, of the death of the represented person.
- Complete Deceased Represented Person Notification template on PACMAN – this will be automatically saved in OPA Reports.
- Update PACMAN – Person and Casework details.
- Place a hard copy of the Deceased Represented Person Notification on the file for closure.
- Senior Guardian or Manager Guardianship to sign the hard copy and upload to OPA Reports.

### 4.3 Mandatory Functions to be undertaken by the Guardian after hours

On being contacted after hours, via the On-Call service, and advised of the death of a represented person the on-call guardian must:

- Call the notifier and establish who has been informed of the represented person's death.
- Record on the On Call Record Sheet the full name and contact details of the caller, and the date and time of the call.
- Enquire and record on the On Call Record Sheet whether key interested parties have been informed of the death; who was informed, when were they informed (date and time) and how were they informed (telephone call, present, email).
- Confirm and record on the On Call Record Sheet contact details for key interested parties – contact key interested parties if not already informed.

| *Notification to Key Parties of the Death of a Represented Person.* | VERSION 1 |
|---|---|
| | Page 3 of 5 |

- Establish if there is a lead family member who will advise other family members and any close contacts.
- Contact family members if not already informed, either directly or through a lead family member where there is no conflict, regardless of the time.
- Clarify that, where there is a history of conflict, which family members and close contacts will be contacted by the lead family member and who will need to be contacted by the on-call guardian.
- At the minimum a key family member should be contacted, 3 attempts should be made, at the earliest opportunity and regardless of time.
- Contact aged care facilities and service providers if not already informed and record on the On Call Record Sheet.
- Record on the On Call Record Sheet the date, time and any message received or left, if contact with key interested parties is unsuccessful.
- Notify On-Call Manager and the Public Advocate promptly where contact with a key family member was unsuccessful who will advise if follow-up action required.
- Email a copy of the On Call Record Sheet to the delegated guardian and copy to the Senior Guardian or, if the delegated guardian is a senior, the relevant Manager Guardianship.
- Provide a hard copy of the On Call Record Sheet to the delegated guardian on the next working day after on-call.

## 5. Relevant Legislation/Policy

This Practice Standard should be read in conjunction with:

- *Guardianship and Administration Act 1990*
- Office of the Public Advocate Practice Standard - Delegated Authority for Guardians and Administrators
- Office of the Public Advocate Practice Standard - Guardianship Practice
- Office of the Public Advocate Practice Standard - End of Life Care Decision Making for Represented Persons
- Office of the Public Advocate Practice Standard – After-hours Calls

## 6. Checklist: Notification to Key Parties on the Death of a Represented Person

The Notification of Death Checklist is a tool to assist guardians in the Office of the Public Advocate in providing advice to the Public Advocate when a notification of death has been received for a represented person.

Complete the checklist with reference to the Office of the Public Advocate Practice Standard - Notification to Key Parties on the Death of a Represented Person.

The checklist can be commenced by the delegated guardian, duty guardian, on-call guardian, Senior Guardian or Manager Guardianship, collecting the information of who is notifying our office, their relationship to the represented person, and date of death. The checklist is then to be completed by the delegated guardian for submission to the senior guardian or Manager Guardianship for signing and uploading to PACMAN prior to closing file. (See overleaf)

| | |
|---|---|
| *Notification to Key Parties of the Death of a Represented Person.* | VERSION 1 |
| | Page 4 of 5 |

NOTIFICATION OF DEATH OF A REPRESENTED PERSON
INTERNAL FORM

**Represented Person's name:** _____

**Delegated Guardian:** _____

**Information recipient and date notified:**

_____
*(Name)* *(Date)*

**Title:** Guardian, Duty Guardian, On-Call Guardian, Senior Guardian, Manager Guardianship
(strike though not appropriate titles)

**Date of death:**
(dd/mm/yyyy) _____

**Notified by:**
(Write full name and position if caller if from an Organisation) _____

**Information source:** ☐ Telephone _____ *(Number)*

☐ In person

☐ In writing (attach copy to form)

**Relationship to Represented Person:** _____

ACTION CHECKLIST - to be completed by the delegated guardian

**Key Parties Notified** ☐ _____ *(Date completed)*

"Key Interested Parties": people who played a significant role in a represented person's life. This includes family members, including family members who have had minimal contact, close personal contacts, aged care facilities and/or service providers.

| Who have you called – Full name | Title/Position/Relation to RP | Date and time completed |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**SAT and PTO Notified** ☐ _____ *(Date completed)*

**PACMAN updated**
(Person Details and Casework) ☐ _____ *(Date completed)*

Senior Guardian or Manager Guardianship _____ *(Name)* *(Date)*

_____ *(Signature)*

| *Notification to Key Parties of the Death of a Represented Person.* | VERSION 1 |
|---|---|
| | Page 5 of 5 |

# 12 Appendix 2: Office of the Public Advocate Practice Standard – After-hours calls

Following the commencement of the Investigation, OPA updated the practice standard, *After-hours calls* to 'incorporate the new procedures relating to notification of the death of a represented person to key parties'.[72] The updated practice standard came into effect on 11 March 2021. OPA highlighted the amendments to the practice standard in yellow in the version provided to the Ombudsman.

[72] OPA provided this information to the Ombudsman in response to information required, and questions asked, by the Ombudsman during the Investigation.

# Office of the Public Advocate
# Practice Standard

| | | |
|---|---|---|
| **After-hours Calls** | ***Version:*** 5<br>11 March 2021 | ***Approved***:<br>Public Advocate |
| | ***Contact Officer***:<br>Managers Guardianship | ***Approval date***:<br>11 March 2021 |
| | ***Review Date:***<br>11 March 2024 | ***Last Amended:***<br>11 March 2021 |
| | ***Distribution:***<br>Senior Guardians, Guardians | ***Distribution Date:***<br>11 March 2021 |

**Amendments**

| *Version* | *Date* | *Author* | *Section* | *Summary* |
|---|---|---|---|---|
| 2 | 12.02.09 | | | Public Advocate added as on-call for staff consultation |
| 3 | 9/11/10 | | | Amended due to changes to G&A Act following Proclamation of Acts Amendment (Consent to Medical Treatment) Act 2008 |
| 4 | 21/12/17 | | | Updated to reflect current practices. |
| 5 | 11/3/2021 | | 1, 4.3, 4.8 & 6 | Expanded to include death of a represented person, and clarify expectations of the on-call guardian. |

This practice standard assists guardians who are rostered on-call to respond to urgent matters after-hours.

This practice standard should be read in conjunction with those practice standards and documents identified below under **Relevant Legislation/Policy.**

## 1. Definitions

***"Delegated Guardian":*** a person delegated by the Public Advocate pursuant to Section 95 of the *Guardianship and Administration Act 1990* to carry out the functions of a guardian.

***"Guardianship and Administration Act 1990":*** an Act to provide for the guardianship of adults who need assistance in their personal affairs … to provide for the appointment of a public officer with certain functions relative to thereto, to provide for enduring powers of attorney, enduring powers of guardianship and advance health directives, and for connected purposes.

***"Proposed Represented Person":*** a person subject to an application in Section 40 of the *Guardianship and Administration Act 1990* or a person subject to an investigation under section 97 (1) (c) of the *Guardianship and Administration Act 1990.*

***"Represented Person":*** means any person in respect of whom:
- a guardianship order is in force;
- an administration order is in force; or
- both a guardianship order and an administration order are in force.

***"Treatment":*** is defined in Part 1, section 3(1) of the *Guardianship and Administration Act 1990* to mean any medical, surgical or dental treatment or other health care, including a life-sustaining measure or palliative care.

***"Treatment Decision":*** means a decision to consent, or refuse consent, to the commencement or continuation of any treatment of the person.

***"Urgent Hearing":*** a hearing date set less than 14 days from the application being lodged, for a guardianship and/or administration order, with the State Administrative Tribunal.

***"Urgent Treatment":*** treatment that in the opinion of the medical practitioner or dentist is needed to save the life of the person: to prevent serious damage to the person patient's health; or to prevent the person suffering or continuing to suffer significant pain or distress. (Section 110 ZI and 110 ZIA of the *Guardianship and Administration Act 1990*), but does not include sterilisation.

## 2. Position Statement

The Public Advocate maintains a 24-hour contact service so that urgent matters can be dealt with after-hours.

The enquiries that are responded to may be in relation to making an urgent decision for a represented person where the Public Advocate is the appointed guardian, or a concern is raised that a person is in need of a guardian and/or an administrator, which may require an urgent hearing of the State Administrative Tribunal.

## 3. Scope

A roster system has been developed which requires all guardians to be on-call out of usual business hours. For weekends this commences close of business Friday (4.30pm) and finishes at 8:30am the following Monday. For weekdays, this is between 4.30pm and 8:30am the following morning.

The Managers Guardianship and the Manager Advocacy, Investigation and Legal share on a fortnightly basis the responsibility of being available after-hours for advice and consultation, by the on-call guardian, between 4.30PM – 10:00PM. The Public Advocate is contactable by OPA Managers after-hours if her delegated authority is required.

The Public Advocate is available between 10:00PM – 8:30AM (Monday – Sunday) for advice and consultation if her delegated authority is required.

After-hours enquiries are dealt with routinely over the telephone. In the unlikely event that a 'call out', to visit the proposed or represented person, is thought to be required by the rostered guardian, consultation with the Manager on-call is required and their endorsement sought. Staff security after-hours is a key consideration at all times.

On-call allowance is payable and overtime is approved if calls add up to 30 minutes or more on any work night or weekend period. Claims must deduct any work hours recorded on your timesheet that overlap with your roster period on-call.

As per the award being on-call requires the on-call guardian to be in a state of readiness for immediate return to duty. This requires the on-call guardian to carry the on-call phone at all times and to have access to the on-call laptop when not at the office.

## 4. Minimum Practice Standards

### *4.1 Accessing Information*

The on-call guardian must collect the dedicated on-call mobile telephone for after-hours and weekend contact, as well as the after-hours laptop which allows direct access to all client information contained on Pacman. The on-call guardian should check on the laptop that Pacman is accessible before the shift commences at 4.30pm.

The information on the laptop and Pacman includes:

- Public Advocate guardianship orders for represented persons.
- Event notes for represented persons and current investigation/advocacy cases.
- A list of numbers for crisis and emergency agencies.
- A list of relevant Public Advocate staff after-hours telephone numbers.
- Procedural advice regarding making contact with the State Administrative Tribunal in relation to requesting an urgent hearing and contact phone numbers for the Executive Officer.
- Office of the Public Advocate Practice Standards.
- Sexual Assault Resource Centre (SARC) Protocol with OPA, 'Sexual Assault: obtaining consent to medical treatment or forensic examination when a person is unable to consent because of a decision-making disability'.
- OPA's Memorandum of Understanding (MOU) with Police, 'Procedures for the reporting of allegations of sexual assault of adults with decision-making disabilities'.

All information contained on the laptop is to be kept strictly confidential and the security of the laptop should be considered at all times. Never give out the number of the on-call mobile or the private numbers of colleagues or SAT staff.

### *4.2 Incoming Calls*

The after-hours answering service is provided by ORACLE CMS in Melbourne. The public number for use by after-hours callers is

ORACLE CMS answer calls from the public by identifying themselves as the Office of the Public Advocate's after-hours answering service. After-hours calls will be notified via a text message from the answering service to OPA's On-call mobile phone. The text will contain a reference ID and brief information about the caller and the reason for the call. Guardians are to contact ORACLE CMS by text acknowledging receipt of the text quoting only the reference number.

| *After – Hours Calls* | VERSION 5 |
|---|---|
| | Page 3 of 7 |

ORACLE CMS will send a maximum of 3 follow up texts if the original text is not acknowledged.

Guardians are required to respond immediately to any text messages. Initial enquiries must be made to establish the nature and urgency of the call. If for any reason the mobile battery is flat, or there is any difficulty receiving messages, telephone ORACLE CMS and ask for the calls received that day to be listed.

The State Administrative Tribunal after-hours telephone message refers urgent enquiries to the Office of the Public Advocate's after-hours service.

Week-nights, Guardians rostered on-call are expected to remain at OPA until their shift starts at 4.30PM and they are required to remain within the metropolitan area to be able to adequately respond to any urgent matters.

**4.3 Use of the laptop**

The on-call guardian is provided a laptop with remote access capabilities to ensure access to the same information and resources as they have when working in the office. This ensures the on-call guardian is able to carry out all the duties of a guardian remotely.

It is appreciated that during the period of being on-call the guardian may be out of their home for a range of reasons. It is a requirement that the on-call guardian have access to the computer within a maximum of 30 minutes from receiving a call.

As such, if the on-call guardian is planning to be away from their home, at a venue more than 30 minutes from their home, then the on-call guardian is required to take the laptop with them.

***4.4 Requests for Urgent Hearings***

Very occasionally an after-hours inquiry may involve a request for an urgent hearing of the State Administrative Tribunal (SAT) to determine whether a guardian or administrator may need to be appointed.

The person making the urgent request should be asked to provide relevant information about the proposed represented person's situation. Information needs to be collected and documented that will help determine to the satisfaction of the Tribunal:

- the person's competency - relevant in determining if hearing needed;
- the need for a guardianship and/or administration order;
- what has been tried to resolve the problem;
- what is the urgent situation – timeframes.

To progress an urgent hearing it is a SAT requirement that competency information be obtained from the proposed represented person's medical practitioner or specialist. A written report is preferred, however if this is not practical due to the urgent nature of the proposed represented person's situation, verbal confirmation would be sought. The treating medical practitioner should be advised that SAT may request that they attend any hearing, by phone or in person, conducted by the Tribunal.

On confirmation of the proposed represented person's incapacity, and that there are no less restrictive alternatives to resolve the concern, the on-call guardian will contact the rostered Manager on-call. This is to obtain endorsement to contact the Tribunal to provide the relevant information with a recommendation of the need to list for an urgent hearing.

Only the Public Advocate, Manager Advocacy Investigation and Legal, or the Managers Guardianship, have delegated authority to instigate a community referred investigation under Section 97(1)(c) of the *Guardianship and Administration Act 1990*, or to approve contact with the State Administrative Tribunal after-hours.

The out of hours contact number at the State Administrative Tribunal is this will automatically divert to mobile of the Human Rights Stream Manager – should the Manager be unavailable backup is provided by the Team Leader.

If does not answer contact can be made on the following mobile numbers:

HR Stream Manager - mobile number is
HR Stream Team Leader - mobile number is

The role of the on-call Guardian is to:

- Establish the evidence to support the allegation;
- Establish whether the person concerned is at physical risk or the risk of immediate financial abuse;
- Establish that the matter cannot wait until the next working day; and
- Take all relevant details and contact the relevant OPA Manager on-call.

### *4.5 Urgent Medical Treatment*

Where a person with a decision-making disability requires urgent medical treatment it can be provided under section 110ZI of the *Guardianship and Administration Act 1990*, if the medical practitioner or dentist believes that where the requirements are met. Further information about urgent medical treatment is provided in the Office of the Public Advocate's Practice Standard: *Role of the Public Advocate as Guardian with Authority for Medical Treatment and Health Care Decisions*.

General guardianship enquiries regarding non-urgent treatment decisions where the Public Advocate is not appointed do not require assistance after-hours. If the treatment is not urgent the need for a guardianship order can be followed up by the Telephone Advisory Service, (TAS), during normal business hours.

The on-call guardian should obtain the contact details for the person making the request and forward the information to the TAS officer.

### *4.6 Emergency Provisions to Appoint an Administrator*

Section 65 of the *Guardianship and Administration Act 1990* provides for the State Administrative Tribunal to appoint an administrator when it appears that:

- the person is a person in respect to whom a declaration should be made under Subsection (1) of Section 64; that is, is in need of an administrator, and
- it is necessary to make an immediate provision for the protection of the person's estate.

Any guardian who considers action should be commenced under section 65 of the Act must discuss the person's circumstances with the rostered Manager on-call prior to any approach being made to the State Administrative Tribunal.

### *4.7 Guardian of Last Resort*

Where a call is received for a treatment decision, or other decision-making relating to a person for whom the Public Advocate has been appointed the guardian, the on-call guardian must establish the urgency of the situation and whether a decision needs to be made immediately, or can be deferred to the next working day.

If a decision is needed immediately, and it has been established that the necessary authority is contained within the SAT order, the on-call guardian can make *routine* decisions. The endorsement of the Public Advocate, Manager Advocacy, Investigation and Legal or the Manager Guardianship is required when decisions are *non-routine* or outside a guardian's delegated authority. Further details are provided in the *Office of the Public Advocate Practice Standard: Delegated Authority for Guardians and Administrators.*

Where treatment involves a general anaesthetic the guardian will ordinarily provide consent in writing; verbal consent is not sufficient unless there are exceptional circumstances. When consent for a general anaesthetic is required the on-call guardian will provide verbal consent and request that the standard consent form be faxed to the Office of the Public Advocate by the represented person's treating practitioner or anaesthetist for completion the next business day. The standard consent form should then be completed and signed by the on-call guardian on return to the office and scanned with the on-call record. A copy of the signed consent form should be returned to the represented person's treating practitioner or anaesthetist.
Further details are provided in the *Office of the Public Advocate Practice Standard: Role of the Public Advocate as Guardian with Authority for Treatment and Health Care Decisions.*

***4.8 Death of a represented person***

The Office of the Public Advocate may be advised of the death of the represented person by a family member, a member of the treating team, the facility where the represented person resided, or by some other party.

Where the on-call guardian receives a call advising of the death of a represented person they should obtain:

- the full name of the caller
- the contact phone number for the caller
- their relationship to the represented person,
- where a professional - the facility they work at.
- details of who has been contacted about the death and when they were contacted.

The on-call guardian should ensure that key family members identified in PACMAN have been advised of the death of the person, and, in the event they wish to view the body, where the person's body is being held. This action can be through a lead family member where there is no conflict.

Where contact with key family members is unsuccessful the on-call guardian should confirm the contact details with the aged care facility, treating team or service provider.

The on-call guardian should complete the on-call record sheet in relation to the death of the represented person and email this to the delegated guardian with a copy to the relevant Senior Guardian or Manager Guardianship.

On the next business day the delegated guardian is to follow up if any other family or support agencies need to be advised of the death. The delegated guardian is also to advise SAT, and the Public Trustee's Office, where appointed administrator, of the death of the represented person.

The delegated guardian is responsible for completing the Deceased Represented Person Notification on PACMAN and saving it in OPA Reports.

If the delegated guardian is on leave then the relevant line manager (Senior Guardian or Manager Guardianship) is to ensure that these actions are completed.

The delegated guardian will be responsible for closing the file once all parties have been notified. Further information on the process for closing the file on the death of the represented person is within the document "Guideline for closing a file for a represented person under the guardianship of the Public Advocate".

## 5. Responsibility/Accountability

When on-call, guardians must act within their delegated authority at all times and seek the endorsement of the Managers or Public Advocate when required.

Consistent with good practice, private telephone numbers of staff or Tribunal members should not be divulged under any circumstances. If there are any concerns about attending a call out, the Public Advocate or Managers should be contacted for advice. It may also be appropriate to seek the assistance of the WA Police following consultation with the Manager or the Public Advocate.

Timely completion of the 'On-Call Record Sheet', located in templates on Pacman, is required for all enquiries. Substantial interventions must be signed the following morning by the Public Advocate, or relevant Manager, in instances where their endorsement was sought. It is the on-call guardian's responsibility to ensure these documents are provided to the Manager or the Public Advocate.

On-call allowance, and overtime claims, are submitted to the On-Call guardian's line-manager for approval. Overtime is payable in accordance with the provision of the Public Service Award.

## 6. Relevant Legislation/Policy

This Practice Standard should be read in conjunction with:

- On-call Remote Access Procedures – November 2017 (attached)
- *Guardianship and Administration Act 1990*
- OPA Practice Standard: Community Referred Investigations
- OPA Practice Standard: Delegated Authority for Guardians and Administrators
- OPA Practice Standard: Security Procedures and Incident Management
- OPA Practice Standard: Allegations of Sexual Abuse or Sexual Assault
- OPA Practice Standard: Role of the Public Advocate as Guardian with Authority for Medical Treatment and Health Care Decisions
- OPA Practice Standard: Guardianship Practice
- OPA Practice Standard: Notification to Key Parties on the Death of a Represented Person
- Sexual Assault Resource Centre (SARC) Protocol with OPA, 'Sexual Assault: obtaining consent to medical treatment or forensic examination when a person is unable to consent because of a decision-making disability'.
- OPA's Memorandum of Understanding (MOU) with Police, 'Procedures for the reporting of allegations of sexual assault of adults with decision-making disabilities'.

| *After – Hours Calls* | VERSION 5 |
|---|---|
| | Page 7 of 7 |

# 13 Appendix 3: Office of the Public Advocate letter to service providers upon appointment as guardian

Following the commencement of the Investigation, OPA updated the letter OPA sends to service providers at the time of OPA's appointment as guardian. OPA highlighted the amendments to the letter in yellow in the version provided to the Ombudsman.

Our Ref:
Your Ref:

ATTN: Facility Manager / Disability Accommodation Manager / Service Provider
***(delete those not required)***
NAME OF CARE PROVIDER
Address

Dear Name

**RE:**

At a hearing of the State Administrative Tribunal on hearing date the Tribunal appointed the Public Advocate as **NAME**'s limited /plenary guardian and I am the delegated guardian. Attached is a copy of the guardianship order.

The Public Advocate was appointed with the following authorities*:*
***(delete those not required)***

(a) To decide where the represented person is to live, whether permanently or temporarily;
(b) To decide with whom the represented person is to live;
(c) Subject to subsection (4) of the *Guardianship and Administration Act 1990*, make treatment decisions for the represented person;
(d) To determine the services to which the represented person should have access;
(e) To consent to the use of physical or chemical restraint in respect of the represented person and to decide matters incidental thereto;
(f) To decide whether the represented person should work and, if so, the nature or type of work, for whom s/he is to work and matters related thereto;
(g) To decide what education and training the represented person is to receive;
(h) To decide with whom the represented person is to associate;
(i) As the next friend of the represented person, commence, conduct or settle any legal proceedings on behalf of the represented person, except proceedings relating to the estate of the represented person; and
(j) As the guardian *ad litem* of the represented person defend or settle any legal proceedings taken against the represented person, except proceedings relating to the estate of the represented person.

***(delete if no treatment authority)***
You will note the attached guardianship order authorises the Public Advocate to consent to any treatment or health care for **NAME**, subject to Division 3 of the *Guardianship and Administration Act 1990* – which refers to sterilisation and is not a consideration in relation to **NAME**. The Public Advocate's consent will therefore need to be obtained for any treatment or health care, with the exception of the administration of non-prescription medications or first aid treatments. I have enclosed a sticker to attach to the cover of **NAME** 's file. The sticker is designed to highlight the need to contact the Public Advocate for treatment or health care consent.

If urgent treatment is required, and it is not practicable to obtain the Public Advocate's consent, treatment should be provided. This Agency has adopted the definition of "urgent treatment" as outlined in the *Guardianship and Administration Act 1990,* which is treatment to save the life of the person, to prevent serious damage to their health or to prevent the person from suffering or continuing to suffer significant pain or distress. Position statements relating to treatment are available on the website www.publicadvocate.wa.gov.au.

Underpinning any decision-making by the Public Advocate is the principle of 'best interests'. The Public Advocate must ensure that any decisions made are in the best interests of **NAME**. In order to ensure that decisions about **NAME**'s are made in his/her best interests it is imperative that the Public Advocate is informed about all aspects of **NAME**'s treatment, health care and support needs ***(delete if the Public Advocate does not have treatment authority)***.

The Public Advocate is not next of kin and does not take the place of relatives, friends, carers or other service providers assisting the person with the decision-making disability in day to day activities, or attending medical appointments.
Unless the Public Advocate has plenary authority, or a limited authority specifying authority to make decisions with regard to contact with others, the Public Advocate does not have a role in making decisions in relation to visits by family of friends and it is important that family and friends continue to be informed and updated on **NAME's** condition .

The delegated guardian can be contacted during business hours on . If the delegated guardian is not available and an urgent decision is required, please phone and ask to speak to the Duty Guardian.

If urgent consent is required outside of business hours, please phone the After-Hours Paging Service on . The on-call Guardian will return your call as soon as possible. I have included a simple chart which indicates when it may be appropriate to contact the After Hours Paging Service.

Please do not hesitate to contact me with regard to decision-making relating to the above authorities for **NAME** or if you would like to discuss any issues raised in this

letter. I will be in contact over the next few weeks to arrange an appointment to meet with you and **NAME**.

Yours sincerely

**Name**
**SENIOR/GUARDIAN**

Date

# Major Investigations and Reports

| Title | Date |
|---|---|
| *Preventing suicide by children and young people 2020* | September 2020 |
| *A report on giving effect to the recommendations arising from Investigation into ways to prevent or reduce deaths of children by drowning* | November 2018 |
| *A report on the monitoring of the infringement notices provisions of The Criminal Code* | December 2017 |
| *Investigation into ways to prevent or reduce deaths of children by drowning* | November 2017 |
| *A report on giving effect to the recommendations arising from the Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities* | November 2016 |
| *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities* | November 2015 |
| *Investigation into ways that State Government departments and authorities can prevent or reduce suicide by young people* | April 2014 |
| *Investigation into ways that State Government departments can prevent or reduce sleep-related infant deaths* | November 2012 |
| *Planning for children in care: An Ombudsman's own motion investigation into the administration of the care planning provisions of the Children and Community Services Act 2004* | November 2011 |
| *The Management of Personal Information - good practice and opportunities for improvement* | March 2011 |
| *2009-10 Survey of Complaint Handling Practices in the Western Australian State and Local Government Sectors* | June 2010 |

**Ombudsman Western Australia**
Level 2, 469 Wellington Street Perth WA 6000
PO Box Z5386 St Georges Terrace Perth WA 6831
Tel 08 9220 7555 • Freecall (free from landlines) 1800 117 000 • Fax 08 9220 7500
Email mail@ombudsman.wa.gov.au • Website www.ombudsman.wa.gov.au