A report on giving effect to the recommendations arising from *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

About this Report

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ABORIGINAL WESTERN AUSTRALIANS

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

WE ARE PROUD OF DIVERSITY

We take pride in diversity and equal opportunity. The Ombudsman and the office of the Ombudsman stands with the LGBTQIA+ community. The Ombudsman's pronouns are he/him/his.

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1. 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 (**Investigation**).

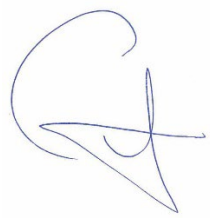
As a result of the Investigation, I formed a number of opinions regarding OPA's role in notifying the families of Mrs Joyce Savage, Mr Robert Ayling and Mr Kenneth Hartley of the deaths of Mrs Savage, Mr Ayling and Mr Hartley.

Arising from these opinions, I made seven recommendations to OPA. I was very pleased that OPA agreed to all seven recommendations. As with all of my own motion investigations, twelve months after tabling the report of an investigation in Parliament, I report to Parliament on the steps taken to give effect to the recommendations arising from an investigation.

Having very carefully considered the information provided by OPA regarding their implementation of the seven recommendations, I am pleased to report that I am of the view that OPA has taken steps to give effect to each of the seven recommendations. In no instance have I found that no steps have been taken to give effect to a recommendation. This is an important and pleasing outcome.

I am also pleased to report that the Public Advocate and her staff have been highly cooperative, open and timely during the undertaking of the Investigation and this report. A preparedness to accept oversight and accountability and take positive steps to improve the provision of their essential services to some of Western Australia's most vulnerable citizens reflects very well on OPA.

I again express my sincerest condolences to the families on the passing of Mrs Savage, Mr Ayling and Mr Hartley. I hope it is a level of comfort for each family that the Investigation, and OPA's response, has resulted in clear improvements to the way that OPA notifies families upon the death of a loved one.



Chris Field
OMBUDSMAN

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2. About this report

2.1. Background

2.1.1. Own motion investigations

Under section 16(1) of the *Parliamentary Commissioner Act 1971*, the Ombudsman is able to investigate, on her or his own motion, any administrative decision, recommendation or action by State government departments and authorities within his or her jurisdiction, as follows:

> Without prejudice to the provisions of section 15 any investigation that the [Ombudsman] is authorised to conduct under this Act may be so conducted, either on [her or his] own motion or on a complaint …[1]

In undertaking an investigation, the Ombudsman has the rights, privileges and responsibilities 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.

2.1.2. Giving effect to the recommendations of the Ombudsman

The Ombudsman also actively monitors the implementation and effectiveness of recommendations arising from own motion investigations, in accordance with section 25(4) of the *Parliamentary Commissioner Act 1971*, which states:

> (4) If under subsection (2) the [Ombudsman] makes recommendations to the principal officer of an authority he [or she] may request that officer to notify him [or her], within a specified time, of the steps that have been or are proposed to be taken to give effect to the recommendations, or, if no such steps have been, or are proposed to be taken, the reasons therefor.

2.2. Investigation into OPA's role in notifying the families of Mrs Savage, Mr Ayling and Mr Hartley of their deaths

2.2.1. Background to the Investigation

On 2 March 2021, 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 followed a request to me by the Honourable John Quigley MLA, Attorney General, to investigate OPA's role in notifying the family of Mrs Joyce Savage of the death of Mrs Savage and to include in my investigation, the circumstances of OPA's

[1] *Parliamentary Commissioner Act 1971* s. 16(1).

notification to the families of Mr Robert Ayling and Mr Kenneth Hartley of the deaths of Mr Ayling and Mr Hartley.

2.2.2. The Investigation

To undertake the Investigation, the office of the Ombudsman (**the Office**):

- 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 (by phone) and shared their experiences and views. These experiences and views have informed the Investigation;
- Considered 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 on the deaths of Mrs Savage, Mr Ayling and Mr Hartley;
- Required information from OPA including case files, correspondence, relevant policies and procedures as well as answers to questions from the Office and then carefully considered the information provided by OPA;
- Developed a preliminary report and provided it to OPA for its consideration and response; and
- Considered OPA's response to the preliminary report and prepared a final report.

An investigation into the Office of 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 (**the Report**) was tabled in Parliament in July 2021. To assist the reading of this report, the recommendations arising from the Report are reproduced at Chapter 4.

2.3. A report on giving effect to the recommendations arising from the Investigation Report

2.3.1. Objectives

The Report made seven recommendations to OPA regarding OPA's role in notifying the families of Mrs Savage, Mr Ayling and Mr Hartley of the deaths of Mrs Savage, Mr Ayling and Mr Hartley.

The objectives of this report were to consider, in accordance with sections 25(4) and (5) of the *Parliamentary Commissioner Act 1971*:

- The steps that have been taken to give effect to the recommendations;
- The steps that are proposed to be taken to give effect to the recommendations;

- If no such steps have been, or are proposed to be taken, the reasons therefor; or
- If relevant, whether it appeared to the Ombudsman that no steps that seem to him to be appropriate have been taken within a reasonable time of his making of the Investigation Report and recommendations.

2.3.2. Methodology

On 16 March 2022, I wrote to the Public Advocate, requesting a report on the steps that have been taken, or were proposed to be taken, to give effect to the recommendations of the Report.

Additionally, the Office:

- Obtained further information from OPA, in order to clarify or validate information provided in OPA's report to the Office;
- Reviewed and considered the information provided by OPA and the information, clarification or validation provided to the Office;
- Developed a preliminary view and provided it to OPA for its consideration and response; and
- Developed a final report.

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3. Steps taken to give effect to the recommendations

3.1. Recommendation 1

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.

In 2019, OPA was appointed as a limited guardian for Mrs Savage with functions relating to accommodation, treatment, and the provision of services.

The Report considered OPA's role as limited guardian of Mrs Savage:

> … 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".[2] 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".[3] 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".[4] OPA contacts the family of a represented person to seek their views about a treatment decision for palliative care (**palliative care treatment decision**).

The Report further considered OPA's contact with Mrs Savage's daughter in relation to the palliative care treatment decision:

> … 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, but "the mobile phone number was no longer connected".[5] 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.[6]
>
> 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.[7] OPA contacted Sir Charles Gairdner

[2] *Guardianship and Administration Act 1990*, s. 3.
[3] *Guardianship and Administration Act 1990*, s. 3.
[4] *Guardianship and Administration Act 1990*, s. 3.
[5] OPA provided this information to the Ombudsman in response to information required, and questions asked, by the Ombudsman during the Investigation.
[6] This comment is not adverse to Acacia Living Group's Menora Gardens. This comment is not adverse to delegated staff of OPA.
[7] 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.

> 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 call the phone number.[8] 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.[9] Mrs Savage died at Sir Charles Gairdner Hospital on Sunday 14 February 2021.

The Ombudsman, in his opinion in the Report, stated:

> 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.

For the above reasons, the Ombudsman made Recommendation 1.

The Office requested that OPA inform the Office of the steps taken to give effect to the recommendation. In response, OPA provided the following information:

> The implementation of this recommendation is complete.
>
> When the Public Advocate is appointed as guardian with treatment authority, part of the intake process involves making contact with family to confirm the Public Advocate's appointment and explain the authority.
>
> The standard letter to family members has been updated to reflect the importance of OPA having up to date contact details in order to contact family at critical times such as making palliative care decisions.
>
> The practice standard outlining the process to be followed by delegated guardians has been updated to reflect this.

[8] 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.
[9] This comment is not adverse to Sir Charles Gairdner Hospital.

OPA provided evidence in support of its stated progress towards the implementation of Recommendation 1, specifically:

1. Standard letter to family on appointment of Public Advocate;
2. *OPA Practice Standard: End of Life Care Decision Making for Represented Persons*;
3. *OPA Practice Standard: Guardianship Practice*; and
4. Email to staff regarding the release of the Ombudsman WA Report and related changes to practices.

Careful review of the above information provided by OPA indicates:

- Following OPA's appointment as a person's legal guardian, the letter OPA sends to the person's family has been updated to reflect the criticality of ensuring that OPA is informed of any change in phone number, by inserting:

  > As it is critical that family and key parties can be readily contacted at such times, please alert this office when your contact details change to ensure that we have current telephone, email and, postal address details.

- Following OPA's appointment as a person's legal guardian, the letter OPA sends to the person's family has been updated to better inform families of OPA's role in relation to making palliative care treatment decisions, by inserting the following:

  > The Public Advocate was appointed with the following authorities … to make treatment decisions for the represented person …
  >
  > … the Public Advocate is appointed to make treatment decisions, this would include a palliative care or end of life decision.

- On 9 July 2021, the *OPA Practice Standard: End of Life Care Decision Making for Represented Persons* was updated and distributed to staff, by inserting the following:

  > Advise family and other key interested parties in writing of the Public Advocate's appointment with the authority to make treatment decisions, including palliative care withholding or withdrawing treatment or refraining from resuscitation procedures. It is imperative that this communication highlights the importance of parties keeping the Office informed of any changes to their contact details, particularly their telephone number, so that if the guardian needs to make a palliative care or end-of-life decision, they can readily contact them.

- On 19 July 2021, *OPA Practice Standard: Guardianship Practice*, was updated and distributed to staff, by inserting the following:

  > Where the Public Advocate is appointed as guardian with the authority to make treatment decisions, family and other key interested parties must be informed of the appointment. It is imperative that this written communication highlights the importance of parties keeping the Office informed of any changes to their contact details,

> particularly their telephone number, so that if the guardian needs to make a palliative or end-of-life decision, they can readily contact them. …
>
> … Highlight with family and key parties, importance of keeping OPA informed of changes to contact details, particularly phone number.

Careful analysis of the above information provided by OPA indicates:

- OPA updated their standard letters and practices, and also informed staff as to the changes, as well as the reasons for, and importance of, the changes; and
- Pleasingly, the adoption of language such as "*critical*" and "*imperative*" is indicative of the fact that OPA now see it as a part of their role to 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. It is further evident from such language in their updated Practice Standards and standard letter, that not only is this their role, but that this is an important and essential function of a guardian.

Careful analysis of data provided by OPA indicates that in the majority of cases, OPA contacted family members at the commencement of OPA's role as guardian (or a friend who was the listed next of kin). Where OPA had not contacted family members, there were appropriate reasons that contact had not been made. Furthermore, and importantly, in every instance OPA contacted family members (or a friend who was the listed next of kin) regarding palliative care.

Overall, it is pleasing that OPA, without prompting by the Office, undertook an empirical process, in the form of data collection, to test the effectiveness of their new practices to implement Recommendation 1. It is further pleasing that this data collection process is evidentiary demonstration of OPA's improvements flowing from taking steps to give effect to Recommendation 1.

Having carefully considered the information provided by OPA, I am of the view that steps have been taken to give effect to Recommendation 1.

3.2. Recommendation 2

Recommendation 2: OPA should see it as part of their role to contact family following the death of a represented person.

During the Investigation, OPA submitted that their authority as guardian ends upon the death of a represented person and that they therefore do not have a statutory function to notify family of the death of a represented person. This view had a very strong bearing on OPA's actions following the death of Mrs Savage, whereby 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.

The Report considered the specific statutory function in question in relation to OPA's view and related conduct:

> 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.

The Report further considered OPA's conduct in relation to contacting other bodies and notifying them of the death of represented persons:

> 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.[10] Indeed, OPA provides guidance to its delegated staff to do so …
>
> …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).[11] 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.

[10] This comment is not adverse to delegated staff of OPA.
[11] 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 …
>
> … 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.

The Ombudsman, in his opinion in the Report, stated:

> 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.

For the above reasons, the Ombudsman made Recommendation 2.

The Office requested that OPA inform the Office of the steps taken to give effect to the recommendation. In response, OPA provided the following information:

> The implementation of this recommendation is complete.
>
> Following the Ombudsman's investigation, OPA procedures were changed to ensure this important role was captured in procedural documents. These changes and the importance of this role was communicated to guardians and continues to be communicated to new guardians as part of their induction process.
>
> A new practice standard 'Notification to Key Parties on the Death of a Represented Person' was introduced on 11 March 2021, along with a dedicated 'OPA RP Death inbox' and an internal form 'Notification of Death of a Represented Person'.
>
> The Notification to Key Parties on the Death of a Represented Person Practice Standard was updated on 8 July 2021 to reflect the July 2021 Ombudsman's Report Recommendations. The practice standard was updated in November 2021 following a scheduled review. This practice standard details the specific actions a delegated guardian undertakes to notify key interested parties of the death of a represented person for whom the Public Advocate has been appointed plenary or limited guardian.
>
> The Notification of Death of a Represented Person Internal Form, which is referenced in the practice standard and which forms a record of actions taken in the notification process, is currently being updated to improve functionality as an electronic form. This is becoming increasingly important with working from home arrangements due to COVID-19.
>
> The criticality of OPA's role in informing family of the death of a represented person is also now evident in other supporting practice standards, namely, the Guardianship Practice, End of Life Care Decision Making for Represented Persons and After-Hours Calls.

> In addition, guardians have been directed to use a standard out of office email message which is activated at the end of each work-day. The message instructs people what to do if they are emailing the delegated guardian with regard to the death of a represented person.
>
> This new practice aims to ensure that if a guardian is not at work for any reason, for example they take planned or unplanned leave, or they work part-time, parties emailing their individual inbox with a death notification, are made aware that the guardian is unavailable and that they need to contact the Office directly with the notification.
>
> The after-hours recorded telephone message was also amended to clearly highlight to callers outside of office hours, what to do if their call is regarding notification of death of a represented person.

OPA provided evidence in support of its stated progress towards the implementation of Recommendation 2, specifically:

1. Email to all staff regarding the release of the Ombudsman WA report and related changes to practices;
2. Emails to Senior Guardians and Guardians regarding changes to practice standards;
3. *OPA Practice Standard: Notification to Key Parties on the Death of a Represented Person* (including OPA Internal Form: Notification of Death of a Represented Person);
4. *OPA Practice Standard: Guardianship Practice*;
5. *OPA Practice Standard: End of Life Care Decision Making for Represented Persons*;
6. *OPA Practice Standard: After-Hours Calls*;
7. Email instructing Senior Guardians and Guardians to use out-of-office email reply;
8. Out of office email reply template; and
9. After-hours phone message script.

Careful review of the above information provided by OPA indicates:

- On 8 July 2021 and additionally on 1 November 2021, *OPA Practice Standard: Notification to Key Parties on the Death of a Represented Person* was updated and subsequently distributed to staff on 2 November 2021. The Practice Standard was updated by inserting the following:

  > The Office has a responsibility to act on such notification in an urgent manner, as it is a high priority to ensure that family and other key parties of a represented person are notified of their death. …
  >
  > … Where a call or email is received from a facility, hospital, or other party regarding the death of a represented person, the guardian must, as a **high priority** alongside other urgent decisions, take action to notify the family of the death. …

> … Where the after-hours on-call service is notified of the death, the on-call guardian must undertake every reasonable endeavour to notify key family members, as per the mandatory functions set out in part 4.3 below.

- On 8 July 2021, the *OPA Practice Standard: After-hours Calls* was updated and distributed to staff, by inserting the following:

> Where a call is received from a facility, hospital, or other party regarding the death of a represented person, the on-call guardian must, as a high property alongside other urgent decisions, take action as prescribed in the *Office of the Public Advocate Practice Standard: Notification to Key Parties on the Death of a Represented Person*, which articulates the steps to be followed.

- On 9 July 2021, the *OPA Practice Standard: End of Life Care Decision Making for Represented Persons* was updated and distributed to staff, by inserting the following:

> On notification of the death of the represented person, guardians must take action as prescribed in the Office of the Public Advocate Practice Standard: Notification to Key Parties on the Death of a Represented Person. …
>
> … Represented person deceased … Refer to OPA Practice Standard: Notification to Key Parties on the Death of a RP.

- On 19 July 2021, the *OPA Practice Standard: Guardianship Practice* was updated and distributed to staff, by inserting the following:

> **4.10 Death of a represented person**
>
> Where a guardian is notified by a facility, hospital, or other party regarding the death of a represented person, the guardian must, as a **high priority** alongside other urgent decisions, take action as prescribed in the *Office of the Public Advocate Practice Standard: Notification to Key Parties on the Death of a Represented Person,* which articulates the steps to be followed. …
>
> … **Death of represented person:** take urgent action as prescribed in the *Practice Standard: Notification to Key Parties on the Death of a Represented Person.*

Careful analysis of the above information provided by OPA indicates:

- OPA updated their practice standards, and also informed staff as to the changes, the reasons for the changes, and the importance of the changes; and
- Pleasingly, the adoption of language such as "*mandatory function*" and "*high priority*" is indicative of the fact that OPA now see it as part of their role to contact family following the death of a represented person. It is further evident from such language in their updated Practice Standards, that not only is this their role, but that this is an important and essential function of a guardian.

Careful analysis of data provided by OPA indicates that in a very significant majority of cases, OPA contacted family following the death of a represented person. Where OPA had not contacted family members, there were appropriate reasons that contact had not been made.

Overall, it is pleasing that OPA, without prompting by the Office, undertook an empirical process, in the form of data collection, to test the effectiveness of their new practices to implement Recommendation 2. It is further pleasing that this data collection process is evidentiary demonstration of OPA's improvements flowing from taking steps to give effect to Recommendation 2.

Having carefully considered the information provided by OPA, I am of the view that steps have been taken to give effect to Recommendation 2.

3.3. Recommendation 3

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.

Mrs Savage died at Sir Charles Gairdner Hospital on Sunday 14 February 2021 and 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.

The investigation determined that in addition to believing that they do not have a statutory function to notify family of the death of a represented person, there were two other reasons as to why OPA did not notify Ms Davis of the death of Mrs Savage, those being as follows:

1. 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; and
2. 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).

The Report considered OPA's standard conduct in relation to seeking family views on palliative care treatment:

> 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. …
>
> … 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.[12]

The Report further considered OPA's conduct in relation to contacting the family of a represented person:

> 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.[13] 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.

The Ombudsman, in his opinion in the Report, stated:

> 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. …
>
> … 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.

[12] This comment is not adverse to delegated staff of OPA.
[13] This comment is not adverse to Sir Charles Gairdner Hospital.

For the above reasons, the Ombudsman made Recommendation 3.

The Office requested that OPA inform the Office of the steps taken to give effect to the recommendation. In response, OPA provided the following information:

> The implementation of this recommendation is complete.
>
> Following the Ombudsman's investigation, OPA procedures were changed to ensure this important role was captured in procedural documents.
>
> These changes and the importance of this role was communicated to all guardians and continues to be communicated to new guardians as part of their induction process.
>
> OPA's Practice Standards, 'End of Life Care Decision Making for Represented Persons' and 'Notification to Key Parties on the Death of a Represented Person' have been updated to reflect this recommendation.

OPA provided evidence in support of its stated progress towards the implementation of Recommendation 3, specifically:

1. *OPA Practice Standard: End of Life Care Decision Making for Represented Persons*;
2. *OPA Practice Standard: Notification to Key Parties on the Death of a Represented Person*; and
3. Email to staff regarding the release of the Ombudsman WA Report and related changes to practices.

Careful review of the information provided by OPA indicates:

- On 9 July 2021, the *OPA Practice Standard: End of Life Care Decision Making for Represented Persons* was updated and distributed to staff, by inserting the following:

> ***4.1.4 Before making an end-of-life or palliative care treatment decision***
>
> Guardians must make every reasonable endeavour to contact family and other key interested parties before making such decisions.
>
> Utilise all phone numbers of which OPA are, or become, aware. Where a current and in service phone number is not available, the guardian must contact the Public Trustee (during office hours and where the PTO is 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 and other key interested parties. …

… ***4.1.6 After making an end-of-life or palliative care treatment decision***

Guardians must make every reasonable endeavour to contact family and other key interested parties where it was not possible to contact them at the time of the end-of-life or palliative care decision, to inform them of the decision.

Utilise all phone numbers of which OPA are, or become, aware. Where a current and in service phone number is not available, the guardian must contact the Public Trustee (during office hours and where the PTO is 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 phone number for family and other key parties.

- On 8 July 2021 and additionally on 1 November 2021, the *OPA Practice Standard: Notification to Key Parties on the Death of a Represented Person* was updated and subsequently distributed to staff on 2 November 2021. The Practice Standard was updated by inserting the following:

4.2 Mandatory functions to be undertaken during office hours

…

- If not already notified, make every reasonable endeavour to contact family and other key parties as a matter of **high priority** alongside other urgent decisions, record the time and date of contact and whether a message was left and enter into PACMAN. …
- … If key family are already aware of the death, the delegated guardian should endeavour to make contact with key family members on the same business day. …
- … Utilise all phone numbers of which OPA are, or become, aware until family are contacted. …
- … Where a current and in service phone number is not available, contact the Public Trustee (where the PTO is 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. …

4.3 Mandatory functions to be undertaken by the on-call guardian

…

- … Make every reasonable endeavour to contact the lead family member and other family as required, regardless of the time, except where family members have recently indicated a preference to only be contacted regarding the death of their family member during the day.
- Utilise all phone numbers of which OPA are aware of, or become aware of, until family are contacted.
- Where a current and in-service phone number for family is not available, contact 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.

Careful analysis of the above information provided by OPA indicates:

- OPA updated their practice standards, and they also informed staff as to the changes, the reasons for the changes, and the importance of the changes;
- Pleasingly, the adoption of language such as "*mandatory function*" and "*high priority*" is indicative of the fact that OPA now see it as a part of their role to contact family in relation to palliative care treatment decisions as well as following the death of a represented person. It is further evident from such language in their updated Practice Standards, that not only is this their role, but that this is an important and essential function of a guardian; and
- Additionally, it is pleasing that by using the phrase "*make every reasonable endeavour*" in relation to conduct, OPA have not limited guardians' actions to contact family in such circumstances.

Careful analysis of data provided by OPA indicates that in a significant majority of cases, OPA made every reasonable endeavour to contact family on every occasion that OPA was making, or had made, a palliative care treatment decision for a represented person or after the death of represented person.

Overall, it is pleasing that OPA, without prompting by the Office, undertook an empirical process, in the form of data collection, to test the effectiveness of their new practices to implement Recommendation 3. It is further pleasing that this data collection process is evidentiary demonstration of OPA's improvements flowing from taking steps to give effect to Recommendation 3.

Having carefully considered the information provided by OPA, I am of the view that steps have been taken to give effect to Recommendation 3.

3.4. Recommendation 4

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.

Even though OPA's process did not include notifying families of represented persons, 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.

The Report considered 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**).[14]
>
> 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.

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

The Report further considered 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.[15] 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 … On Tuesday 23 February 2021, OPA contacted Acacia Living Group's Menora Gardens, SAT and the Public Trustee.[16]

The Ombudsman, in his opinion in the Report, stated:

> 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.

For the above reasons, the Ombudsman made Recommendation 4.

The Office requested that OPA inform the Office of the steps taken to give effect to the recommendation. In response, OPA provided the following information:

> The implementation of this recommendation is complete. Following the Ombudsman's investigation, OPA procedures were changed to ensure this important role was captured in procedural documents.
>
> These changes and the importance of this role and the need for urgent action being taken when OPA is notified of the death of a represented person was communicated to all guardians and is communicated to new guardians as part of their induction process.
>
> The criticality of OPA's role in informing family of the death of a represented person and the urgent action that is required is now evident in OPA's Practice Standards, 'Notification to Key Parties on the Death of a Represented Person', 'After Hours Calls' and 'Guardianship Practice'.
>
> Ensuring urgent actions are undertaken when a delegated guardian is on planned or unplanned leave, or a part-time employee, has been addressed with a number of procedural

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

changes as outlined in OPA's Practice Standard, 'Notification to Key Parties on the Death of a Represented Person'.

In addition, a standard out of office email message which is activated at the end of each work-day, has been introduced. The message instructs people what to do if they are emailing the delegated guardian with regard to the death of a represented person.

This new practice aims to ensure that if a delegated guardian takes planned or unplanned leave, or they are not in the office because they work part-time, parties emailing their individual inbox with a death notification, are made aware that the delegated guardian is unavailable and that they need to contact the Office directly with the notification.

The after-hours recorded telephone message was also amended to clearly highlight to callers outside of office hours, what to do if their call is regarding notification of death of a represented person.

OPA provided evidence in support of its stated progress towards the implementation of Recommendation 4, specifically:

1. *OPA Practice Standard: Notification to Key Parties on the Death of a Represented Person*;
2. *OPA Practice Standard: After Hours Calls*;
3. *OPA Practice Standard: Guardianship Practice*;
4. Email instructing Senior Guardians and Guardians to use out-of-office email reply;
5. Out-of-office email reply template; and
6. After-hours phone message script.

Careful review of the information provided by OPA indicates:

- On 8 July 2021 and additionally on 1 November 2021, the *OPA Practice Standard: Notification to Key Parties on the Death of a Represented Person* was updated and subsequently distributed to staff on 2 November 2021. The Practice Standard was updated by inserting the following:

  2. Position statement

  … The Office of the Public Advocate is required to be contactable 24 hours a day, seven days a week in relation to urgent matters, including parties notifying the Office of the death of a represented person.

  The Office has a responsibility to act on such notification in an urgent manner, as it is a high priority to ensure that family and other key parties of a represented person are notified of their deaths. All reasonable measures are to be taken to ensure this notification is provided in a timely manner. …

4.1. Notification of death received

Where a call or email is received from a facility, hospital, or other party regarding the death of a represented person, the guardian must, as a **high priority** alongside other urgent decisions, take action to notify the family of the death. …

… In the delegated guardian's absence, the notification is to be passed on to the duty guardian and copied to the delegated guardian's Senior Guardian or relevant Manager Guardianship, where the delegated guardian is a Senior Guardian.

Where the duty guardian is unable to undertake the actions requires due to work load, the duty guardian is to promptly send an email to … for follow-up.

Where the after-hours on-call service is notified of the death, the on-call guardian must undertake every reasonable endeavour to notify key family members, as per the mandatory functions set out in part 4.3 below. …

4.2.1 Mandatory functions to be undertaken during office hours

…

- … If not already notified, make every reasonable endeavour to contact family and other key parties as a matter of **high priority** alongside other urgent decisions, record the time and date of contact and whether a message was left and enter into PACMAN. …
- If key family are already aware of the death, the delegated guardian should endeavour to make contact with key family members on the same business day. …
- … Utilise all phone numbers of which OPA are, or become, aware until family are contacted.
- Where a current and in service phone number is not available, contact the Public Trustee (where the PTO is 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. …

4.3 Mandatory functions to be undertaken by the on-call guardian

…

- … Make every reasonable endeavour to contact the lead family member and other family as required, regardless of the time, except where family members have recently indicated a preference to only be contacted regarding the death of their family member during the day.
- Utilise all phone numbers of which OPA are aware of, or become aware of, until family are contacted.
- Where a current and in-service phone number for family is not available, contact 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.

- On 8 July 2021, the *OPA Practice Standard: After-hours Calls* was updated and distributed to staff, by inserting the following:

> **4.7 Death of a represented person**
>
> Where a call is received from a facility, hospital, or other party regarding the death of a represented person, the on-call guardian must, as a **high priority** alongside other urgent decisions, take action as prescribed in the *Office of the Public Advocate Practice Standard: Notification to Key Parties on the Death of a Represented Person*, which articulates the steps to be followed.

- On 19 July 2021, the *OPA Practice Standard: Guardianship Practice* was updated and distributed to staff, by inserting the following:

> **4.10 Death of a represented person**
>
> Where a guardian is notified by a facility, hospital, or other party regarding the death of a represented person, the guardian must, as a **high priority** alongside other urgent decisions, take action as prescribed in the *Office of the Public Advocate Practice Standard: Notification to Key Parties on the Death of a Represented Person,* which articulates the steps to be followed.
>
> …
>
> **Death of represented person:** take urgent action as prescribed in the *Practice Standard: Notification to Key Parties on the Death of a Represented Person.*

Careful analysis of the above information indicates:

- OPA updated their practice standards and templates, and also informed staff as to the changes, the reasons for the changes, and the importance of the changes;
- It is particularly pleasing that the advice and specific instructions provided to on-call guardians in relation to the practice changes and procedures are clear and unambiguous to both delegated guardians as well as on-call guardians; and
- Pleasingly, the adoption of language such as "*mandatory function*" and "*high priority*" is indicative of the fact that OPA now see it as a part of their role to contact family following the death of a represented person and that this is important no matter whether it is during OPA office hours, or outside of hours.

Having carefully considered the information provided by OPA, I am of the view that steps have been taken to give effect to Recommendation 4.

3.5. Recommendation 5

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.

OPA was appointed as guardian of Mr Ayling with functions relating to accommodation and treatment. As Mr Ayling's limited guardian, one of the functions that OPA was authorised to undertake related to treatment for Mr Ayling. OPA contacts the family of a represented person to seek their views about a palliative care treatment decision.

OPA's role in notifying Mr Ayling's son of the death of Mr Ayling 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.

As such, the Report considered OPA's attempts to contact Mr Ayling's son to seek his views about a palliative care treatment decision for Mr Ayling:

> 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'.[17]

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

The Ombudsman, in his opinion in the Report, stated:

> 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.
>
> 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.

For the above reasons, the Ombudsman made Recommendation 5.

The Office requested that OPA inform the Office of the steps taken to give effect to the recommendation. In response, OPA provided the following information:

> The implementation of this recommendation is complete.
>
> Following the Ombudsman's investigation, OPA's Practice Standard 'End of Life Care Decision Making for Represented Persons' was amended to ensure this important role was captured in procedural documents.
>
> These changes were communicated to all guardians and continue to be communicated to new guardians as part of their induction process.

OPA provided evidence in support of its stated progress towards the implementation of Recommendation 5, specifically:

1. *OPA Practice Standard: End of Life Care Decision Making for Represented Persons*;
2. *OPA Practice Standard: Guardianship Practice*; and
3. Email to staff regarding the release of the Ombudsman WA Report and related changes to practices.

Careful review of the information provided by OPA indicates:

- On 9 July 2021, the *OPA Practice Standard: End of Life Care Decision Making for Represented Persons* was updated and distributed to staff, by inserting the following:

> ***4.1.1 Inform Interested Parties of Authority***
> …
> Advise family and other key interested parties in writing of the Public Advocate's appointment with the authority to make treatment decisions, including palliative care withholding or withdrawing treatment or refraining from resuscitation procedures. It is imperative that this communication highlights the importance of parties keeping the Office informed of any changes to their contact details, particularly their telephone number, so that if the guardian needs to make a palliative or end-of-life decision, they can readily contact them.

> …
> ***4.1.4 Before making an end-of-life or palliative care treatment decision***
>
> Guardians must make every reasonable endeavour to contact family and other key interested parties before making such decisions.
>
> Utilise all phone numbers of which OPA are, or become, aware. Where a current and in service phone number is not available, the guardian must contact the Public Trustee (during office hours and where the PTO is 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 and other key interested parties.
> …
> ***4.1.6 After making an end-of-life or palliative care treatment decision***
>
> Guardians must make every reasonable endeavour to contact family and other key interested parties where it was not possible to contact them at the time of the end-of-life or palliative care decision, to inform them of the decision. …

- On 19 July 2021, the *OPA Practice Standard: Guardianship Practice* was updated and distributed to staff, by inserting the following:

> Before making an end-of-life or palliative care treatment decision, guardians must make every reasonable endeavour to contact family and other key interested parties by utilising all pone number of which OPA are, or become, aware. Where a current and in service phone number is not available, the guardian must contact the Public Trustee (during office hours and where the PTO is 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 and other key interested parties.

Careful analysis of the above information indicates that OPA updated their practice standards and procedures, and also informed staff as to the changes, the reasons for the changes, and the importance of the changes.

Careful analysis of the data provided by OPA indicates that in every case, where OPA made a palliative care decision, details of the contact made with family and the views of family were recorded (or friends where there were no family members to contact).

Overall, it is pleasing that OPA, without prompting by the Office, undertook an empirical process, in the form of data collection, to test the effectiveness of their new practices to implement Recommendation 5. It is further pleasing that this data collection process is evidentiary demonstration of OPA's improvements flowing from taking steps to give effect to Recommendation 5.

Having carefully considered the information provided by OPA, I am of the view that steps have been taken to give effect to Recommendation 5.

3.6. Recommendation 6

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.

The findings of the Investigation were that in several instances, the guidance provided by OPA to delegated guardians and service providers was wrong. This guidance included OPA's policies, practice standards and templated letters.

Following the commencement of the Investigation, OPA instituted changes to its guidance which was pleasing.

Firstly, OPA introduced a new practice standard, being the *Notification to key parties on the death of a represented person*, that commenced on 11 March 2021. The Report considered the new practice standard:

> *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.

Secondly, OPA 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, namely, *After-hours calls*.

Thirdly, OPA updated the letter that it sends to service providers at the time of OPA's appointment as guardian regarding OPA's contact with the family of represented persons.

Lastly, OPA circulated an internal email 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.

The Ombudsman, in his opinion in the Report, stated:

> 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.
>
> 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;[18] 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.

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

> 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 …

For the above reasons, the Ombudsman made Recommendation 6.

The Office requested that OPA inform the Office of the steps taken to give effect to the recommendation. In response, OPA provided the following information:

> The implementation of this recommendation is complete.
>
> The following practice standards were amended to ensure guidance to delegated guardians is consistent with the recommendations of the Ombudsman's investigation:
>
> - OPA Practice Standard – Notification to Key Parties on the Death of a Represented Person
> - OPA Practice Standard – After-hours Calls
> - OPA Practice Standard – End-of-Life Care Decision Making for Represented Persons
> - OPA Practice Standard – Role of the Public Advocate as Guardian with Authority for Treatment and Health Care Decisions
> - OPA Practice Standard – Guardianship Practice.
>
> These changes were communicated to all guardians and these practice standards are included in the induction of new guardians. The standard letters to service providers and family members were amended to ensure OPA's communication with key interested parties is consistent with the recommendations of the Ombudsman's investigation.

OPA provided evidence in support of its stated progress towards the implementation of Recommendation 6, specifically:

1. *OPA Practice Standard – Notification to Key Parties on the Death of a Represented Person*;
2. *OPA Practice Standard – After hours Calls*;
3. *OPA Practice Standard – End-of Life Care Decision Making for Represented Persons*;
4. *OPA Practice Standard – Role of the Public Advocate as Guardian with Authority for Treatment and Health Care Decisions*;
5. *OPA Practice Standard – Guardianship Practice*;
6. Emails to Guardians and Senior Guardians regarding changes to practice standards;
7. Standard letter to Service Providers on appointment of Public Advocate; and
8. Standard letter to family on appointment of Public Advocate.

Careful analysis of the above information provided by OPA indicates:

- OPA updated their standard letter and practices, and also informed staff as to the changes, as well as the reasons for and importance of the changes; and
- Pleasingly, OPA's guidance to delegated guardians is consistent internally and all guidance is consistent with the recommendations of the Investigation.

Having carefully considered the information provided by the OPA, I am of the view that steps have been taken to give effect to Recommendation 6.

3.7. Recommendation 7

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.

As a result of the Investigation, it was, and remains, my 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.

The Report considered the need for OPA to provide an apology to the families of Mrs Savage, Mr Ayling and Mr Hartley:

> … expressing regret and sympathy for things that have gone wrong is a hallmark of a strong organisation …
>
> 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.

The Ombudsman, in his opinion in the Report, stated:

> 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.
>
> 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.[19]
>
> 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.

For the above reasons, the Ombudsman made Recommendation 7.

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

The Office requested that OPA inform the Office of the steps taken to give effect to the recommendation. In response, OPA provided the following information:

> The implementation of this recommendation is complete.
>
> On 8 July 2021, following the release of the Ombudsman's report, the Public Advocate, Ms Pauline Bagdonavicius contacted Ms Kaye Davis (daughter of Mrs Savage), Mr Robert Ayling Junior (son of Mr Ayling) and Mr Phillip Hartley (brother of Mr Hartley) via telephone to deliver an unreserved apology for not notifying them of their respective family members' deaths.
>
> During the telephone conversations the Public Advocate also offered to meet in-person at a time convenient to each party, to discuss the matter further, or to discuss the matter further over the telephone on that day or another day convenient to them.
>
> The Public Advocate also committed to writing to each party following the telephone conversation and providing them with her contact details in that written correspondence, in the event they wished to discuss the matter further.
>
> Following the telephone calls, the Public Advocate sent letters via the post to Ms Kaye Davis, Mr Robert Ayling Junior and Mr Phillip Hartley to again deliver an unreserved apology for not notifying them of their respective family members' deaths. The Public Advocate also provided contact details in the event they wanted to discuss the matter further.
>
> Ms Kaye Davis wanted to consider the Public Advocate's offer after she received the written apology letter. To date, Ms Davis has not contacted the Public Advocate.
>
> Mr Robert Ayling Junior lives in Albany. He planned to visit Perth in the week of 19 July 2021 and was considering meeting with the Public Advocate during that visit. He was going to make contact with the Public Advocate to arrange.
>
> Due to COVID-19 restrictions he cancelled his visit but was aware that he had an open invitation to meet with the Public Advocate at a time that was convenient to him in the future. To date, Mr Ayling Junior has not made further contact with the Public Advocate.
>
> Mr Phillip Hartley indicated that he "wholeheartedly accepted the apology" and mainly held the aged care facility responsible. He was in the process of moving and indicated he was unlikely to make contact to discuss the matter further. To date, Mr Hartley has not contacted the Public Advocate.
>
> On 8 July 2021, the Office of the Public Advocate released a media statement to publicly acknowledge the unreserved apologies being offered that day to the families of Mrs Savage, Mr Ayling and Mr Hartley for not notifying them of their family members' deaths.

OPA provided evidence in support of its stated progress towards the implementation of Recommendation 7, specifically:

1. Public Advocate letter to Ms Davis;
2. Public Advocate letter to Mr Ayling Junior;

3. Public Advocate letter to Mr Phillip Hartley; and
4. Media statement: New death notification practices introduced by WA's Public Advocate.

Careful analysis of the above information provided by OPA indicates that OPA have apologised to the families of Mrs Savage, Mr Ayling and Mr Hartley and provided the opportunity to further discuss the matter at their convenience, and in person. It is pleasing that the media statement has ensured transparency and accountability.

Having carefully considered the information provided by OPA, I am of the view that steps have been taken to give effect to Recommendation 7.

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4. Recommendations arising from the Investigation into OPA's role in notifying the families of Mrs Savage, Mr Ayling and Mr Hartley of their deaths

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.

5. Summary of Views by Recommendation

Recommendation	View
1	Steps have been taken
2	Steps have been taken
3	Steps have been taken
4	Steps have been taken
5	Steps have been taken
6	Steps have been taken
7	Steps have been taken

Major Investigations and Reports

Title	Date
A report on giving effect to the recommendations arising from the Investigation into the handling of complaints by the Legal Services and Complaints Committee	**September 2022**
A report on the steps taken to give effect to the recommendations arising from Preventing suicide by children and young people 2020	**September 2021**
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	**July 2021**
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**
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**

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