

**Investigation into the
improper release of autopsy information by a
Victorian Institute of Forensic Medicine employee**
Whistleblowers Protection Act 2001

May 2011

Ordered to be printed
Victorian government printer
Session 2010 - 11
P.P. No. 29

Letter to the Legislative Council and the Legislative Assembly

To

The Honourable the President of the Legislative Council

and

The Honourable the Speaker of the Legislative Assembly

Pursuant to section 103 of the *Whistleblowers Protection Act 2001*, I present to Parliament the report of an investigation into the improper release of autopsy information by a Victorian Institute of Forensic Medicine employee.



G E Brouwer
OMBUDSMAN

3 May 2011

Contents	Page
Introduction	5
The disclosure	5
Background – the Victorian Institute of Forensic Medicine	5
The investigation	7
Investigation methodology	7
Legislation and policy on privacy and confidentiality	9
Legislative background	9
The Victorian Public Sector Code of Conduct	9
Institute privacy and confidentiality policies	10
Improper use of autopsy related information	12
Professional background of employee A	12
Unauthorised release of information	12
Release of autopsy information concerning deceased persons referred to in the disclosure	15
Potential impact on coronial investigations	16
Unauthorised removal of records	16
Access to autopsy information	21
Conclusions	23
Recommendations	26

Introduction

The disclosure

1. On 29 September 2010 my office received correspondence from the Secretary of the Department of Justice (the department) outlining an anonymous disclosure made to the department's Protected Disclosure Coordinator. It was alleged that an employee of the Victorian Institute of Forensic Medicine (the Institute) had released confidential information to a third party. In particular, the correspondence to my office alleged that:
 - employee A, a Forensic Technician at the Institute had emailed photographs and descriptions of autopsy cases to a friend on a number of occasions
 - the information was sent from employee A's work email account to person B at a private company email account
 - employee A emailed details about the autopsies of three persons.
2. On 29 September 2010 I determined the disclosure to be a public interest disclosure pursuant to the *Whistleblowers Protection Act 2001* (the Act).

Background – the Victorian Institute of Forensic Medicine

3. The Institute was established under the *Coroners Act 1985*, later retitled the *Victorian Institute of Forensic Medicine Act 1985*. This Act sets out a number of objectives of the Institute, many of which relate to education, training and the promotion of forensic pathology.
4. The Act also refers to the Institute's key functions, including:
 - the provision of facilities and staff for the conduct of examinations in relation to deaths investigated by the Victorian Coroner
 - the examination of deceased persons under the jurisdiction of the Victorian Coroner
 - the conduct of other appropriate investigations or examinations in relation to the cause of death of any person
 - reporting to Coroners about the medical causes of deaths and the findings and results of investigations and examinations.
5. The Institute is associated with Monash University, particularly in a research, teaching and training capacity.
6. Non-executive employees of the Institute are employed by the department under a delegation to the Director of the Institute.

7. Institute staff are often privy to extremely sensitive and confidential information, including:
 - autopsy reports
 - documentation from crime scenes
 - photographs of deceased persons
 - information on investigations into causes of death.
8. Staff also acquire knowledge about the Institute's work through discussions with colleagues and others.
9. The Institute conducts autopsies and prepares autopsy reports following the Victorian Coroner's commission of an autopsy.
10. The Victorian Coroner, Judge Jennifer Coate informed my officers of the following record management processes during a meeting on 24 December 2010:
 - Approximately 10 to 15 reports regarding deaths of persons are made to the Coroner per day. These reports are registered on the Coroners Court's computer system. This computer system can be accessed by the Institute for the purposes of the Institute conducting medical investigative work on the Coroner's behalf. Forensic Technicians¹ may be privy to this material should a Forensic Pathologist² working on an investigation require the Technician's assistance.
 - There are two main computer programs within the Institute – the Institute's internal Case Management System; and the National Coroners Information System, a shared national database for Australian coronial cases.
11. Judge Coate also stated:

... autopsy reports directed by coroners to be prepared by the Victorian Institute of Forensic Medicine are provided to the investigating coroner by the Institute. It is a matter for the coroner to direct or authorise any further release of those reports ... the view that it is the coroner only who has control of the report is consistent with advice obtained from the Victorian Government Solicitor's Office ... this issue has been one of some controversy between the Court and the Institute.
12. In response to the above, the Institute said:

The single conclusion drawn in the quotation from the State Coroner is only one interpretation ... VIFM [the Institute] has also obtained independent legal advice from senior counsel that leads to different conclusions in relation to control over, and the use of information included within autopsy reports ... this situation may need to be resolved legislatively.

1 A Forensic Technician assists in admitting bodies, preparing bodies for autopsy, retrieving donor tissues and providing assistance to the Forensic Pathologist.

2 A Forensic Pathologist is responsible for identifying and examining deceased persons and providing medical explanations about the cause of death.

The investigation

13. On 30 September 2010 I wrote to the Secretary of the department stating that I determined the disclosure to be a public interest disclosure within the meaning of the Act. I advised that I was satisfied that the information provided to my office was sufficient to show or tend to show that a public officer had engaged in improper conduct as defined in the Act.
14. I also wrote to the Acting Director of the Institute at the time, to advise of my determination in accordance with the Act.

Investigation methodology

15. My investigation involved my officers:
 - examining Institute policy, particularly in relation to confidentiality and privacy
 - examining documentation from employee A's personnel file at the Institute
 - summoning and examining email data from employee A's Institute account
 - summoning and examining email data in relation to other witnesses
 - examining access logs of the Institute's electronic files
 - conducting interviews with persons within and external to the Institute
 - meeting with the Victorian Coroner
 - making enquiries with the Office of the Victorian Privacy Commissioner
 - meeting with staff from the Office of the Health Services Commissioner.
16. In the course of my investigation, my officers conducted five interviews. Two witnesses, employee A and person B were summonsed to attend for interview and produce Institute related documents in their possession which employee A had released without authorisation. Other witnesses were interviewed voluntarily.
17. Employee A was provided with the opportunity to seek legal advice prior to attending my office for interview. He was also authorised to seek legal advice to assist him in providing a response to relevant sections of my draft report.
18. Employee A was provided with all sections of my draft report that related to his conduct. Employee A's lawyer subsequently argued that he should have been provided with the whole report and transcripts of this office's interviews. I denied this request bearing in mind that the report is not solely about employee A's conduct, but also about processes within the Institute and the conduct of other persons. I did however provide employee A's lawyer with the opportunity to attend my office and listen to the audio recording of my office's interview with employee A. Employee A's lawyer did not take-up this offer.

19. I also provided employee A with an extension to allow him more time to respond to parts of my draft report that concerned his conduct. Employee A was advised that should a response not be received by my office, the report would proceed without his comments. Employee A did not respond to my draft report.
20. Person B was provided with parts of my draft report that related to his conduct. He advised my office that he did not want to respond.
21. My draft report was also provided to the Victorian Coroner, the Institute and the Secretary of the department for comment. The Secretary responded that she was 'most concerned about the serious breaches that you have found'.
22. In the course of my investigation information and potentially distressing material was discovered. I have decided not to include most of that information in this report in order to protect the families of deceased persons. I consider that my investigation identified conduct which presents a significant concern to the public and persons who have an implicit trust in the work of the Institute and its employees. It is for this reason that I decided to make this report public, although in an edited form.

Legislation and policy on privacy and confidentiality

Legislative background

23. The *Information Privacy Act 2000* was enacted to regulate the Victorian public sector's collection and handling of personal information about individuals. In accordance with policy documentation drafted during the compilation of the Act, its intention is to apply only to living persons.³ As such, the Information Privacy Act does not regulate the collection and handling of information relating to deceased persons.
24. The *Health Records Act 2001*, however does apply to deceased persons' records. The purpose of the Health Records Act is to promote fair and responsible handling of health information. According to section 95(1) of the Health Records Act:

This Act applies in relation to a deceased individual who has been dead for 30 years or less, so far as it is reasonably capable of doing so, in the same way as it applies in relation to an individual who is not deceased.
25. My officers sought advice from the Office of the Health Services Commissioner, the responsible authority for handling complaints about non-compliance with the Health Records Act. The Deputy Health Services Commissioner and a Legal Advisor informed my officers that the application of the Health Records Act in relation to autopsy information was untested therefore making it difficult to determine whether unauthorised release or use of such information constitutes non-compliance with the Act.

The Victorian Public Sector Code of Conduct

26. The Victorian Public Sector's Code of Conduct (the Code of Conduct) was issued by the Public Sector Standards Commissioner pursuant to the *Public Administration Act 2004*. It serves the purpose of promoting compliance with public sector values. The Code of Conduct is binding on most public sector employees and a breach of its values may constitute misconduct.
27. Of specific relevance to my investigation are sections 3.4 *official information*, 6.2 *privacy and confidentiality* and 6.3 *maintaining confidentiality*. These sections provide:

3.4 Official information

Public sector employees with access to official information ensure it is only used for official purposes and in an approved manner. Official and personal information is handled according to relevant legislation and public sector body policies and procedures. Public sector employees only disclose official information or documents acquired in the course of their public employment when required to do so by law, in the legitimate course of duty, when called to give evidence in court, or when proper authority has been given. In such cases comments are confined to factual information only.

³ Office of the Victorian Privacy Commissioner, *Guidelines to the Information Privacy Principles*, September 2006.

6.2 Privacy and confidentiality

Public sector employees understand the importance of privacy and confidentiality. Confidential information requires special treatment and protection. Those people who provide confidential information to public sector employees have the right to expect this information will be treated as confidential. Public sector employees with access to confidential information ensure it remains confidential, and at all times act in accordance with legislation and policies relating to dealing with private information.

6.3 Maintaining confidentiality

Public sector employees receive and manage information in such a manner that its confidentiality will be maintained and that it will not be used to advantage a prospective employer or business, or disadvantage the Victorian Government.

Institute privacy and confidentiality policies

28. There are a number of internal policy documents which are accessible to Institute staff and detail confidentiality and privacy requirements. For example, the Institute's Policy Manual states:

All aspects of the work of the Institute are privileged and subject to legal and medical confidentiality. The utmost discretion and confidentiality is required by all staff of the Institute in all aspects of their duties. Details of the work of the Institute are not to be discussed with persons outside the Institute. Records or reports of investigations, or photographs, are not to be improperly or without authority disclosed to other persons whether such disclosure is within or outside the Institute.

29. Upon commencing employment at the Institute, staff are required to sign a confidentiality agreement to acknowledge that they have read and understood the confidentiality provisions and agree to abide by these provisions. In accordance with the Institute's current confidentiality agreement, the confidentiality obligations of all Institute staff extend to information about:

- deceased persons whose deaths have been reported to the coroner (such as identity, cause of death, medical history, next of kin, photographs and images)
- patients of the VIFM's [the Institute's] clinical forensic medical services
- the nature and source of all material we [the Institute] receive for scientific analysis
- the nature and results of any examination or testing conducted
- tissue collected for donation, medical research or scientific purposes
- the medical histories and personal details of donor or recipient families, and
- approved research and teaching activities.

30. Records obtained by my office show that employee A signed the confidentiality agreement on 25 August 2004.
31. The version of the confidentiality agreement which was signed by employee A specified the following:
 - ... Records or reports of investigations, or photographs, are not to be improperly or without authority disclosed to other persons whether such disclosure is within or outside the Institute.
 - ...
 - Wilful breaches of trust and confidentiality to unauthorised persons may result in immediate dismissal and may constitute a contempt of court or criminal act.
 - ...
 - Institute staff and visiting personnel must ensure that all information pertaining to cases is not divulged to another person outside the organisation, unless specific permission is obtained from the Director or Division Head or a necessary part of the legal process ...
32. Electronic spreadsheets were provided to my office from the Institute which show employee A's access and acknowledgement of having read relevant internal policies regarding privacy and confidentiality requirements.
33. Employee A's manager at the Institute advised my officers that staff are informed about confidentiality provisions on an ongoing basis through emails, meetings and discussions.

Improper use of autopsy related information

Professional background of employee A

34. Employee A was employed as a Forensic Technician at the Institute since 1 September 2004. His employment involved shift work as the Institute is a 24-hour service and at least one staff member is rostered to work at nights.
35. The work of a Forensic Technician primarily involves:
 - admitting bodies of deceased persons
 - assisting Forensic Pathologists with autopsies
 - retrieving tissues for the Donor Tissue Bank of Victoria
 - undertaking general mortuary duties.
36. With over six years experience at the Institute, employee A has assisted with complex autopsy matters involving homicide victims, persons who died in suspicious circumstances and victim identification.
37. On 3 January 2011, shortly after being interviewed by my office, employee A submitted a letter of resignation effective as at 28 January 2011.

Unauthorised release of information

38. The disclosure to my office included the allegation that employee A had, on a number of occasions, released autopsy information to a third party without authorisation. In investigating this disclosure, I sought to establish whether information was released and, if so, the autopsy cases the information related to and the method by which the information was disclosed.
39. At interview on 20 December 2010 the nature of the disclosure to my office was put to employee A and he was provided with the opportunity to respond to the allegations against him. Employee A said:

... well I guess it's fair to say that on occasion I do send some emails to a group of people that I'm friends with – just about – I guess – work related stuff that I've found out of the ordinary or um interesting.
40. Employee A told my investigators that he had released information to his group of friends for 'probably maybe the last four or five years'. Employee A stated that there are at least 15 people in this friendship group, some of whom go on an annual bus trip together.
41. Employee A said that the earliest case in which he recalls releasing information involved:

...bizarre circumstances of somebody who asphyxiated while performing sexual acts on themselves.

42. Employee A said that he released information concerning the above described case to his friend, person B during a conversation. Employee A further informed my officers that he did not release the name of the deceased person to person B, however the information he disclosed was not available to the general public.
43. Employee A stated that at the time he did not consider the release of this information to be inappropriate but further stated that in 'hindsight it was probably inappropriate'.
44. Employee A said that he had also made comments to his friends about deaths reported in the media, stating that comments were made in conversation 'over a beer at the pub or something'. He further said that he did not believe that he disclosed information that was not reported in the media regarding high profile matters.
45. Employee A said that he had disclosed further information via email, text message or during conversation about four cases investigated by the Institute. Out of respect and concern for the victims and their families, I have decided not to identify the cases publicly. The Victorian Coroner, the Institute and the Secretary of the department have been advised of the specific cases involved.
46. At interview on 17 December 2010 person B stated that employee A provided him with information about the deaths and/or investigations into the four cases referred to above and a number of other deaths.
47. Person B said he had received information from employee A via email, during conversations and text messages. Person B described employee A as a close friend, stating:

... I [we] have that sort of relationship where we can talk to each other and trust each other ... we've kept secrets in the past for each other ... he does confide in me about a lot of things but not just work ...
48. Person B stated that he had not received or seen images or reports from employee A or in employee A's possession, however he said that employee A had disclosed information to him since he commenced work at the Institute.
49. My summons to employee A required him to provide my office with Institute related documents which he had released without authorisation. At interview, employee A presented one document to my officers. This document was a copy of an email dated 6 October 2010 and sent from employee A's Institute email address to his wife's email account. The email contained a directive to employee A from his manager concerning the appropriate recording of an earring and genital piercing found on deceased persons. The manager provided this direction to employee A through the Institute email account.
50. Employee A's wife sent a reply email to employee A's hotmail account. Employee A then forwarded his manager's email from his hotmail account to person B on 8 October 2010.

51. My officers questioned employee A about why he forwarded a confidential Institute email to other parties. Employee A said:
- ... I forwarded it to my wife because it irritated me and because of the response I gave I thought, you know, that it was something that was slightly humorous so I forwarded it to [person B].
52. At interview, employee A's manager advised that she had not authorised the email to be sent to any other persons and that the unauthorised distribution of any emails about Institute related case work is highly inappropriate.
53. Employee A said that he had sent other emails to his wife, although he could not recall the specific details of these emails. He said that his work at the Institute had caused frustration and 'mental anguish' resulting in him 'vent[ing] about things that happened at work' to his wife.
54. Employee A informed my officers that he had sent other Institute emails to his hotmail account for the purpose of responding to these emails at home. When asked if he had also distributed these emails to third parties, employee A responded:
- ... maybe yeah – possibly – oh I can't recall ... I can't recall specifically but I'll say yes ...
55. At interview, employee A was presented with a number of emails located by my investigators on employee A's or person B's work email accounts. This email data was provided to my office by the Institute and person B's employer following the issuing of summonses. One of the email chains titled 'beer and girlfriends' dated 23 August 2010 which included employee A, provided the following description of an Institute case:
- had a ripsnorter just recently ... I could indulge you all with a few details, but would need to stay within the cone. [Employee A then proceeded to describe the case in detailed and derogatory terms.]
56. At interview, employee A said that the above description related to a case that was handled by the Institute. He said that he became familiar with the details of the case after he read the police report to the Coronor and observed images on the Institute's Case Management System. Employee A confirmed that while he accessed information concerning this case, he was not assigned to work on it. He further said that he accessed the case because:
- ... it was an unusual case ... [and] would be of interest to the people in this group email.
57. I note that the description of the case was sent to 16 people, none of whom work at the Institute or are entitled to receive this information. Whether this email was distributed further by the recipients is unknown.
58. Employee A said that he sent the description of the case to his friends as a means to 'impress the group'. He confirmed that he had previously sent information regarding the same case to person B.

59. In an email dated 10 August 2010 employee A sent the following information to person B from his hotmail account:
- Thought this might tickle your 'puerile little mind' ... Had an auto-erotic asphyx. case the other week ... [Employee A then proceeded to describe the case in detailed and derogatory terms.]
60. My investigators located an email on person B's workplace account dated 10 August 2010 and titled 'I have friends that work in weird places'. The email contained the same description as that above and was sent from person B to three of his work colleagues.
61. My investigators made enquiries with the Acting Director of the Institute who confirmed that the description in the emails sent by employee A, dated 10 and 23 August 2010 appeared to be about the same Institute case. The Acting Director advised that there were enough 'unusual and distinctive features' which enabled him to draw a conclusion that both emails very likely referred to a case admitted to the Institute in 2010.

Release of autopsy information concerning deceased persons referred to in the disclosure

62. Employee A said that he was aware of an unauthorised release of information to the media concerning the death of one of the persons referred to in the disclosure to my office. When asked if he was involved in the release of this information employee A responded:
- Ah no, no direct involvement.
63. My investigators questioned employee A on his involvement. Employee A said that he sent a text message to person B describing the injuries sustained by the deceased person. Employee A stated that he did not release any further information regarding this death.
64. Person B provided a similar account, stating that employee A described the deceased person's injuries. He stated that no further information was disclosed to him in relation to this case.
65. As part of my investigation, my investigators requested logs detailing the access to the deceased person's electronic autopsy file at the Institute. The logs show that employee A accessed the ambulance report and the autopsy report on 5 August 2010.
66. At interview employee A said that he was not involved in the autopsy of this deceased person. His manager confirmed that he was not assigned to work on the case.
67. Employee A said that he had accessed medical information concerning the deceased person for the purpose of:
- morbid curiosity, yeah voyeurism I guess.

68. Employee A said that he had not released any information about the two other deceased persons referred to in the disclosure to my office. Statements from other witnesses interviewed during the course of my investigation do not support the allegation that employee A disclosed information about these two persons. An examination of the computer logs revealed that employee A did not access the electronic autopsy reports on these deceased persons through the Institute's Case Management System.

Potential impact on coronial investigations

69. The Victorian Coroner, Judge Coate was informed by my officers about the nature of the disclosure to my office and was provided with an overview of the evidence obtained in the course of my investigation. Judge Coate expressed her concern about the release of information to parties not entitled to receive it, stating:

As for sending out of emails about our material to persons on a list ... I'm deeply disturbed to hear that. That sounds to me at every level totally inappropriate conduct.

70. Judge Coate also said that the unauthorised release of information can be of significant detriment to a coronial enquiry and that such a release of information is 'absolutely and totally prohibited' without a coroner's authorisation. She gave the following example:

... Sometimes what will happen in the course of investigating what appears to be a fairly straight forward suicide, as you gather the material in, you realise that there's something now slightly untoward that doesn't match up. So umm you'll cause some more investigations to be made ... until a Coroner completes an investigation and makes a finding, it is crucial that the Coroner contains what information goes into what place and for the purposes of his or her investigation. So any information going outside ... the investigation that we control, without our knowledge or authority, in my view is absolutely prohibited and potentially extremely detrimental to our work.

71. In response to my draft report Judge Coate said:

... it was a matter of deep concern that unauthorised and inappropriate leaking of material to unauthorised persons contains deeply intimate and distressing detail about a deceased person or persons had occurred ... knowledge that this had happened was likely to add to the trauma and distress of family and friends ... and cause a lack of confidence in the institutions charged with the delicate and sensitive task of post mortem examination and reporting. Such a situation is in direct opposition to the reassurances given to families about the care and respect with which their loved ones will be treated.

Unauthorised removal of records

72. Through an analysis of employee A's emails, my investigators had reason to believe that employee A had removed documentation from the Institute and retained this information at his home.

73. At interview, employee A informed my officers that he kept the following information at his home:
- photographs of victims' remains which employee A copied onto a compact-disk (CD) from an Institute computer and transferred onto his personal hard-drive
 - autopsy reports on homicide victims
 - a scrap book with newspaper clippings relating to cases admitted to the Institute.
74. Employee A said that he kept the information at home for the purpose of:
- ... a memory aide for myself to not forget what I went through and what I've done – there's no other purpose.
- ... I guess I rationalised in my mind that it's work that I've done so it's – not that I'm entitled to them – but just for my own reference later on if I wanted to recall a case that I've worked on.
75. Employee A agreed to provide my officers with the documentation held at his home.
76. My officers attended at employee A's house on 20 December 2010. He showed them 49 hardcopy autopsy reports in the bottom of a cupboard in a spare room of his home.
77. Photographs A to C were taken at the time:



Photograph A. Cupboard in which employee A kept confidential autopsy documents.



Photograph B: A folder located in employee A's home containing autopsy reports.



Photograph C: A folder located in employee A's home containing autopsy reports of homicide victims.



Photograph D: Documents and CD obtained from employee A's residence.

78. Employee A also provided my officers with a CD of Institute related photographs which he stated he had transferred onto his portable hard-drive. My officers then accessed his portable hard-drive and obtained a copy of the photographs saved to this drive. An analysis of the CD and hard-drive data by my office shows that the photographs on the hard-drive are the same as those on the CD. In total, there were 1 279 work related photographs on the CD and hard-drive, 77 of which were of the remains of deceased persons.
79. The majority of the remaining photographs were of crime scenes and scenes of death.
80. A scrapbook of various newspaper articles collated by employee A was also produced to my officers. The scrapbook includes articles for the period April 2005 to July 2006. I note that in some instances employee A has made comments under articles such as 'admissions' and 'CT scan' or 'autopsy'. It appears that these comments reflect employee A's workplace involvement in the investigation of each case.
81. Employee A also produced a handwritten list of Institute victim identification cases and handwritten notes which appear to be copied from suicide letters of deceased persons admitted to the Institute. Documentation in employee A's home also included coronial inquest records and copies of internal Institute emails.
82. Judge Coate expressed concern about autopsy reports and photographs being located in a Forensic Technician's home, stating:

He certainly has no authority whatsoever to have that autopsy report in his possession in his home ... It has never occurred to me ... that a Technician in the mortuary has ever had possession of an autopsy report, needs an autopsy report or would ever have an autopsy report outside his or her work environment. I can anticipate that a Technician might say 'I was waiting for the toxicology report and the Forensic Pathologist had directed me to ... [edit] the autopsy report once the toxicology report came in and I had to do that piece of work ... under the direction of the Pathologist'. I'd accept that that might well be so but to have them collected in that way in one's home, I would be [interested] to hear the explanation as to why that seems to be in the course of a Technician's employment.

83. The Acting Director of the Institute was presented with the autopsy reports and photographs for comment at interview on 21 December 2010. The Acting Director was informed that the material had been located in employee A's home and was asked whether there were any circumstances in which employee A could remove such material from the Institute with approval. In response the Acting Director said:

Look, I can't. I mean the only thing I would say is that ... if he was undergoing some sort of academic study on these sorts of cases.

I don't know [employee A] well enough ... to know whether he's talked to somebody about a project or a particular area of academic study which would justify perhaps him having access to some of this material, unwisely though outside of work ... however I can't see a reason for this given the breadth of the material you have given me.

84. At interview on 23 December 2010 employee A's manager was also shown the documentation located in employee A's home. She said:

... he [employee A] has no reason to have this information at home or no reason to print out this information that I recall ...

85. Employee A's manager further said that she did not authorise the removal of records from the Institute at any time.

86. Employee A informed my officers that he had possession of autopsy documents relating to victims who died from a specific syndrome because he was compiling a research database. Employee A's manager confirmed at interview that employee A was conducting research in the area.

87. In relation to the matter of accessing material for the purposes of conducting legitimate research, Judge Coate said:

The Victorian Institute of Forensic Medicine has a research function that cannot be engaged, this is my view, without that research being properly put before the ethics committee of the Victorian Institute of Forensic Medicine ... I'd be surprised and disturbed if there was a piece of research authorised inside the Institute to allow a Technician to do this ... without such research going through the Institute's research ethics committee process and thereafter being appropriately supervised and logged.

88. I have examined the Institute's policy on the procedure for conducting research. The policy provides for the following steps:
1. discuss proposed research with a colleague and/or management regarding feasibility
 2. draft a project plan
 3. submit the project plan to the Research Advisory Committee which will review the plan for completeness, viability and merit as well as consider whether there are any risks associated with the research
 4. if the research is considered higher risk the research project will be considered by the Human Research Ethics Committee
 5. once approval is granted from the Research Advisory Committee, and if necessary the Human Research Ethics Committee, the research can commence.
89. In accordance with the above policy framework, not all research proposals are considered by the Human Research Ethics Committee. I note that the Human Research Ethics Committee comprises four Institute staff and six external persons including a Coroner, Deputy Chief Magistrate and Project Manager within Victoria Police.
90. On 5 January 2011 my investigators made enquiries with the Institute in relation to employee A's participation in research approved by the Institute. In response, my office was advised that neither the Human Research Ethics Committee nor the Research Advisory Committee had received an application regarding proposed research to be undertaken by employee A. Although employee A's manager was aware that employee A was undertaking research into deaths caused by a specific syndrome, employee A failed to register the project with the Research Advisory Committee in the first instance, as required by Institute policy.

Access to autopsy information

91. As part of my investigation, I sought to establish the type of documentation employee A had access to and whether or not such access was necessary for him to perform his role as a Forensic Technician.
92. At interview on 20 December 2010 employee A stated that his role did not involve writing autopsy reports, however he needed to view autopsy reports on occasion. When my investigators questioned employee A on what occasions he required access to autopsy reports, he replied:
- In looking at the circumstances surrounding deaths involved in my work. Instances where out of a professional curiosity I'll look at records to see how a case was finalised I guess.

93. In response to my draft report Judge Coat said:
- ... since the introduction of the *Coroners Act 2008*, a considerable amount of work has been undertaken by the Court to improve the security of coronial information generally. This work includes consideration of whether or not autopsy reports should be automatically placed on the National Coroners Information System ... [I] have consistently expressed concern about both the security of information and the appropriateness of such information being available beyond the coroner's directions.
94. Employee A's manager informed my officers that her reporting staff require her approval to access additional documentation on a case, such as autopsy reports or photographs. The process involves a written request to her outlining why access is necessary. Upon approving the request employee A's manager informs the Institute's IT staff who then ensure that such access is available.
95. Employee A's manager also said that should approval be granted for access to documentation in one case or a collection of cases, this approval does not restrict a staff member from accessing other cases without authorisation from her. For example, if a staff member is granted access to view photographs of deceased elderly persons for the purpose of a research task, access is not restricted to cases concerning the elderly. The staff member can also access photographs on other cases without authorisation.
96. This is compounded by the ease with which staff are able to download or upload information held by the Institute onto a disk or personal email. I note that computer access for mortuary staff is not restricted to one computer. Rather, staff 'hot desk' and share five computers, all of which have access to the internet. Staff are able to access personal email accounts such as hotmail from the Institute. While access to various internet sites is auditable, the content of emails through private accounts or any associated attachments is not.

Conclusions

97. The disclosure received by my office includes the allegation that employee A emailed information about the autopsies of three deceased persons. Employee A admitted that he divulged general descriptions of the fatal injuries sustained by one of these persons via text message.
98. My investigation established that employee A has, over approximately six years, on numerous occasions released confidential autopsy related information to third parties not entitled to receive the information. Details of autopsies or investigations into deaths have been released by employee A through email, text message and discussions with his friends and wife.
99. Interview and email evidence obtained during the course of my investigation demonstrates that person B in particular was a key recipient of autopsy information disclosed by employee A. However, employee A had also disclosed information to his broader friendship group. Email data obtained by my office demonstrates that information which employee A accessed from the Institute has been released to a group of at least 16 people. Whether this information was forwarded to other persons is unknown.
100. I consider that employee A's conduct amounts to a breach of the Victorian Public Sector Code of Conduct and the Institute's internal confidentiality and privacy policies.
101. It was apparent during interview that employee A's manager was concerned about the impact of employee A's conduct on the Institute and on families of deceased persons examined by the Institute.
102. The Victorian public and families of deceased persons have, in my view, an implicit trust in agencies such as the Institute to investigate deaths of deceased persons with integrity and respect. Breach of this trust reflects poorly on the reputation of the Institute and has implications for the families and friends of deceased persons.
103. I consider that employee A's actions constitute corrupt conduct within the meaning of the Whistleblowers Protection Act. In particular, section 3(1)(c) and (d) which states that corrupt conduct amounts to:
 - conduct of a public officer, a former public officer or a public body that amounts to a breach of public trust; or
 - conduct of a public officer, a former public officer or a public body that amounts to the misuse of information or material acquired in the course of the performance of their functions as such (whether for the benefit of that person or body or otherwise).

104. As employee A has since resigned from the Institute I have not made recommendations for the department to initiate disciplinary action. However, I consider that the serious nature of the allegations against him require consideration by Victoria Police in relation to the common law offence of misconduct in public office. I note that much of the Institute's work is undertaken on behalf of the Coroner and the potential for the release of information to affect a coronial investigation adversely is a significant risk and contrary to the public interest.
105. Misconduct in public office refers to an abuse of power or misbehaviour while working in the public service. While dishonesty is often an element of misconduct, it is not required in order for a public officer's behaviour to constitute 'misconduct in public office'. Rather, the act in itself requires an element of wrongfulness that impacts on the interest of the public.⁴ Pursuant to the *Crimes Act 1985*, the common law offence of misconduct in public office carries a maximum of 10 years imprisonment should the offence be proven.
106. I have therefore recommended that the Institute refer the matter to Victoria Police.
107. The ease with which employee A was able to access documentation, download photographs onto a disk and remove information from the Institute reflects the need for the Institute to review its security and auditing arrangements as well as consider restricting access to cases. In my view, access to sensitive information should be restricted to a 'need to know' basis, thereby limiting the opportunity for information to be misused.
108. I note that employee A's manager was aware of his conducting research into deaths caused by a specific syndrome, however the Research Advisory Committee and the Human Research Ethics Committee did not have a record of this research being undertaken. I note Judge Coate's view that all research projects conducted by the Institute on behalf of the Coroner should be considered by a properly constructed ethics committee on which a Coroner sits as a representative of the Court. I have therefore recommended that the process and practice by which research proposals are reviewed should be reconsidered in consultation with the Victorian Coroner.
109. The Institute has provided my office with a revised version of the ethics guidelines for research projects. I consider that the Institute should consult with Judge Coate regarding the adequacy of these guidelines, as referred to in my recommendation.
110. This investigation provides an illustration of a public officer in a trusted position misusing his authority to inappropriately release information about deceased persons to his friends. My investigation focussed on the conduct of employee A, however it has implications for internal controls and processes within the Institute and the partnership between the Institute and the Coroner.

⁴ Halsbury's Laws of Australia, 130 – Criminal Law [130-12335].

III. The Deputy Director of the Institute responded to my draft report on the Institute's behalf, stating:

I am very grateful to the Office of the Ombudsman for taking up what I believe to be a very important issue for the Institute.

As I informed your investigators at the outset the Victorian Institute of Forensic Medicine, as a medical service provider, takes matters of privacy and confidentiality very seriously and in the past has dismissed a staff member for a similar breach of trust.

... Your report has identified a number of potential weaknesses in our internal security and auditing arrangements which I believe need to be addressed and we will now be able to focus our review of these as a direct response to the issues highlighted in your draft report ...

II 2. My investigation has highlighted some tension between the Coroner's statutory role and the role of the Institute in providing autopsy reports to the Coroner. I consider that in ensuring the interests of justice are best served, the Attorney-General should consider reviewing the relationship between the Coroner and the Institute to ensure that the statutory functions of the Coroner are supported and not impeded.

Recommendations

I recommend that the Victorian Institute of Forensic Medicine:

Recommendation 1

Refer employee A's conduct to Victoria Police for its consideration in relation to the offence of 'misconduct in public office'.

The Institute's response

Accepted

[H]aving now been provided by you with the facts regarding [employee A's] actions ... his conduct should be reported to Victoria Police.

Recommendation 2

Review physical and information technology security and auditing arrangements at the Institute in consultation with the Victorian Coroner. A copy of this review should be provided to my office within three months. The review should consider:

- a) staff access to autopsy cases
- b) the appropriateness of the data uploaded by the Institute on the National Coroners Information System
- c) the ease with which Institute data can be downloaded, attached to personal emails and removed from the Institute
- d) ongoing management to minimise the risk of staff inappropriately accessing and releasing information.

The Institute's response to recommendation 2(a),(c) and (d)

Accepted

This incident and your investigation have afforded us an opportunity to review and reflect on our policies, procedures and compliance systems around the privacy and confidentiality of the highly sensitive information we work with on behalf of the Victorian Public.

The Institute's response to recommendation 2(b)

Accepted in theory

[T]he Victorian Institute of Forensic Medicine has no governance role in determining the policy regarding data items that are uploaded to or held by the NCIS [National Coroners Information System] or how they are used.

... with the recent creation of a completely separate Coroners Court case management system linked to the Victorian Courts System there is no reason why the Coroners Court of Victoria should not put in place the facilities for uploading the scientific and medical reports of the VIFM [the Institute] themselves as the reports are available to them in both paper and electronic formats ...

The Coroner's response

In response to my draft report, Judge Coate advised that the Court has undertaken a considerable amount of work to improve the security of coronial information. This has included consideration as to whether or not autopsy reports should be automatically placed on the National Coroners Information System.

Recommendation 3

Review Institute policies and practices in consultation with the Victorian Coroner to ensure that all research requiring access to autopsy documentation or other information obtained as a result of a coronial investigation is appropriately considered by a research or ethics committee on which a representative of the Court sits.

The Institute has accepted the above recommendation

I recommend that the Attorney-General:

Recommendation 4

Consider reviewing the relationship between the Institute and the Victorian Coroner to ensure that the statutory functions of the Victorian Coroner are supported and not impeded.

The Secretary of the department's response

I propose to brief the Attorney-General in support of your recommendation that he consider reviewing the relationship between the Institute and the Victorian Coroner to ensure that the statutory functions of the Victorian Coroner are supported and not impeded.

Ombudsman's Reports 2004-II

2011

Ombudsman investigation – Assault of a Disability Services client by Department of Human Services staff
March 2011

The Brotherhood – Risks associated with secretive organisations
March 2011

Ombudsman investigation into the probity of The Hotel Windsor redevelopment
February 2011

Whistleblowers Protection Act 2001 Investigation into the failure of agencies to manage registered sex offenders
February 2011

Whistleblowers Protection Act 2001 Investigation into allegations of improper conduct by a councillor at the Hume City Council
February 2011

2010

Investigation into the issuing of infringement notices to public transport users and related matters
December 2010

Ombudsman's recommendations second report on their implementation
October 2010

Whistleblowers Protection Act 2001 Investigation into conditions at the Melbourne Youth Justice Precinct
October 2010

Whistleblowers Protection Act 2001 Investigation into an allegation of improper conduct within RMIT's School of Engineering (TAFE) – Aerospace
July 2010

Ombudsman investigation into the probity of the Kew Residential Services and St Kilda Triangle developments
June 2010

Own motion investigation into Child Protection – out of home care
May 2010

Report of an investigation into Local Government Victoria's response to the Inspectors of Municipal Administration's report on the City of Ballarat
April 2010

Whistleblowers Protection Act 2001 Investigation into the disclosure of information by a councillor of the City of Casey
March 2010

Ombudsman's recommendations – Report on their implementation
February 2010

2009

Investigation into the handling of drug exhibits at the Victoria Police Forensic Services Centre
December 2009

Own motion investigation into the Department of Human Services – Child Protection Program
November 2009

Own motion investigation into the tendering and contracting of information and technology services within Victoria Police
November 2009

Brookland Greens Estate – Investigation into methane gas leaks
October 2009

A report of investigations into the City of Port Phillip
August 2009

An investigation into the Transport Accident Commission's and the Victorian WorkCover Authority's administrative processes for medical practitioner billing
July 2009

Whistleblowers Protection Act 2001 Conflict of interest and abuse of power by a building inspector at Brimbank City Council
June 2009

Whistleblowers Protection Act 2001 Investigation into the alleged improper conduct of councillors at Brimbank City Council
May 2009

Investigation into corporate governance at Moorabool Shire Council
April 2009

Crime statistics and police numbers
March 2009

2008

Whistleblowers Protection Act 2001 Report of an investigation into issues at Bayside Health
October 2008

Probity controls in public hospitals for the procurement of non-clinical goods and services
August 2008

Investigation into contraband entering a prison and related issues
June 2008

Conflict of interest in local government
March 2008

Conflict of interest in the public sector
March 2008

2007

Investigation into VicRoads' driver licensing arrangements
December 2007

Investigation into the disclosure of electronic communications addressed to the Member for Evelyn and related matters
November 2007

Investigation into the use of excessive force at the Melbourne Custody Centre
November 2007

Investigation into the Office of Housing's tender process for the cleaning and gardening maintenance contract – CNG 2007
October 2007

Investigation into a disclosure about WorkSafe's and Victoria Police's handling of a bullying and harassment complaint
April 2007

Own motion investigation into the policies and procedures of the planning department at the City of Greater Geelong
February 2007

2006

Conditions for persons in custody
July 2006

Review of the *Freedom of Information Act 1982*
June 2006

Investigation into parking infringement notices issued by Melbourne City Council
April 2006

Improving responses to allegations involving sexual assault
March 2006

2005

Investigation into the handling, storage and transfer of prisoner property in Victorian prisons
December 2005

Whistleblowers Protection Act 2001 Ombudsman's guidelines
October 2005

Own motion investigation into VicRoads registration practices
June 2005

Complaint handling guide for the Victorian Public Sector 2005
May 2005

Review of the *Freedom of Information Act 1982* Discussion paper
May 2005

Review of complaint handling in Victorian universities
May 2005

Investigation into the conduct of council officers in the administration of the Shire of Melton
March 2005

Discussion paper on improving responses to sexual abuse allegations
February 2005

2004

Essendon Rental Housing Co-operative (ERHC)
December 2004

Complaint about the Medical Practitioners Board of Victoria
December 2004

Ceja task force drug related corruption – second interim report of Ombudsman Victoria
June 2004