VICTORIAN CIVIL AND ADMINISTRATIVE TRIBUNAL

administrative DIVISION

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| REVIEW AND REGULATION LIST | vcat reference Nos. Z485/2019 & Z74/2020 |
| CATCHWORDS | |
| Review and Regulation List – findings of fact in relation to allegations of professional misconduct or unprofessional conduct by a medical professional involving nine patients – whether lack of informed consent for examinations – whether inappropriate and unnecessary physical contact – whether for a sexual purpose – some allegations established | |

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| APPLICANT | Medical Board of Australia |
| RESPONDENT | Dr Atheer Hmood |
| WHERE HELD | Melbourne |
| BEFORE | Vice President Judge Marks  Member Dr Robyn Mason  Member Dr Peter McNeill |
| HEARING TYPE | Hearing |
| DATE OF HEARING | 5, 6, 7, 9, 13, 14, 15, 20 September 2022 |
| DATE OF original ORDER | 19 December 2022 |
| date of correction order | 23 December 2022 |
| CITATION | Medical Board of Australia v Hmood (Review and Regulation) (Corrected) [2022] VCAT 1451 |

## Order

1. Proposed orders and submissions arising from the findings on fact contained in this judgment are to be provided to the Tribunal by the Board by 4pm on 30 January 2023, and by Hmood by 4pm on 24 February 2023.

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| **Judge Marks**  **Vice President** | **Dr Robyn Mason**  **Health Practitioner Member** | **Dr Peter McNeill**  **Health Practitioner Member** |

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| **APPEARANCES:** |  |
| For Applicant | Mr B Jellis of counsel, with  Mr A Sala of counsel |
| For Respondent | Mr S Reid of counsel |

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# Reasons

1. This decision concerns allegations of professional misconduct, or unprofessional conduct, made by the Medical **Board** of Australia against Dr Atheer **Hmood**. They relate to consultations he had with nine female patients over the period from February 2010 to October 2013.
2. At the time of each consultation, Dr Hmood was registered under what is known as the **National Law** (that is, the *Health Practitioner Regulation National Law Act 2009* (Qld) as applied by s 4 of the *Health Practitioner Regulation National Law (Victoria) Act 2009* (Vic)).
3. The medical profession is regulated by the National Law. The Board must refer a matter regarding a registered medical practitioner to a responsible tribunal (here, the Victorian Civil and Administrative Tribunal) where it forms a reasonable belief that a practitioner has engaged in professional misconduct. That is what happened here, in relation to Hmood’s alleged conduct with the nine patients at the centre of this case.
4. The Board alleges that Hmood engaged in professional misconduct or, alternatively, unprofessional conduct, under s 196(1)(b) of the National Law. It claims that he performed, or purported to perform a chest auscultation[[1]](#footnote-2) on nine female patients during separate consultations:
5. without obtaining any or adequate informed consent and/or providing any or adequate explanation for the examination or purported examination; and/or
6. in a manner that was not necessary and/or appropriate in the circumstances, including in that it involved inappropriate and/or unnecessary physical contact with the patient; and/or
7. for a sexual and/or inappropriate and/or non-clinical purpose.[[2]](#footnote-3)
8. This decision concerns the Tribunal’s findings as to fact in relation to the allegations. Did Hmood perform or purport to perform a chest auscultation of each of the nine patients in the manner claimed?
9. The parties agreed that once the parties have reviewed the facts the Tribunal finds have been established (in this decision), they will then make submissions regarding how the conduct is to be characterised: did it amount to professional misconduct or unprofessional misconduct under s 196(1)(b) of the National Law? They will also make submissions regarding determinations: that is, what consequences should follow. A further hearing on these matters will follow if necessary.
10. In summary, the Tribunal has found the allegations set out in the table below have been established in relation to the relevant patients. Detailed reasons for this follow.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Patient[[3]](#footnote-4) | Allegation Number[[4]](#footnote-5) | Lack of informed consent | Inappropriate and unnecessary contact | For a sexual purpose |
| BL | 1 | No | Yes | Yes |
| SD | 2 | No | Yes | Yes |
| SW | 3 | No | Yes | Yes |
| NT | 6 | No | Yes | Yes |
| HM | 9 | No | No | No |
| KT | 5 | No | No | No |
| QC | 8 | No | No | No |
| TN | 7 | No | No | No |
| FM | 4 | No | Yes | Yes |

## The hearing

1. The hearing took place via videoconference over eight days.
2. Hmood made a number of preliminary applications which were considered at the outset of the hearing. One was for reconstitution of the Tribunal under s 108 of the *Victorian Civil and Administration Act 1998* (Vic) (**VCAT Act**). Another was to strike out the Board’s allegations concerning the three patients who were not called to give evidence at the Tribunal. Another application was for the Tribunal not to admit any of the evidence of Dr Mark Overton, the medical expert the Board sought to rely on. These applications were the subject of written and oral submissions by both parties. All were dismissed, with reasons given orally. The hearing then proceeded.
3. The Board called six of Hmood’s patients to give evidence (BL, SD, SW, KT, NT and HM). It also called Dr Mark **Overton** as an expert witness. Each of the six patients had made written witness statements to the Board’s solicitors, which they adopted at the Tribunal hearing. They were cross-examined about these and gave further oral evidence. Overton adopted into evidence his expert report dated 19 November 2019. He also adopted the contents of a note of a conference held on 2 September 2022 between Overton and the Board’s instructing solicitors and counsel.
4. The Board also relied on evidence of three of Hmood’s patients (FM, TN and QC) who were not called to give evidence at the Tribunal hearing, but had earlier given evidence in related criminal proceedings. This was by way of tendering their written statements made in those proceedings, as well as transcript and audio of their earlier evidence. The audio was played in the Tribunal hearing.
5. Hmood did not give evidence at the Tribunal hearing, nor call any expert evidence. He relied on transcript of evidence he had given in earlier criminal proceedings relating to some of the incidents in question here (none of which resulted in a conviction). He also relied on information he had sent to the Board at different times in letters. All this information and evidence was included in the Tribunal Book.
6. In reaching a decision, the Tribunal has had regard to all of the materials that it was taken to in the Tribunal Book, the witnesses’ oral evidence, and the submissions made by the parties.

## Chronology

1. The following facts are adapted from a joint chronology and list of agreed facts filed by the parties.
2. In June 2000, Hmood completed his Bachelor of Medicine and Surgery at the University of Baghdad in Iraq. From this time, until November 2007, he worked as an intern, resident and subsequently, a general practitioner, in Iraq.
3. In September 2008, Hmood completed the Australian Medical Council (**AMC**) Multiple Choice Questions Examination.
4. In August 2009, Hmood commenced working at Barwon Health as a Hospital Medical Officer (**HMO**). He worked there until June 2010.
5. On about 1 September 2009, Hmood first obtained limited registration as a medical practitioner under the National Law.
6. On 20 February 2010, BL was admitted to Geelong Hospital (Barwon Health), where Hmood was on duty as a HMO.
7. On 28 February 2010, between the hours of 2.30am and 5am, Hmood attended at BL’s hospital bed. The conduct the subject of Allegation 1 is alleged to have occurred at this time.
8. At some point on 28 February 2010, BL made a report to Geelong Hospital staff about Hmood’s alleged conduct.
9. On 2 March 2010, BL made a statement to police regarding the conduct the subject of Allegation 1.
10. On 11 March 2010, Hmood was interviewed by police in relation to the conduct the subject of Allegation 1. Hmood denied the allegations put to him.
11. In June 2010, Hmood ceased working at Barwon Health.
12. On or about 12 November 2011, Hmood completed the AMC clinical examination which was a necessary requirement to achieve recognition of his Iraqi qualification.
13. On about 1 August 2012, Hmood obtained general registration as a medical practitioner.
14. In October 2012, Hmood commenced practising at the Kilmore Medical Practice.
15. At some point between February and July 2013, the conduct the subject of Allegation 7 is alleged to have taken place during a consultation between Hmood and TN, at Kilmore Medical Practice. TN attended at least seven consultations with Hmood on 12, 16 and 20 November 2012, 24 and 31 January 2013, 5 February 2013 and 21 November 2013.
16. On 15 March 2013, the conduct the subject of Allegation 3 is alleged to have occurred during a consultation between Hmood and SW at Kilmore Medical Practice. This consultation was one of five consultations between Hmood and SW, with other consultations taking place on 5, 6, 9 and 22 March 2013.
17. On 25 March 2013, the conduct the subject of Allegation 9 is said to have taken place during a consultation between Hmood and HM at the Kilmore Medical Practice. The consultation on this date was one of nine between Hmood and HM, with consultations taking place on 25 to 27 March 2013, 3 April 2013, 23 to 27 September 2013 and between May and October 2013.
18. On 27 March 2013, the conduct the subject of Allegation 2 is alleged to have taken place between Hmood and SD at the Kilmore Medical Practice. SD attended the consultation as a first time patient.
19. On 18 April 2013, SD made a statement to police.
20. On 21 May 2013, Hmood was interviewed by police in relation to the matters reported by SD. He denied the allegations put to him.
21. On 28 May 2013, the Australian Health Practitioner Regulation Agency (**AHPRA**) received a notification from Victoria Police regarding the alleged conduct the subject of Allegation 2.
22. On 30 May 2013, the Board decided to commence an investigation into Hmood’s conduct.
23. On 31 May 2013, the conduct the subject of Allegation 8 is alleged to have taken place during a consultation between Hmood and QC at the Kilmore Medical Practice. The consultation on this date was one of nine consultations between Hmood and QC, with consultations taking place on 29, 31 January 2013, 1, 4, 5 and 9 February 2013, 10 and 31 May 2013 and 3 June 2013.
24. On 4 July 2013, AHPRA informed Hmood of the Board’s decision to commence an investigation into the conduct the subject of Allegation 1, and that the investigation would be placed on hold until the conclusion of the police investigation.
25. On 29 July 2013, the conduct the subject of Allegation 4 is alleged to have taken place between Hmood and FM at the Kilmore Medical Practice. The consultation on this date was the third between Hmood and FM with the prior consultations taking place on 11 and 17 July 2013.
26. On 5 and/or 9 September 2013, the conduct the subject of Allegation 5 is alleged to have taken place during a consultation between Hmood and KT at the Kilmore Medical Practice. The consultation on this date was one of eight consultations between Hmood and KT, with consultations taking place on 7, 16 and 28 March 2013, 9 April 2013, and 5, 9, 12 and 17 September 2013.
27. On 1 October 2013, the conduct the subject of Allegation 6 is alleged to have taken place during a consultation between Hmood and NT at the Kilmore Medical Practice. The consultation on this date was the third between Hmood and NT with the prior consultations taking place on 7 December 2012 and 17 July 2013.
28. On 2 October 2013, KT reported the conduct the subject of Allegation 5 and 6 to police.
29. On 14 October 2013, AHPRA received a notification from Victoria Police regarding the conduct the subject of Allegations 5 and 6.
30. On 17 October 2013, the Board treated information they had received, about Hmood as a further notification. The Board decided to investigate the further notifications regarding the conduct the subject of Allegations 1, 5 and 6.
31. On 17 October 2013, KT made a statement to police regarding the conduct the subject of Allegation 5.
32. On 17 October 2013, NT provided evidence to police by way of a Video and Audio Recording of Evidence (**VARE**) regarding the conduct the subject of Allegation 6.
33. On 24 October 2013, an Immediate Action Committee (**IAC**) of the Board proposed to take immediate action under s 156(1)(a) of the National Law, in respect of Hmood.
34. On 31 October 2013, the IAC decided to take immediate action pursuant to s 156 of the National Law by imposing conditions on Hmood’s registration. They were:
35. Hmood will only work in a group medical practice and other sites approved by the Board.
36. Hmood will work under the supervision of a general practitioner approved by the Board.
37. Hmood will ensure that the Board receives a report from his supervisor every three months confirming his compliance with the conditions on his registration.
38. Hmood will not consult with any female patient without a parent or guardian or a chaperone present for the entire consultation.
39. Hmood will practice medicine in accordance with the Chaperone Guidelines of the Medical Board of Australia.
40. Hmood is responsible for any costs associated with the chaperone and reports to the Board.
41. Hmood will ensure that the Practice Manager and Director of Medical Services are aware of the conditions on his registration by providing them with a copy of the conditions.
42. Hmood is to provide a statutory declaration to the Board, addressed to the Compliance Officer, by the fifth day of each calendar month declaring that he has complied with the conditions on his registration at all times throughout the preceding month.
43. Hmood is to obtain Board approval prior to changing the nature or place of his practice.
44. These conditions are subject to random compliance checks by AHPRA Victoria.
45. In late October 2013, there was a report in the Northern Central local paper regarding a local doctor that was being investigated for inappropriate behaviour. SW gave evidence that seeing the article encouraged her to report the conduct the subject of Allegation 3 to the police. The Northern Central report itself was not in evidence.
46. In late October 2013, SW reported the conduct the subject of Allegation 3 to police.
47. On 2 November 2013, FM made a statement to police regarding the conduct the subject of Allegation 4.
48. On 20 November 2013, SW made a statement to police regarding the conduct the subject of Allegation 3.
49. On 10 December 2013, Hmood was charged with six counts of indecent assault and one count of indecent assault of a child under the age of 16 in respect of the conduct the subject of Allegation 1, 2, 3, 4, 5 and 6.
50. In January 2014, QC reported the conduct the subject of Allegation 8 to police.
51. On 29 January 2014, TN made a statement to police regarding the conduct the subject of Allegation 7.
52. On 5 February 2014, Hmood was interviewed by police in relation to the conduct the subject of Allegation 7 and 8. He made ‘no comment’ to the allegations put to him. On the same day, Hmood was charged with two further counts of indecent assault in respect of the conduct the subject of Allegation 7 and 8.
53. In June 2014, Hmood submits that he applied for fellowship to The Royal Australian College of General Practitioners (**RACGP**), and in August 2022 successfully completed all examinations to apply for fellowship.
54. On 25 June 2014, AHPRA received a notification from a doctor at Barwon Health advising that police had informed Barwon Health that Hmood had been charged with offences regarding one of their patients for the conduct the subject of Allegation 1.
55. On 21 August 2014, the Board decided to investigate the notification made 25 June 2014 regarding the conduct the subject of Allegation 1.
56. Between 4 - 11 May 2015, a contested committal hearing proceeded in the Melbourne Magistrates’ Court in relation to the conduct the subject of Allegations 1 - 8. Specifically, six charges of indecent assault regarding complainants BL, SD, SW, FM, TN and QC, two charges of indecent assault regarding complainant KT, and one charge of indecent act with a child under 16 regarding NT were in issue.
57. Between 3 - 13 August 2015, a trial proceeded in the County Court of Victoria, before His Honour Judge Punshon. The hearing related to the conduct the subject of Allegation 2, 3, 4 and 6. The hearing related to four indecent assault charges against Hmood, in relation to allegations made by each of the complainants SD, SW, FM, and NT. The jury returned a not guilty verdict in respect of the charges concerning SW, FM and NT. The jury could not reach a verdict in respect of SD. Hmood was acquitted of the charges concerning SW, FM and NT.
58. From 17 - 20 August 2015, a trial proceeded in the County Court, before His Honour Judge Punshon. The jury was discharged without verdict on the basis that a note was found in the jury room from the previous trial (which mentioned Hmood and a different complainant).
59. From 24 - 27 August 2015, a trial proceeded in the County Court, before His Honour Judge Punshon. The hearing related to the conduct the subject of Allegation 1, the alleged assault of BL. The jury returned a not guilty verdict. Hmood was acquitted.
60. On 9 June 2016, the charges regarding the conduct the subject of Allegation 5, 7 and 8 were discontinued.
61. From 8 - 10 August 2016, a trial proceeded in the County Court, before Her Honour Judge Hampel. The trial was a re-trial regarding the conduct the subject of Allegation 2. The jury was discharged without verdict on the basis of an article that was published in The Age.
62. On 5 December 2016, a trial proceeded in the County Court, before His Honour Judge Ryan. The trial was a re-trial regarding the conduct the subject of Allegation 2. The jury was directed to return a not guilty verdict. Hmood was acquitted.
63. On 17 December 2018, the Board decided to refer the matter regarding the conduct the subject of Allegation 1, 2, 3, 4, 5, 6, 7 and 8 to the Tribunal pursuant to s 193(1)(a)(i) of the National Law as it was reasonably believed that Hmood had engaged in professional misconduct.
64. On 4 March 2019, AHPRA received a notification from HM regarding the conduct the subject of Allegation 9.
65. On 18 March 2019, the Board decided to commence an investigation into the notification of HM regarding the conduct the subject of Allegation 9.
66. On 14 June 2019, the Board made a First Referral, relating to the conduct the subject of Allegations 1 to 8, to the Tribunal pursuant to s 193(1) of the National Law.
67. On 24 October 2019, the Board decided to refer the matter regarding the conduct the subject of Allegation 9 (regarding HM) to the Tribunal pursuant to s 193(1)(a)(i) of the National Law.
68. On 9 December 2019, the Board sought the Tribunal’s leave to amend the Notice of Allegations in the First Referral, having regard to the expert report received from Overton. The Notice of Allegations was then amended.
69. On 31 January 2020, the Board made a Second Referral, regarding the subject of Allegation 9, pursuant to s 193(1) of the National Law.
70. On 19 March 2020, the Tribunal stayed the proceedings due to the impact of COVID-19.
71. On 14 August 2020, the Tribunal consolidated the First and Second Referral proceedings.
72. By 6 November 2020, the Board and Hmood had filed the material they sought to rely on.
73. On 20 January 2021, a compulsory conference took place.
74. On 12 April 2021, Hmood confirmed that he did not intend to file any further material.
75. On 13 October 2021, the Tribunal listed the matter for a 10 day hearing commencing 31 January 2022.
76. On 18 October 2021, the Tribunal relisted the matter for hearing in March 2022.
77. On 1 March 2022, the hearing was adjourned to a date to be fixed, due to Hmood’s unavailability. It was later relisted for September 2022, and proceeded then.

## Standard of proof

1. The claims made against Hmood are serious. There is no dispute that the Board must prove its case on the balance of probabilities to the level of satisfaction set out in ***Briginshaw*** *v Briginshaw* (1938) 60 CLR 336. In other words, the Tribunal must reach a comfortable level of satisfaction in finding the relevant matters are established on the balance of probabilities, consistent with the seriousness of the allegations and in view of the serious consequences of any findings.
2. As Hmood submits:[[5]](#footnote-6)

11. The Board must prove its allegations to the Briginshaw standard. The following passage from the judgment of Dixon J at 361-2 explained the standard as follows:

“At common law two different standards of persuasion developed. It became gradually settled that in criminal cases an accused person should be acquitted unless the Tribunal of fact is satisfied beyond reasonable doubt of the issues the burden of proving which lie upon the prosecution. In civil cases such a degree of certainty is not demanded ...

The truth is that, when the law requires the proof of any fact, the Tribunal must feel an actual persuasion of its occurrence or existence before it can be found. It cannot be found as a result of a mere mechanical comparison of probabilities independently of any belief in its reality. No doubt an opinion that a state of facts exists may be held according to indefinite gradations of certainty; and this has led to attempts to define exactly the certainty required by the law for various purposes. Fortunately, however, at common law no third standard of persuasion was definitely developed. Except upon criminal issues to be proved by the prosecution, it is enough that the affirmative of an allegation is made out to the reasonable satisfaction of the Tribunal. But reasonable satisfaction is not a state of mind that is attained or established independently of the nature and consequence of the fact or facts to be proved. The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the question whether the issue has been proved to the reasonable satisfaction of the Tribunal. In such matters ‘reasonable satisfaction’ should not be produced by inexact proofs, indefinite testimony, or indirect inferences. Everyone must feel that, when, for instance, the issue is on which of two dates an admitted occurrence took place, a satisfactory conclusion may be reached on materials of a kind that would not satisfy any sound and prudent judgment if the question was whether some act had been done involving grave moral delinquency” (emphasis added).

…

14. The continued importance and application of the Briginshaw standard is apparent in the decision of Anderson v Blashki [1993] 2 VR 89, Gobbo J. His Honour after citing the passage from Briginshaw noted the following at pages 96-97

. . . When, in a civil proceeding, a question arises whether a crime has been committed, the standard of persuasion is, according to the better opinion, the same as upon other civil issues ... But, consistently with this opinion, weight is given to the presumption of innocence and exactness of proof is expected."

…

These being civil proceedings, the assault allegation is required to be proved on the lesser standard on the balance of probabilities despite the criminal nature of the allegation. But, because of the gravity of the allegation, proof of the criminal act must be "clear cogent and exact and when considering such proof, weight must be given to the presumption of innocence". See Cuming Smith and Co Ltd v Western Farmers Cooperative Ltd [1979] VR 129, at 147.

…

In applying the Briginshaw test to the facts in this case and keeping in mind the words of Lord Diplock in Mahon's Case, the nature of the allegation here demands a high standard of proof. The allegation involves a deliberate assault by way of kicking with a shod foot of some force when the patient was lying on the floor. There is no question of accident or negligence. The extremely deleterious effect the finding has upon the plaintiff's character, reputation and employment prospects demand a weight of evidence that is commensurate with the gravity of the allegation.

15. Like the situation in Blashki, Hmood is being accused of a sexual, inappropriate or non-clinical purpose. Applying Gobbo’s J words here, given the extremely deleterious effect the finding has upon Hmood’s character, reputation and employment prospects it demands a weight of evidence commensurate with the gravity of the allegation.

16. Anderson v Blashki has been cited with approval at the Tribunal in 16. this list see Medical Board of Australia v Kanathigoda [2012] VCAT 75 at [66] – [67]

…

66. In Anderson v Blashki [1993] VicRp 60; (1993) 2 VR 89 at 95-96 the Supreme Court stated as follows:

These being civil proceedings, the assault allegation is required to be proved on the lesser standard on the balance of probabilities despite the criminal nature of the allegation. But, because of the gravity of the allegation, proof of the criminal act must be ‘clear, cogent and exact and when considering such proof, weight must be given to the presumption of innocence’ ... The extremely deleterious effect the finding has upon the plaintiff’s character, reputation and employment prospects demand that a weight of evidence that is commensurate with the gravity of the allegation.

67. Applying that standard to the allegations before us (except allegation 2(b) which we will deal with below), we are of the view that the required satisfaction of proof has not been met. On the evidence before us, we are not satisfied that the examination as described by CZ, or any examination at all, took place on 7 January 2010. That is, we are not satisfied that the respondent performed an examination on CZ in the consultation on 7 January 2010 in the manner described by CZ or at all. We make this finding on the basis that the evidence given by CZ is unsatisfactory and we believe it would be dangerous to rely upon the same. Thus, the allegations made herein except for the allegation in paragraph 2(b) of the allegations will be dismissed…

1. Hmood submits that the way the Board conducted its case was unfair, and so findings regarding the allegations cannot be made to the *Briginshaw* standard:

[2] There is an unfairness in the manner in which the Board is conducting its case. It requires Hmood and the Tribunal to work through and reconcile, in many instances, multiple versions of events given by various complainants, sometimes under oath and at multiple forums. The majority of the alleged events are approaching 10 years of age and the matter concerning witness BL is in excess of 12.5 years old. Proper analysis of materials contained in the Tribunal Book reveals that there would be no basis to arrive at findings to the allegations set out in the two Notices of Formal Hearing to the *Briginshaw* standard of proof.

1. However, the Tribunal disagrees that the manner in which the Board conducted its case is unfair. Relevant material has been put before the Tribunal, witnesses called and submissions made as to the weight to be given to different matters. Where witnesses gave evidence in other forums, the weight to be given to that evidence has been considered. The allegations are indeed more than nine years old, but many were the subject of contemporaneous or near contemporaneous complaint. The Tribunal has taken the length of time since the events complained of into account, together with the various statements and evidence made by the witnesses, in weighing up the evidence and reaching its findings. The Tribunal has the requisite satisfaction of the findings made below (the *Briginshaw* test).

## Tendency evidence

1. The Board sought to rely on tendency evidence (in a manner consistent with s 97(1) of the *Evidence Ac*t *2008* (Vic)) in relation to some of the allegations. In final submissions, it said that tendency reasoning in this instance ‘is useful in an overarching way to properly contextualise’ Hmood’s behaviour.
2. In its initial submissions, the Board submitted:

282. Tendency evidence is evidence, which may be accepted, to prove that a person has either a tendency to:

(a) Act in a particular way; or

(b) Have a particular state of mind.

283. It can be used to find it more likely that the account of the witness is accurate and therefore the allegations are made out.

284. Tendency evidence does this by virtue of allowing a Tribunal of fact to infer that a person's behaviour is indicative of either a tendency to act in particular way to a tendency to have a particular state of mind and – once satisfied of such a tendency – the Tribunal of fact may infer a person behaved in accordance with that tendency on other occasions.

1. In its final submissions, the Board stated:

287. …at its heart the tendency in this matter is relatively simple – Hmood has a tendency to use the performance of purported examinations in the left lateral recumbent position on female patients to engage in inappropriate touching of the patients. His intention is not clinical, but selfish and sexual.

288. To that end the Board submits that the Tribunal will be comfortably satisfied that:

(a) the inappropriate touching has two components;

(i) prolonged and inappropriate touching of their chest (breast) area; and/or

(ii) inappropriate and uncalled for pushing of his groin into their body;

(b) the state of mind on behalf of Hmood – that is his intention to utilise an examination in the left lateral recumbent position – is for non-clinical reasons and for his own purposes.

1. Hmood submitted that tendency evidence should not be relied on.
2. The Tribunal does not rely on tendency evidence.
3. Where allegations have been found to be established, the evidence the Tribunal accepted was sufficient without more being needed. And where the Tribunal did not find particular allegations established, the overall weakness in the evidence related to those allegations could not be elevated – into amounting to satisfactory proof – by relying on tendency evidence. The devil is in the detail, as the saying goes, and in those cases the necessary detail of the examinations was not established.

## Expert evidence of Dr Overton

1. Each of the allegations refers to the relevant patient being placed in the left lateral recumbent position (**LLRP**) for an examination (or purported examination) by Hmood. It is claimed that in each case the examination was done:
2. without obtaining any or adequate informed consent and/or providing any adequate explanation for the examination or purported examination;
3. in a manner that was not necessary and/ or appropriate in the circumstances, including that it involved inappropriate and/or unnecessary physical contact between Hmood and the patient; and
4. for a sexual and/or inappropriate and/or non-clinical purpose[[6]](#footnote-7).
5. Overton gave expert evidence as to the following general matters: the role of a general practitioner; the training general practitioners receive to conduct a chest examination in the LLRP; and the clinical purposes of such a chest examination. He then considered, for each of the patients, the presenting complaint, reported and recorded history (in clinical notes) and any identified concern regarding the manner in which the examination was performed. He went on to refer to what he said was required to be given to each patient by way of explanation for the purported examination, and to give his opinion on the adequacy of what he had been told was said by Hmood, in giving his view as to whether informed consent was obtained.
6. The Tribunal accepts Overton’s expert report and evidence. He is well qualified. He was cross-examined and not shaken in his fundamental conclusions. Overton’s evidence was well reasoned, and consistent with common sense and the experience of the medical members on this Tribunal panel. Hmood did not call any expert witness to state the contrary to Overton’s evidence and opinions.
7. As the Board submits:

28. There was no challenge to expertise and qualifications of Dr Overton. This was addressed in his report. He is a fellow of the RACGP and an experienced general practitioner, who has practised in Victoria, Hong Kong, Mainland China and New Zealand. He has worked in international detention centres providing treatment to Vietnamese refugees. He has experience working in a hospital context, including as an emergency department doctor at the Cabrini Hospital and Freemason Hospital in Melbourne.

29. He has practised as a general practitioner for more than thirty years.

30. As he explained in his evidence, his opinion is based on his education, training and experience , and positions held in training and evaluating candidates for fellowship with the RACGP: “what I was basing my opinion on was my over 30 years of experience and general practice including the training of GP Registrars, being an examiner for the College exam …”

1. Overton was cross-examined on whether his opinions were affected by the knowledge Hmood had been involved in criminal proceedings in relation to some of the patients, or that it compromised his objectivity. The Tribunal accepts Overton’s evidence that this did not affect his opinions, or compromise his objectivity. It agrees with the Board’s submissions about this:

[35] An attempt was made to impugn the evidence of Dr Overton, on the basis that he had been informed that there had been criminal complaints made by the various patients. That challenge was misplaced. In his report, Dr Overton explains, for each patient, the particular facts and assumptions to which he has had regard. He refers to the clinical notes and features of the patient’s presentation. He says nothing about a criminal complaint. That is to be expected, and is consistent with his evidence that it is not relevant, because he bases his opinion on the standards of the profession, which do not change whether or not there has been a criminal complaint. As he said to the Tribunal: “I was careful to put those allegations apart from the medical situations I was asked to give an opinion on” and that, regardless of allegations, the standard of practice is the same.

1. Overton gave evidence in relation to matters of conduct of medical practice, specifically in a general practice setting (part 1 of his report). The Tribunal accepts that evidence (which was not seriously challenged, and was not the subject of any contradictory expert evidence). It is summarised by the Board as follows:

39. General practice is different from hospital medicine. It involves a focussed targeted examination on the basis of the patient’s age, presenting symptoms and history.

40. For adults, if there were a history of respiratory symptoms, such as breathlessness or a cough, or a suspicion of a heart problem on the basis of chest pain or other symptoms, a GP’s general chest examination would include an abbreviated version of a combined heart and lung (chest) examination.

41. This would take the form of:

-   Explaining the purpose of the examination and obtaining the patient’s consent

-   Inspection eg. observing the patient for signs such as chest wall shape, breathing pattern, surgical scars, respiratory distress, finger clubbing, leg swelling, anemia, cyanosis.

-   Taking the patient’s vital signs if indicated i.e. blood pressure and heart rate, temperature, oxygen saturation, respiratory rate.

-   Palpation eg. if there was a history of lumps on the chest, examining those. Examining for tenderness any areas where the patient reported pain.

-   Percussion. This involves tapping the patient’s chest at the back to check for fluid in the lungs – in practice, this would only be done by a GP if the next step (auscultation) showed that there was decreased air entry in a part of the lungs.

- Auscultation i.e. listening to the patient’s lungs and heart with a stethoscope.

42. In the GP setting, it would rarely be necessary to examine the patient in the left lateral recumbent position. If done, the purpose would be to listen specifically for the S3 and S4 heart sounds and the sound of a mitral valve lesion.

43. This could be done if the patient presented with a history of a mitral valve disorder or murmur and the GP wanted to check, or if the patient presented with conditions that are rarely seen in general practice: (i) SBE; (ii) rheumatic fever (uncommon in major cities), (iii) scarlet fever (a bacterial throat infection mainly occurring in children 4 to 8 years).

44. Dr Overton has never diagnosed rheumatic fever in an urban setting in his career.

45. The examination is only done as part of a specialist heart examination and is not needed in a GP setting when the presenting problem is a lung issue.

46. A cardiac lesion is not something a GP can rule out pretty quickly with the performance of an examination with a stethoscope. In general practice, if you’re concerned about mitral valve lesion, then the GP would go on to arrange an echocardiogram. In answer to a question from Member McNeill, he agreed that if a GP is really concerned about rheumatic fever, they would go straight to performing an echo and may do an ECG as well.

47. Breathing heavily is not an indication for an examination in the left lateral recumbent position. Had this been a concern you would expect: vital signs to be recorded, listen to heart and lungs, and take a proper history from the patient. The concern would also be documented. You would also expect an explanation of the examination to the patient.

48. Dr Overton could not understand why a GP, on the clinical notes with which he was provided, would need to do a left lateral cardiac examination

49. A period of five to fifteen seconds would normally be long enough to determine if there was any abnormality in the heart sounds in this position. If an abnormality was detected, then the doctor may need to listen for a further 10 to 20 seconds to enable a good assessment of the abnormality.

50. It is not usual or necessary for the body of the doctor to be in contact with the body of the patient during left lateral recumbent examination of the chest.

51. Dr Overton acknowledged in response to narrow and leading questions, that it is possible for inadvertent or incidental contact to be made with a patient while performing a cardiac examination in the left lateral recumbent position. However, he said that a medical practitioner would be expected to be aware of that, and adjust. He also made clear in re-examination, that the conduct described by the patients in this case could hardly be described as inadvertent or incidental.

52. It is possible to examine a patient in the left lateral recumbent position without pressing your body against the patient’s body. It does not depend on the practitioner’s height, indeed, “if they’re tall, then there would be less chance of inadvertent contact”.

53. The examiner’s body would not be resting on the back of the patient.

54. The examiner’s body would not be down towards the bottom of the back of the patient. He said “the examination should be nowhere near the backside”. This does not depend on the height of the doctor either.

55. There is never a reason to rub or cup the patient’s breasts when a patient in the left lateral recumbent position.

56. If a chest examination (including a heart examination) was done in the left lateral recumbent position, the clinical record should record this by stating what was done and the findings of the examination.

57. You should see a relevant history of cardiac symptoms that are present or negative.

58. If the practitioner was concerned about a differential diagnosis of rheumatic fever, you would expect that to be recorded in the clinical notes. So too with orthostatic hypotension.

59. When a male doctor plans to perform a chest, heart or lungs examination of a female patient, he needs to obtain consent from the patient. For a chest examination, this can be as simple as saying to the patient, “You have a cough and fever, can I listen to your chest to make sure there is no signs of pneumonia”. The patient can then nod or verbalise consent, or decline to be examined.

60. If the examination involves an intimate body part (such as around the breast area), then it would be appropriate to explain in more detail the reason for the more intimate examination and ensure the patient consents, offer a chaperone, offer the patient privacy (such as behind a curtain) to prepare for the examination, covering such as a sheet while doing the examination, and to tell the patient afterwards what has been found by the examination.

61. After an examination, the patient ought to be informed by the doctor of the findings of the examination. In the example above, the doctor may say, “Your lungs sound clear, there is no sign of pneumonia”.

1. Hmood submits that expert evidence is not required at all, to assist the Tribunal in this case, as the Tribunal panel comprises two experienced medical practitioners and a vice presidential member ‘clearly capable of assessing the evidence’.
2. The Tribunal rejects that submission. Expert evidence is both required and helpful. The medical expertise of those on the Tribunal panel hearing the case will not necessarily overlap precisely with issues in any particular case, and it is important that evidence is able to be tested.
3. Hmood also submits that Overton’s evidence ‘impermissibly corroborate the evidence of the complainants’. The Tribunal disagrees. Overton gives his expert opinion on the basis of assumptions. He does not ‘corroborate’ them. If those assumptions were not established on the evidence before the Tribunal, his expert evidence would not be relevant.
4. Hmood submits that Overton was asked to comment (and should not have been) on the ultimate issues in the case, such as consent and the appropriateness of the examinations.
5. However, the Tribunal is satisfied that what constitutes informed consent is an appropriate subject of expert evidence. Whether it was given or not is a matter of fact to be established for each allegation. The same is the case in relation to the appropriateness of the examinations and other matters about which Overton gave evidence.
6. Hmood further challenges Overton’s expertise in relation to giving his opinion about LLRP examinations:

[30(d)] ... Dr Overton stated that he does not perform a LLRP examination and as such he cannot be seen to have any particular expertise on the subject. He had no knowledge as to its use, no knowledge of how other practitioners perform the examination and no actual knowledge on the specific factors in this proceeding. For example:

i. He has never observed another practitioner performing a LLRP in their place of work

ii. He made no reference in his report to any data, study pointing to its use or otherwise in general practice T

iii. He never made any enquiries about Hmood’s qualifications and training

iv. He made no enquiries as to Hmood’s height

v. He never made any enquiries about the height of the treatment bed

vi. He made no enquiries about the width of the treatment bed

vii. He gave no consideration to the height of Hmood in preparation of his report

viii. He did not ask for any information as to the sizes and physical dimensions of the particular patients concerned

1. The Tribunal is satisfied that given his experience generally, Overton is able to give expert evidence regarding when, clinically, a LLRP examination is required.
2. Overton was cross-examined about issues regarding Hmood’s height, the width of the treatment bed, and the size and physical dimensions of particular patients concerned, and whether he had taken these things into account in giving his opinion. He was very clear this made no difference to his opinion, which the Tribunal accepts.
3. The Tribunal takes into account the following matters which Overton agreed with in cross-examination (as Hmood submits):

[31] …

i. The LLRP is not a novel way of listening to the heart with a stethoscope

ii. That GPs are trained to perform the LLRP

iii. That it is expected knowledge of the RACGP Fellowship Examination

iv. That there is a permissible degree of subjective decision making between general practitioners in relation to whether they utilise the LLRP

v. That he assumed the Australian Medical Course (AMC) for recognition of an International Medical Graduates would include reference to the LLRP

vi. That in the performance of the LLRP examination there is the possibility of inadvertent contact between practitioner and patient during the performance of it

vii. That inadvertent contact can occur whilst a doctor is performing a legitimate examination,

…

33. Overton also agreed that in the performance of a LLRP examination that it was possible for “inadvertent and unintended contact with a female patient’s breasts as the stethoscope is being manoeuvred as part of the examination” .

## Informed consent

1. The Board alleges that adequate informed consent was not given for the examinations performed, and in particular that no explanation was given by Hmood when he performed an LRRP examination.
2. Overton’s report gave his opinion of what amounts to informed consent:

“A patient needs to give consent before undergoing any examination, investigation, procedure or treatment. In many instances, this consent is implied; for example, a patient holding out their arm to have their blood pressure checked”.

https://www.racgp.org.au/download/documents/AFP/2011/April/201104bird.pdf

As noted in the above quote, when a male doctor plans to perform a chest, heart or lungs examination of a female patient, he needs to obtain consent from the patient. For a chest examination, this can be as simple as saying to the patient, “You have a cough and fever, can I listen to your chest to make sure there is no signs of pneumonia”. The patient can then nod or verbalize consent, or decline to be examined.

If the examination involves an intimate body part (such as around the breast area), then it would be appropriate to explain in more detail the reason for the more intimate examination and ensure the patient consents, offer a chaperone, offer the patient privacy (such as behind a curtain) to prepare for the examination, covering such as a sheet while doing the examination, and to tell the patient afterwards what has been found by the examination.

## Inferences regarding purpose of examinations

1. Allegations are made regarding each of the nine patients that Hmood’s conduct was for a sexual purpose.
2. The Board made the following general submissions about this:

9. In light of the evidence of Dr Overton, the Tribunal should be comfortably satisfied that the conduct of Hmood was for a non-clinical and sexual purpose. It is tolerably clear that in each case:

9.1 examining the patient in the left lateral recumbent position gave Hmood the opportunity to press his body into the rear backside area of the patients and to conduct an examination on or around their breasts;

9.2 the purported examination was not clinically necessary having regard to the patient’s presenting issue;

9.3 no meaningful attempt was made by him to explain any clinical reason for the purported examination to the patient;[[7]](#footnote-8)

9.4 the purported examination was conducted in a manner that involved unnecessary and avoidable physical contact. Hmood unnecessarily positioned himself behind the backside of the patients and pressed into them (sometimes moving rhythmically). Some patients felt his fingers on and in between their breasts. For Ms BL, among the most clear and stark examples, her breasts were cupped and rubbed by Hmood, while alone in a hospital bed in the middle of the night. For HM, the touching did not stop even when she told him she was uncomfortable;

9.5 the purported examination went on for longer than it should have;

9.6 the purported examination was not documented in the clinical notes or followed up.

1. Hmood, on the other hand, says that there is insufficient evidence to support that inference being drawn for each patient. He submits that:

279. The Board asks that an inference be drawn that Hmood conducted the examinations for a sexual, inappropriate or non-clinical purpose. There is insufficient evidence to support such an inference. In order to reach this conclusion, the Tribunal must accept the evidence of the complainants at its highest, in light of the cross examination the evidence does not get there. These were all routine, standard, accepted chest auscultation examinations on patients whose presenting complaint, symptoms and possible differentials justified the exam.

280. The Board in support of the inference it seeks relies, in part, upon Hmood’s clinical notes being insufficient and showing some sinister purpose. This should be rejected. If there was a sinister design, which is denied, presumably, it would have been in Hmood’s interest to have included these matters in his notes. The inference is not capable of supporting the conclusion urged upon the Tribunal.

281. The Board also seeks an inference to be drawn from the proposition that these examinations were not clinically indicated, necessary or appropriate and that this shows a sinister purpose and the exams were conducted for a sexual, inappropriate or non-clinical purpose. This must be rejected having regard to the evidence of the “circumstances” of the various consultations that reveal an appropriately conducted examination.

282. In regard to the proposition that “none of the patient’s accounts were undermined in cross examination on any significant matters”, it is put on behalf of Hmood that this misses the point. The witnesses who gave evidence in this matter described the course of a consultation and the performance of a chest auscultation examination that was appropriate in the circumstances. The various description of the contact that occurred and their feelings and impression of that contact are insufficient to prove any sinister motivation.

283. In regard to the proposition that the duration of examination itself is capable of supporting the inference of a sinister purpose this must be rejected also. There is simply no firm evidence from any patient as to the length of time of the examination.

284. In regard to Hmood’s body position the Board urges a conclusion that Hmood positioned his body for a sexual purpose. This must be rejected. The evidence of the complainants is that contact was made while Hmood conducted the examination and contact occurred during its performance. Given the seriousness of the allegation there needs to be clear, cogent and exact evidence and careful consideration of such proof with weight to be given to the presumption of innocence’. This high threshold has not been met.

285. In regard to the proposition that an inference is to be drawn from unnecessary contact occurring only when the female patients are alone and that this is shows a sinister purpose, must be rejected. The consultations in the Notice occurred in circumstances where it was appropriate to perform the exam and who was or was not there is not relevant to that question.

286. The inferences asked to be drawn by the Board of a sexual, sinister or improper purpose with reference to the evidence does not, with reference to the Briginshaw standard, get there.

1. The Tribunal does not draw any inference from the fact that patients were alone when the examinations occurred. Patients are often alone with doctors. However, for each of the patients where it is satisfied that contact occurred for a sexual purpose, the Tribunal makes this finding on the basis that it is satisfied of the facts it sets out for that patient. It takes into account all those circumstances, including where there is no apparent clinical basis for a particular examination. It draws the inference that the examination was conducted in a particular way for a sexual purpose only where it is satisfied to the necessary standard that there was no other realistic reason for it to have occurred that way.
2. The Tribunal has not found that there was a lack of informed consent in relation to some of the consultations. It notes, however, that consent to an examination is not the same as consent to the *manner* in which it was done. It has found that some of the examinations (for which informed consent was given) were conducted in an inappropriate manner, for a sexual purpose.

## Evidence of patients

1. Six patients gave evidence at the Tribunal hearing. The Tribunal considered their evidence honest, and formed the view each was recounting what they recalled to the best of their ability. It was clear that something had happened for each of them that they found traumatic enough to make reports of it, and that certain aspects of the consultation and examination stood out, whilst other parts had receded into the mists of memory. That is something that occurs with memory over time.
2. Three patients about whom allegations are made did not give evidence at the Tribunal hearing. However, each of these made a police statement (variously, between four months and a year after the relevant consultation), which each confirmed in sworn evidence at a committal hearing. Each was cross-examined at that committal hearing, and the Tribunal heard an audio recording of that evidence.
3. The Board filed an affidavit of Ms Louisa Ashton, solicitor for the Board, explaining why these three were not called. The Tribunal accepts that these patients were asked to give evidence, and did not want to give evidence yet again – having given some previously. In the circumstances, the Tribunal does not draw any inference that the evidence of these patients, had they given it at the Tribunal hearing, would not have assisted the Board’s case. It simply considers what evidence there is about these allegations.
4. As set out below, the evidence of FM has satisfied the Tribunal to the *Briginshaw* standard that part of the allegations concerning Hmood’s consultation with her is made out. The Tribunal is not satisfied regarding the allegations concerning TN and QC.

## Evidence of Hmood

1. Hmood did not give evidence at the Tribunal hearing. No adverse inference can be drawn against him, or is drawn against him, arising from that. However, the fact that he did not give evidence means that the Tribunal has no direct evidence from him to contradict the patients’ evidence of what occurred.
2. Hmood relies in part on what he has said previously on some of these matters, including in letters sent by his lawyers in response to the Board/AHPRA’s investigations, in a police interview concerning BL and SD, and on transcripts of evidence he gave at criminal trials concerning SW, NT, SD and FM.
3. The Tribunal gives limited weight to these earlier statements and evidence. However, it accepts the Board’s submissions regarding the earlier statements made by Hmood, and his earlier evidence:

26. His responses to the allegations, as can be ascertained, are inconsistent or directed to peripheral issues, or have no basis in the actual evidence:

(a) He has claimed that “he ensures that he obtains the patient’s informed consent and he explains to the patient the nature of the examination, the reason for the examination, what the examination involves, and why the examination is necessary” But he did not put to this to the patient witnesses who gave evidence before the Tribunal. There is no evidence of any thorough explanation of the examination and its purpose. To the contrary, what was put by his counsel to the various witnesses was much more limited, typically to the effect that he had said he wanted to ‘listen to the patient’s chest’. Moreover, no explanation is recorded in the clinical notes;

(b) For each of the patients he has claimed that there was a clinical indication for the examination. There is no relevant differential diagnosis noted. Nor any findings on examination, or relevant diagnosis made or excluded. He served no expert opinion that there was any clinical indication. He gave no evidence in this proceeding seeking to explain and justify any alleged clinical indication. Questions put by his counsel to Dr Overton (asking, for example, about any potential need to examine for certain differential diagnoses never documented by Hmood) are not evidence that he was concerned about such diagnoses at the relevant time;

(c) Further to the above, whether there was a legitimate clinical indication for the performance of a heart examination in the left lateral recumbent position is not the sole issue. It must be considered together with the appropriate manner in which the purported examinations were also conducted.

(d) It has been suggested on behalf of Hmood that the lack of any differential diagnosis, or findings on examination, in the clinical notes, is explained because he only notes positive findings. There is no evidence from Hmood that this is his practice. If it is his practice, it is not consistent with the expected standards of the profession. In any event, it is disproved by the clinical records that have been produced. For example, in an earlier consultation with NT (not the subject of any allegation), Hmood *did* record a differential diagnosis of “rhematic fever?” and *did* record his findings on examination “no murmur”. Thus the asserted practice of not recording differential diagnoses, or negative findings on examination, for which there is no direct evidence, is contradicted by the very records that are before the Tribunal;

(e) For each of the patients he said that any contact was incidental and inadvertent and that it was inappropriate. However, none of the patients described inadvertent or momentary touching. They described ongoing contact. In many cases, there are further features of the contact inconsistent with the suggestion that it was inadvertent, including the cupping and rubbing of the breasts described by BL, the fingers between her breasts and movement against her buttocks described by SD, and the failure of Hmood to move more than slightly from HM even after she told him he was too close;

(f) One suggestion has been that perhaps Hmood’s contact with the patients was inevitable because of his height. This is nonsense. As explained by Dr Overton, the height of the practitioner makes no difference (indeed a taller practitioner, like Hmood, would find it easier to avoid unnecessary contact). If for some reason it did, appropriate adjustments could be made. Further, Hmood has in substance accepted the obvious point that it is possible to examine a patient in the left lateral recumbent position without contact from behind, his solicitors claiming in a later response to the Board “he is now very conscious of the need to be vigilant to keep his personal space separate from that of the patient when conducting a physical examination of a patient in the left lateral recumbent position”;

(g) Even after Hmood was interviewed by the police in response to complaints about examinations conducted in the left lateral recumbent position, he did not stop his behaviour. For example, SW, HM (after police interview for BL), FM, KT, NT (after police interview for BL and SD);

…

(j) It was suggested to some patients that they had felt contact from Hmood, but had not seen it (because he was standing behind them). This is no reason to discount their evidence. As was explained in *Ng v Health Complaints Commission*:[[8]](#footnote-9) “The Plaintiff’s approach appeared to be one of elevating the sense of sight over other senses. The mere fact that a person does not see something occurring does not make the experience any less reliable if they merely heard or felt or perhaps even tasted or smelt something, if the other senses are relevantly involved in the experience."

## Effect of delay

1. The events in question occurred between nine and ten years ago, and the evidence needs to be carefully evaluated given that effluxion of time.
2. Hmood emphasises (and the Tribunal accepts) the need for caution where there is a long period between an event and when it is recalled:

19. In the context of criminal proceedings, McHugh J, in *Longman v The Queen* [[1989] HCA 60](http://www.austlii.edu.au/cgi-bin/viewdoc/au/cases/cth/HCA/1989/60.html);  [(1989) 168 CLR 79](http://www.austlii.edu.au/cgi-bin/LawCite?cit=%25281989%2529%2520168%2520CLR%252079)(at 107) made the following observations about the fallibility of human recollection in testifying about incidents of sexual misconduct:

"The fallibility of human recollection and the effect of imagination, emotion, prejudice and suggestion on the capacity to 'remember' is well documented. The longer the period between an 'event' and its recall, the greater the margin for error. Interference with a person's ability to 'remember' may also arise from talking or reading about or experiencing other events of a similar nature or from the person's own thinking or recalling."

20. His Honour as an appeal justice on the NSW Court of Appeal expressed a similar note of caution in *Herron v McGregor* (1986) 6 NSWLR 246 at 254-255 where he cited the difficulties occasioned by delay, even of five or six years, as recounted by Street CJ in the Humphreys Royal Commission,

"In the intervening five or six years, rumours waxed and waned. In some cases suspicion underwent subtle change to belief, which itself progressed to reconstruction, which in turn escalated to recollection. No presently stated recollection could be safely assumed not to have progressed upwards and not to be the product of one of these earlier stages. The sheer frailty of human memory of necessity required a most anxious and critical appraisal of the evidence of the witnesses, no matter how credit-worthy they might be. It became apparent that in the years since August 1977 the recollections even of those with undoubted first-hand knowledge have in some instances faded, in some instances fermented, and in some instances expanded. Moreover, in many cases the realisation of the significance - indeed, the enormity - of what had occurred has tended to transmute into a more or less cynical acceptance of what had, or was believed or rumoured to have, taken place."

1. The Tribunal’s findings in this case give greater credence to the earliest statements of events made by the patients. Some patients reported their concerns within a few days or weeks of their consultation with Hmood. Others reported the conduct the subject of the allegations to police later, but before there was any media reporting. Others say they had reported it to family or the medical clinic or hospital at the time. Some say they came forward after seeing the October 2013 media report which referred to an unnamed local doctor.
2. Clinical records for each patient are in evidence. The Tribunal takes into account that these do not state a differential diagnosis to justify the LLRP examination, document findings of the examination, nor refer to any appropriate follow-up or findings. The Tribunal accepts Overton’s evidence that these elements of recordkeeping would be expected from an examination carried out for a genuine purpose.

# Patient BL (Allegation 1)

1. The allegation concerning BL relates to events that occurred early in the morning of 28 February 2010 at Geelong Hospital, when Hmood attended AK’s hospital bed.
2. On 2 March 2010 (three days after the alleged conduct occurred), BL reported the matter to the police and made a written police statement.
3. On 11 March 2010, Hmood was interviewed by police, and denied the allegation put to him.
4. On 4 May 2015, BL gave evidence at a committal hearing.
5. On 19 August 2015, BL gave evidence at a criminal trial.
6. On 4 June 2019, BL signed a witness statement prepared by the Board’s solicitors.
7. On 7 September 2022, BL gave evidence at the Tribunal hearing.
8. The Tribunal finds BL was honest in giving evidence at the hearing and that her evidence regarding fundamental aspects and critical issues remained consistent over the times when she has given evidence over the years.
9. The Board submits:
10. Dr Hmood was not her treating doctor.
11. She was starting to feel better by 27 February 2010.
12. On the evening of 28 February, she woke to see a person she now knows to be Dr Hmood standing next to her bed.
13. The purported examination that occurred had two parts:
14. She said:

“The first part involved me lying on my back. … I turned my head so that my face was away from the doctor to give him room to put his hand down the neck of my jumper. I was wearing a bandeau or tube-style crop top underneath my hoodie. I felt the doctor rubbing and cupping my breast with a hand. I was awake but I did not say anything as I was in shock, trying to process what was occurring.”

1. She said further:

“The second part of the examination was when the doctor asked me to roll over onto my side. complied with this request, though I cannot remember if I was facing the door or the wall on the opposite side of the room when I moved my body. After I rolled over, the doctor was standing behind me. He recommenced the examination by reaching his arm over my body and I felt him touching my left breast. This came as a surprise to me at the time because I thought he was going to place the stethoscope on my back, given that my back was facing towards him. This part of the examination was not as long as the first part, and the doctor suddenly stopped and left.”

1. She felt him cup and caress her breast.
2. He just pulled his hand out and “bolted”, he “whipped his hand out really quickly and just walked straight out of the room, there was no communication, nothing”. He went straight towards the lifts and not towards the nurses’ desk.
3. He did not explain the need for the examination, other than to say “I need to listen to your chest”.
4. The contact was unusual, she said “I felt really uncomfortable. I have been to hospital a fair bit in the past I have had doctors liste[n] to my chest heaps of times. Never has a doctor put his hand on my boob and rubbed it around in this way”.
5. He did not ask the reason for her admission.
6. She did not see him review her medical records.
7. BL went home shortly after and medically her condition was stable and she did not have to go back to hospital.
8. There is no evidence that he raised his concern with BL’s treating doctor or nursing staff.
9. Never was any similar examination conducted during her hospital admission.
10. The Tribunal will recall the absolute clarity with which she gave her evidence:

I've had breast surgery and I've never had someone touch me like that, I've had three breast surgeries since I was 14 for medical reasons and I've never had someone touch me like that, like he was cupping my breast, he was rubbing his hand around it, like it was underneath my boob, like underneath cupping it and rubbing his hand around.”

1. Hmood submits:
2. The evidence of BL is critical to this allegation and does not meet the Briginshaw standard.
3. BL in her statement dated 4 June 2019, prepared for this proceeding at paragraph 15, stated, “On page 2 of Annexure A, I have stated that Dr Hmood ‘had the stephoscope (sic) in his hand but was rubbing his hand all over my left boob”. The matter of whether or not Dr Hmood was touching me with his hand or with his stethoscope was the subject of questions put to me when I gave evidence at Dr Hmood’s criminal trial.
4. At paragraph 16, BL stated “To the best of my recollection, Dr Hmood touched my breast directly with his hand and not with a stethoscope.” BL’s at this hearing definitively stated, “There was no stethoscope on my chest”.
5. This evidence, having regard to the Briginshaw standard, is critical for the following reasons:
6. BL’s police statement dated 2 March 2010 attached as Annexure A and referred to at paragraph [40] above contains an express reference to the doctor having a stethoscope in his hand at the time the alleged contact with her breast was made.
7. Contemporaneous Geelong Hospital Barwon Health progress notes made by Nurse Christine Nash on 28 February 2010 where Nurse Nash recorded that BL told her that “she (BL) was dozing off to sleep when a man came to her wearing what she thought was orange trousers and a brown top a dark skinned man, he had a stethoscope around his neck and he put this to her chest underneath her top and touched her breast as she was lying on her side and he reached over her to do this.”
8. Contemporaneous notes made by Detective Senior Constable (DSC) Michelle Robson of conversation with BL on 28 February 2010. DSC Robson’s notes were put to her at committal in the following exchange:

And the notes that then follow, are they notes of what [BL] told you? – Yes.

Can you read those out? ---So, “1445 hours [BL]. Checking every hour. Last night changed” – “changed well. Blood sugar about 0200 hours. After that man standing next to my bed and STE”, for stethoscope”, “around neck. Tags on belt. Listened to chest. She lifted jumper down from neck hoodie”. So I’ve – I’ve obviously started to write she lifted jumper down and then she’s described it as in down, pulling down rather than up.

Can I just confirm that. My notes are cut off at the bottom. Can you just read out that last line again? --- Yes. “Listened to” – sorry, I’m full of a head cold here. “Listened to chest”, with a little strike through – “she lifted jumper down.”

“Lifted jumper down”. And then over the page starts, “From neck (hoddie)”? ---That’s – that’s correct, yep.

Okay. The next line? --- Again “STE”, stethoscope”, “on left breast 30 seconds. Mainly around boob”.

So is that a note that – of what she told you, that she told you that the stethoscope was on her left breast for 30 seconds? ---Yep

Mainly around boob? ---Yep. Yes.

Go on? ---I’ve got – it looks like I’ve got, “O/C. Cn you turn on your side. He leant over and put on her boob again”. O/C?

Can you just read that bit again. Does it say, “he leant over and put it on her boob again”? ---“He leant over and put it on her boob again”, yes, you’re correct.

Yes. And then she said? --- “There was no conversation. She was very sleepy. There was not intro” , as in, you know, “Hi, I’m doctor so and so”.

1. The importance of this evidence is obvious. BL herself, Nurse Nash and DSC Robson record a version at odds with the version given at this hearing. It is evidence of contemporaneous discussions that go directly to the issue of her reliability to recall this incident in this hearing in September 2022. In the context of a 12.5 year plus delay between the alleged incident to this hearing the Tribunal must consider her evidence with great caution. Nurse Nash and DSC Robson were witnesses of significance and the Board carrying the onus of proof and being in a position to do so should have called these witnesses in this proceeding. The Tribunal would be entitled to draw a Jones v Dunkel inference in regard to the failure to call them.
2. ... In summary, BL confirmed she first spoke to Nurse Nash, and that she did not mention the matter to any other hospital staff, she could not say if she had been gently woken up, that she knew a stethoscope was going to be applied to her chest, she confirmed she had taken a sedative to help her sleep believing it was Temazepam.
3. BL states for the first time that the stethoscope remained around Dr Hmood’s neck the whole time. She could not say which hand was used to touch her left breast, BL agreed she was concerned about what had happened, but went to sleep and did not press the nurse attendant button. BL agreed her police statement contained the words “ I wasn’t sure if it was legitimate or not”.
4. At the committal Nurse Nash’s progress note was put to BL, where Nurse Nash recorded that BL had stated a stethoscope was used. When asked if she was now definitely saying that there was no stethoscope in his hand BL answered, “My memory is that – all I remember is his hand cupping and rubbing my breast”. The memory is inconsistent with the account she provided to two people and her own statement.
5. … Nurse Nash remembered BL “and the fact she told me what she did”, the progress note was made by her, on the same day, a couple of hours after she had first spoken to her. Nurse Nash made two pages of clinical notes and was trying to give as much detail and to be as accurate as possible to convey what BL had said. Nurse Nash recorded BL’s description of the clothing worn and the colour of his pants and top. Nurse Nash agreed that BL explained to her what the person had done. The progress note made by her included various references to the stethoscope being put to her chest, and she faithfully recorded what was reported to her in the progress notes. Nurse Nash agreed that progress notes are made to be as accurate and precise as possible.
6. Detective Senior Constable (DSC) had a conversation with BL on 28 February 2010 recorded in her police notes. DSC Robson notes recorded that a stethoscope was on BL’s left breast for about 30 seconds, and that he leant over and put the stethoscope on her boob again. DSC Robson’s notes also recorded BL stating “There was no conversation. She was very sleepy. There was no intro” as in, you know, “Hi, I’m doctor so and so.”. The note of DSC Robson that there was no conversation is also inconsistent with BL’s evidence of recalling a remark that the doctor wanted to listen to her chest.
7. The account provided by BL to Nurse Nash in regard to the clothing described by her as being worn by Dr Hmood was at odds with the evidence of Nurse Lois Thomas

“Chris (being a reference to Nurse Nash) told me that this male person was wearing an orange shirt and orange pants. I told her the doctor on definitely didn’t have a orange shirt and orange pants because I remember Dr HMOOD wearing grey pants and a fine black and white striped shirt.”

1. Nurse Thomas also recalled assisting Dr Hmood, as per his explanation to police, with another patient in the room of BL, a [Mrs D]. Nurse Thomas was not called to give evidence in this proceeding.
2. … The inconsistency of BL’s account is only amplified and highlights the importance of the evidence of Nurse Nash, DSC Robson and Nurse Thomas who were not called to give evidence at this hearing.
3. On the state of the evidence before this Tribunal it would be dangerous to rely on the evidence of BL in light of the inconsistencies recorded by Nurse Nash and DSC Robson of BL’s account to them of what occurred and in the context of the description of the incident contained in BL’s police statement provided in the immediate aftermath of the incident.
4. Under cross examination BL agreed that her memory of the incident was clearer at the time of the event rather than 12 and a half years later.
5. BL also agreed that she spoke at the time of the incident with Nurse Nash and DSC Robson.
6. BL was also unwell with diabetic ketoacidosis and nausea and vomiting and that it was an exhausting schedule she was on and she was “tired, I was pretty exhausted, I had a big week.”
7. BL agreed that the doctor who came to her bedside told her that he wanted to listen to her chest and that she understood what that meant.
8. BL agreed that her police statement made reference to the stethoscope being in his hand, that she had signed it as being true and correct and that there were no changes to the document that she made.
9. BL’s evidence is that she does not remember talking to DSC Robson, not that she didn’t.
10. After the incident BL went back to sleep, did not activate the nurse bell, did not tell any nurse in the immediate aftermath, and her first conversation was with Nurse Nash, and she also spoke to DSC Robson but could not remember the conversation. Given the description of the incident by BL it would be unusual not to immediately report such an incident and to be able to fall asleep soon after.
11. The Tribunal should also have regard to the letter dated 19 March 2010 from Dr Tony Weaver, Executive Medical Director to DSC Robson in relation to the dose of Amitriptyline given to BL for the night 27-28 February 2010, Dr Weaver wrote to DSC Robson and explained

…it is not possible to be precise about it’s sedative effects in this case but it could cause sedation enough to produce heavy breathing. it is possible that it might distort perceptions of activities around a patient

1. The impact of the amitriptyline medication and the general health condition of BL both on and leading up to the incident in question must be carefully considered by the Tribunal.
2. The Tribunal must also take into account Dr Hmood’s denial and explanation provided to Victoria Police on 11 March 2010.

…I was checking this patient with a nurse and we put in – put the cannula…very hard to get cannula in so suggested to put subcutaneous fluid instead of intravenous. When the nurse preparing for this I heard the next patient was breathing heavily and I thought she’s in urgent case because I – the first thing that I was thinking is she may be post surgical patient and sometimes one of the complications of these patients is to get clot inside the arteries of the lung so she may need some help. I ask her if she has any chest pain and I ask her – I will examine – I will listen to her heart and chest and she said OK. And I put my stethoscope on her chest and I heard her heartbeats. Then I asked her if she got any shortness of breath or chest pain. She said no. I then said “you’ll be ok”. And then she – I think she thanks me or I don’t remember. But all the time was about 1 or 2 minutes to check her.

Did not make a notation on the chart because busy with the other patient – no we were busy with the other

Did not know what the patient was in for or her condition thought she was possible post-surgical and she was breathing heavily

Explanation for not checking her chart – to see if she was post-surgical – no I didn’t I had patients on other levels – sometimes if you exclude the more serious things you go to the other patients

Was not wearing mustard coloured jeans

At the time was still undergoing training – and I did some tests here

Not sure if she knew he was a doctor – asked her “are you alright – do you have any chest pains or shortness of breath – I think she said no

And then I asked her “Can I examine you?” she said OK and then I listened to her chest and her heart and I think I ask her again about pain or shortness of breath and she said no.

1. Dr Hmood was candid in explaining how he came to examine BL and conceded not making a progress note. The account given by Dr Hmood must be given some weight. It was an explanation to investigating police contemporaneous to the event in question. He was a junior HMO doctor attending to a patient who he believed may have been in some respiratory distress. His explanation of the circumstances of the interaction with BL provides an appropriate clinical basis to seek to listen to BL’s chest and for the examination that followed.
2. On 4 June 2018 and 10 December 2018, Dr Hmood via his solicitor denied breaching professional boundaries. That explanation was in summary:

* He denied touching breast in manner alleged and denied conducting an examination without clinical justification.
* He was acquitted of all charges in respect of the patient,
* He denied breaching professional boundaries

1. In relation to BL, Dr Overton agreed that it would be appropriate for a junior HMO, in regard to a patient who had been given a dose of amitriptyline who was observed breathing heavily to check a patient’s chest sounds. This was the situation that confronted Dr Hmood.
2. Given the inconsistent accounts of BL, her description of the episode on the day of the incident to other people and their non-appearance at this hearing, her condition and medications (amitriptyline), the failure to ring the nurse bell, not telling other hospital staff in the immediate aftermath, her falling asleep in the immediate aftermath plus the inherent improbability of a doctor checking her chest without a stethoscope points strongly to the conclusion that allegation 1 must fail.

### **Lack of informed consent**

1. The Tribunal is not satisfied that Hmood failed to obtain any or adequate consent from BL, or that he failed to give any or an adequate explanation for the chest auscultation.
2. It accepts BL’s evidence that she was sleeping in the early hours of 28 February 2010, and Hmood woke her up and explained ‘I need to listen to your chest’. (She did not know who he was, but he was the HMO on duty). BL complied with the request and Hmood proceeded to perform the first chest auscultation for approximately 30 seconds:

I was on my back at the start when I woke up to him next to my bed and when he first said that he needed to listen to my chest I was on my back, loosened my jumper, like I turned my head to the side so he could do it, I was on my back initially.

1. The Tribunal accepts BL’s evidence that while Hmood was performing the first part of the chest auscultation, he requested that she adjust herself to be in the LLRP (from lying on her back). Once BL was in the LLRP, Hmood performed the second part of the chest auscultation:

… he asked me to roll over so that he could (listen to my chest) … he said he needed to listen to my chest when I was lying flat on my back and I loosened my jumper for him to do it, and then he goes ‘I need you to roll on your side’ and then I assumed it was to listen to my back with the stethoscope…

1. In circumstances where BL complied with Hmood’s requests for BL to loosen her jumper and adjust her positioning to be in the LLRP for the purposes of a chest auscultation, the Tribunal cannot be satisfied to the *Briginshaw* standard that Hmood failed to obtain any or adequate consent, or failed to give any or an adequate explanation for the chest auscultation.

### **Inappropriate and unnecessary physical contact**

1. The Tribunal is satisfied to the *Briginshaw* standard that Hmood performed a chest auscultation on BL in a manner that was not clinically required, or appropriate in the circumstances, and involved inappropriate and unnecessary physical contact.
2. The Tribunal accepts BL’s evidence given at the hearing that she felt uncomfortable with the physical contact made by Hmood. More importantly – given that discomfort can be felt where appropriate contact occurs – it is satisfied BL vividly recalled the manner in which Hmood made physical contact with her breast:

… I had like a boob tube crop top on, he went under it, and was like cupping my breast, like it was under, and then, like caressing and rubbing it like it was so uncomfortable… I've never had someone touch me like that, like he was cupping my breast, he was rubbing his hand around it, like it was underneath my boob, like underneath cupping it and rubbing his hand around.

1. It does not matter exactly where the stethoscope was placed on BL’s body during the examination (which was the subject of much cross-examination).
2. The Tribunal accepts the conclusions detailed in Overton’s expert report that the contact made to BL’s breast during the chest auscultation constituted inappropriate and unnecessary physical contact:

… it was not clinically necessary or appropriate for a doctor’s hand to touch the patient’s left breast in a rubbing or cupping motion in the manner described, or to do so a second time after asking her to roll on her side.

1. The Tribunal accepts the evidence of Overton that there was no clinical indication for Hmood to perform any kind of chest auscultation on BL. BL was admitted to Geelong Hospital for symptoms related to diabetic keto-acidosis, and the admitting doctors made no record of any heart or lung problems in her clinical progress notes. There is nothing in the records to suggest that a chest auscultation was required that morning.
2. The Tribunal is satisfied on the evidence that, after waking up BL, Hmood did not record any of BL’s vital signs, conduct any other examination of her, or take any other steps to further assess the possibility of a potential diagnosis (which he claims justified the clinical necessity or appropriateness of the chest auscultation). Hmood did not record anything about his examination of BL in the clinical notes. The Tribunal does not accept the explanation he gave to Victoria Police on 11 March 2010, in circumstances where he has not been cross examined on that evidence.
3. The fact that others (Nurse Nash, DSC Robson) recorded particular details in brief notes made in the day or so after the incident does not satisfy the Tribunal that what was recorded was exactly what was said to them by BL at the time. Nor does the fact that at a committal hearing some evidence was given by people who are not called at this Tribunal hearing (such as Nurse Nash). The Tribunal has not heard audio of that evidence. The Tribunal has, on the other hand, had the benefit of assessing BL in giving evidence at the hearing and accepts her evidence.
4. The Tribunal does not accept that the fact BL did not immediately push a bell to call a nurse (after an unknown doctor had attended on her in the middle of the night), and waited to the next morning, detracts from the recollections she has expressed. Nor does it accept that she was drugged or tired to the extent that she misremembered such an unusual touching by a doctor.

### **For a sexual purpose**

1. The Tribunal finds that given the inappropriate manner in which Hmood made physical contact with BL when performing the chest auscultation which was not clinically indicated or necessary, it was performed for a sexual purpose.
2. The Tribunal accepts the evidence of Overton that, in a hospital setting, if a doctor had concerns regarding a patient’s breathing or observed them breathing heavily, the doctor would be expected to record vital signs, including oxygen saturation in blood, listen to the heart and lungs, take a proper history of the medical problem by consulting the patient and reviewing their clinical progress notes and make a record of the examination and any abnormalities observed (for example, heavy breathing). Here, nothing was recorded.
3. The fact Hmood performed the chest auscultation on BL in the manner he did, without being the treating doctor, failing to record any clinical notes or perform any sort of preliminary examination, strongly indicates the chest auscultation was performed for a sexual purpose.
4. The manner in which Hmood conducted the chest auscultation cannot be misconstrued as poor clinical performance or inexperience, nor is it explicable by him being in a hurry.
5. It was not innocuous conduct: Hmood unnecessarily made physical contact with BL’s breast during the first part of the chest auscultation for approximately 30 seconds before requesting she adjust herself into the LLRP, prior to then making physical contact with BL’s breast when she rolled on her side.
6. The finding that there was a sexual purpose is supported by the fact that Hmood failed to provide BL with an explanation of results and abruptly left after completing the second part of the chest auscultation:

He just all of a sudden like pulled his hand out really quickly and abruptly and he bolt – and went straight out the door through the curtain to the corridor out to the exit, he just abruptly quickly stopped, it came straight out and I was still on my side and he’s just all of a sudden stopped, I don’t know what made him stop but he’s just whipped his hand out…he’s gone through the gap of my curtains to the right towards the lifts um towards the exit, the other way would be the nurses’ station and the rest of the ward but he’s gone straight towards the exit.

# Patient SD (Allegation 2)

1. The allegation concerning SD relates to a consultation she had with Hmood at the Kilmore Medical Practice on 27 March 2013.
2. SD reported Hmood’s alleged conduct to the police on the same day and made a police statement on 18 April 2013.
3. On 21 May 2013, Hmood was interviewed by police and denied the allegation put to him.
4. On 4 May 2015, SD gave evidence at a committal hearing.
5. On 19 August 2015, SD gave evidence at a criminal trial.
6. SD also signed a witness statement prepared by the Board’s solicitor on 2 June 2019.
7. On 7 September 2022, SD gave evidence at the Tribunal hearing.
8. The Tribunal finds SD was honest in giving evidence at the hearing and that her evidence regarding fundamental aspects and critical issues remained consistent over the years.
9. The Board submits:
10. SD said that he looked at the rash while she was sitting in a chair and asked some questions about what might have been the cause. He asked if she had any other medical problems, and she said nothing she was aware of, though she gets the occasional headache. He asked if she ever gets dizzy, and she says not really except sometimes if she stands up too fast.
11. Insofar as he looked at the rash it was “so quick and almost like a glance”.
12. She agreed that he said he wanted to listen to her heart.
13. He asked her to lift her dress up and he put his hand under her dress.
14. She was wearing a loose-fitting dress. He could have put the stethoscope down the top of her dress without her pulling it up.
15. Dr Hmood conducted a purported examination of her chest in the left lateral recumbent position.
16. He held the stethoscope on her chest, between her breasts, for about 40 seconds. She “could feel his fingers touching my skin in between my breasts”. In her police statement, signed shortly after the consultation, she estimated that he was moving the stethoscope in between her breasts for what seemed like about three minutes. She was unsure of the time in her oral evidence, but noted it felt like a lifetime. She could not understand why she could feel his fingers between her breasts, rather than him holding the small disc in the middle of the stethoscope, and it felt “wildly inappropriate.
17. He then placed a hand on her hip and pulled her body towards him. In oral evidence she clarified she was not forcefully moved back.
18. He said to her “can you hear that”, “your heart is beating really fast”.
19. She was pushed right up against his groin area. She could feel his pulse against her lower back and it felt like he was rocking back and forth against her, but it was very slight.
20. She cannot say precisely what part of his body was up against her buttocks, she could not tell whether the pressure was deliberately swaying, or heavy breathing. “All I could feel was what I believed to be the pressure of his groin area up against my lower back and the top of my buttocks in hard and soft movements”.
21. He eventually pulled his hand out from under her dress. He said “it’s definitely not ringworm”. He did not say how he formed this conclusion, or explain the significance of the examination. He didn’t tell her about any findings with respect to her heart.
22. She described in clear terms the nature of the purported examination and why it made her uncomfortable:

the awkward silence, the fact that his hand felt like it was right in between my breasts, or was, and because his body weight was against my body, um, and my dress was all - it had to be mostly the whole way up because of the way the stethoscope was, that my dress was pulled up all the way to just underneath my chest, so his body was up against my semi-naked body, and this was going on for a long time in silence, and then when he did finally talk, it was in a - I felt, and I'm just putting it to you that I'm a musician that plays pubs and clubs weekends, and for footy crowds who have been flirtatious and inappropriate, and I've not ever felt uncomfortable in the way that I felt in this room, the way he said, 'can you hear that, um, it's your heart beating really fast'. It was not like a doctor would say to a patient, it felt seedy and um, wrong.

1. She was immediately concerned that what had occurred was inappropriate and that day she informed her then partner.
2. Her evidence was not effectively challenged in cross examination.
3. Hmood submits:
4. SD was a first time patient attending upon Dr Hmood.
5. Dr Overton in relation to a first time patient agreed with the proposition that

Well, if it's a first time patient to the practice, um, then, it would be prudent to take a full medical history, past history, medications, family history, yes, and that takes some time.

Yes. And for those circumstances that you've just detailed, for that to include consideration of the patient's heart?In a general sense, yes.

1. SD’s memory was not very good about all of the circumstances of the consultation.
2. She had a rash for a few months down her side, coming down her thigh, possibly lower back and inner thighs. SD recalled that she was concerned enough about the rash to want to go to the doctor.
3. SD expected Dr Hmood to be thorough and to get a clear picture of her health and what was or what might be wrong with her.
4. The consultation unfolded as a question and answer process and SD agreed that various questions were asked. This included informing Dr Hmood that she suffered from occasional headaches and that if she stood up too fast she could get dizzy.
5. SD was confident that she told Dr Hmood that she got dizzy because she did get dizzy all the time when she stood up.
6. After providing Dr Hmood with this history SD recalled that Dr Hmood asked her to get up onto the treatment table so that he could listen to her heart.
7. SD understood what Dr Hmood meant by listening to her heart, and that this was going to be done with a stethoscope.
8. SD recalled the treatment bed being pushed against the wall but was unable to recall its width or how high off the ground it was.
9. SD recalled that the first part of the chest examination was while she was sitting on the treatment bed.
10. At the time SD felt Dr Hmood may not have recognised that she was wearing loose fitting dress because it was a high necked dress.
11. She had no concern about her dress being raised to various positions so that Dr Hmood could place the stethoscope. All her clothing remained on.
12. SD agreed that after completing listening in the sitting position that Dr Hmood possibly asked her “if it was ok if you lie on your side”? and that she understood that “it was a continuation of the examination with the stethoscope that he’d started with you in the sitting position?
13. SD responded to the request by moving into position. All clothing remained on during this part of the examination.
14. For this part of the examination Dr Hmood placed his stethoscope on the area between her breast. SD could not recall if there was any contact with her stomach.
15. While facing away from Dr Hmood and looking at the wall, SD had no recollection of seeing Dr Hmood.
16. SD was unable to say which part of Dr Hmood’s body was making contact with the back area of her body, “Yes, I think I – I think I recall those questions as well in the court, I just couldn’t exactly recollect just felt like a big mass, I guess, behind me.
17. A big mass is as accurately as she could describe it.
18. In terms of being positioned on the examination table SD stated, “I don’t remember ever, any kind of rough or, um, forceful – it was more if anything it would have been more like a guidance to move back kind of motion, like move back or nudge back kind of feeling”. Dr Hmood did not grab her or pull her back.
19. The examination took place for approximately 40 seconds, or 30 – 40 seconds.
20. While the examination took place SD could feel Dr Hmood’s fingers on the skin between her breasts and that she could not be certain as to what part of Dr Hmood’s body was making contact with the back of her body.
21. SD could not say if what she felt was a hip bone, belt buckle, zips.
22. SD agreed that the stethoscope was in Dr Hmood’s ears, that it had been placed on various areas of her chest in the seated position.
23. The contact to her breast was from Dr Hmood’s fingers as he was holding the disc of the stethoscope, SD could not recall if she wearing a push up bra but agreed that while lying on her left hand side her right breast would fall to the left as a result of gravity.
24. SD agreed that the combination of her bra and gravity created the contact because there was less space.
25. SD agreed that Dr Hmood’s remark about her heart occurred in close proximity to him listening to her chest, and that the comment was made in the context of Dr Hmood listening to her heart in the LLRP.
26. The LLRP examination concluded and Dr Hmood advised SD that she did not have ringworm and prescribed her with medication which cleared up the problem.
27. SD could not recall at this Tribunal hearing all details of the conversation she had with…her partner.
28. The TB sets out the evidence of SD at the trial of the matter in the County Court on this issue

(Dr Hmood) Wanted you to come back for further appointment

Told partner 100% honest with him said you felt yucky but it was probably nothing sent that in a text

[SD’s partner] asked you if anything was going on down there and you said no suspected it was just his breathing

Told [SD’s partner] he was not trying to deliberately touch your breasts

1. The cross examination of SD at the criminal trial is in TB. SD believed the contact was made to her lower back to the bottom of her buttocks and that she could not tell if the movement she felt was Dr Hmood breathing or the swaying of his body. SD could not tell if Dr Hmood was angled and that this all occurred while the stethoscope was on her chest she could not tell whether he was breathing or purposefully moving. SD stated this went on for 2-3 minutes. SD felt uncomfortable because she was aware of contact by Dr Hmood’s fingers holding the stethoscope, that he was leaning over her and it seemed to be lasting longer than it should have. This a subjective perception of discomfort during the performance of an examination that is insufficient to enable the Tribunal to conclude that there was a sexual and/or inappropriate and/or non-clinical purpose.
2. Dr Overton agreed that a report of dizziness on standing did raise the issue of orthostatic hypotension

And that the patient reported  and this is in your assumptions, dizziness on standing?---That was in the assumptions, yeah.

And would you agree that that raises an issue of potential orthostatic hypertension?---Correct.

And that orthostatic hypertension is a condition that can suggest some potential heart problems?---Um, potential.

1. Dr Overton also agreed that this could permit a full chest sounds examination – as part of a targeted examination. He did not agree that this should include a LLRP examination,. The Tribunal should reject Dr Overton’s evidence in relation to the LLRP. The LLRP is an accepted, recognised chest auscultation examination and there is nothing to suggest that it could not be performed here.
2. Given the presenting complaint (as disclosed by the evidence and clinical records), SD’s understanding of the nature of the chest examination with the stethoscope including that it was going to include the LLRP, the fact, agreed to by Dr Overton, that the LLRP can be used to enhance the heart sounds themselves, and the fact that incidental contact can occur in the performance of the examination, this allegation must fail.
3. SD’s subjective feelings of discomfort and/or distress and of the contact itself are not sufficient to prove the allegation.
4. Dr Hmood was interview by Victoria Police in relation to the complaint of SD. The main points in summary were:

He did the Australian Medical Council examinations part 1 and 2 – in 2008 and 2011

[SD] saw her once

Confirmed medical record completed by him

Re rash you think about a diagnosis in the case allergy, contact dermatitis

Treatments

Ask for a history, when it started, if its affecting respiratory airways, heartbeat, severity of it

Then you examine the patient

Check lungs – heartbeat, could be shingles or herpes zoster

Check if pimples or if on a line of the nerves

Can’t remember what part of the body but you would look at that part of the body

To exclude anaphylactic reaction check lungs

Also check the heart beat – the heart rate, listen to heart sounds – sometimes we discover by accident that they have got different heart sounds

Check heartbeat by checking the four spots of the heart – if you want to hear extra sounds you might ask patient to lean forwards

…

Preferred position is to be lying on the bed I asked them to turn to their LHS

If they were sitting up would sometime request them to lay down – YES

Why? Sometimes you can’t hear it with them sitting up I may ask the patient to lie down to listen to his or her heart

Listening for heart sounds and the space between them –

Re medical notes asks about past history, same problem, home situation, social situation – for first time patient allergies, smoking, home situation

Normal practice to write down as much as possible of the observations but sometimes it is a busy and crowded clinic you just write the important things

Agreed very small notes like not in details – I didn’t include the other examinations because I want to review her maybe next week. That’s why I didn’t write and maybe I got another patient

Observations recorded in notes skin rash, she tried anti-fungal treatment, believed it to be contact dermatitis

SW review next week

Re heart check – normally done under clothes – four spots

If you suspect something extra you may ask the patient to take a breath or to change position

Usually asks “is it ok to examine your heart” or “I want to listen to your chest” Will sometimes ask them to take off their clothes - not bra

Normally chest sounds access from top of clothing

1. Dr Hmood also gave evidence on oath at the criminal trial in summary Dr Hmood stated

May have touched the patient to move to the edge of the consultation bed? Yeah, that’s – that maybe happened

When puts stethoscope in his ear can’t hear the patient when they talk he was in an angled position – because when I examine the patient I will be angled to, to the front of the chest of the patient. so my right hip will be in contact with the patient in this way.

Also possible contact with his lower abdomen

1. The account given by Dr Hmood to police and at trial must be given some weight. This was an explanation to investigating police contemporaneous to the events in question and evidence at trial given under oath.
2. On 4 June 2018, and 10 December 2018, Dr Hmood via his solicitor … in response to queries from Ahpra denied breaching professional boundaries~~.~~ His explanation there was provided was as follows:

* That the “[SD] charge” was withdrawn from the jury by the judge
* Dr Hmood did conduct a heart examination in the LLRP
* He denied breaching professional boundaries
* He denied his groin made contact with the buttocks and lower back
* SD said she felt like Dr Hmood was rocking back and forth against her but it was very slight
* Dr Hmood denied it in his record of interview.
* Any contact was incidental and was between the midsection of Dr Hmood and the back of the complainant.
* At committal and trial [SD] not confident that it was a rocking motion.

1. Having regard to the entirety of the evidence allegation 2 must fail. There is no evidence that can support a conclusion that the chest auscultation examination occurred in the manner alleged.

### **Lack of informed consent**

1. The Tribunal is not satisfied that Hmood failed to obtain any or adequate consent from SD, or that he failed to give any or an adequate explanation for the chest auscultation.
2. The evidence establishes that after describing her symptoms to Hmood at the initial stage of the consultation, SD complied with his request for her to sit on the examination table and lift up her dress so that Hmood could check her breathing and perform the first part of the chest auscultation. SD then adjusted herself to be in the LLRP for the second part of the chest auscultation, when requested by Hmood.
3. In the circumstances, the Tribunal cannot be satisfied to the *Briginshaw* standard that Hmood failed to obtain any or adequate consent, or failed to give any or an adequate explanation for the chest auscultation.

### **Inappropriate and unnecessary physical contact**

1. The Tribunal is satisfied to the *Briginshaw* standard that Hmood performed a chest auscultation on SD in a manner that was not appropriate in the circumstances and which involved inappropriate and unnecessary physical contact.
2. The Tribunal accepts the evidence of Overton, given in cross-examination, that as part of a targeted examination it would have been appropriate to conduct a full chest sounds examination of SD, but not in the LLRP.
3. The Tribunal accepts that as SD was a first time patient with Hmood, it would have been prudent for Hmood to take a full medical history which would include consideration of her heart in a general sense. However, there is no evidence to suggest that the verbal exchange that took place regarding SD’s reported symptoms in the initial stages of the consultation provided Hmood with any indication that a chest auscultation in the LLRP was clinically necessary or appropriate in the circumstances.
4. The Tribunal accepts SD’s evidence that she felt uncomfortable with the physical contact made by Hmood, and is satisfied SD clearly recalled the manner in which Hmood made physical contact with her during the chest auscultation:

… I’ve never felt that before, from any other doctor why he couldn’t just have held that (the smaller part of the stethoscope as opposed to the stethoscope disc) instead of making me feel extremely uncomfortable, both my breasts were pushed in together on the side, so obviously you create, you know, a sort of cleavage area when his fingers were encapsulated the entire round part as it is right in between, you could feel his fingers around in between my breasts, felt wildly inappropriate.

1. It does not matter exactly how Hmood held the stethoscope on SD’s body during the examination (which was the subject of much cross-examination). The Tribunal is satisfied that Hmood’s fingers made physical contact with the area in between SD’s breasts in a manner that was not accidental nor fleeting.
2. The Tribunal accepts the conclusions detailed in Overton’s expert report that the contact made to SD’s breasts during the chest auscultation constituted inappropriate and unnecessary physical contact:

… it is not clinically necessary or appropriate for a doctor’s fingers to touch the skin between a patient’s breasts in the manner described while performing a left lateral recumbent chest examination.

1. During the performance of the second part of the chest auscultation, when SD was in the LLRP, she felt Hmood place his hand on her hip and pull her body back so that her backside made contact with Hmood’s groin or crotch area:

Dr Hmood then removed his hand and the stethoscope from my chest. He then placed a hand on my hip and pulled my body towards him. He then commenced examining my chest again…

… All I could feel was what I believed to be the pressure of his groin area against my lower back and the top of my buttocks in hard and soft movements.

1. The Tribunal is satisfied that the physical contact Hmood made to SD’s backside area during the examination, while having his hand on her hip, was inappropriate and unnecessary. It accepts the evidence of Overton:

… it is not clinically necessary or appropriate for a doctor’s groin area to be touching a patient in the manner described while performing a left lateral recumbent chest examination.

… it is not clinically necessary or appropriate for a doctor’s hand to be touching a patient’s hip in the manner described while performing a left lateral recumbent chest examination.

### **For a sexual purpose**

1. The Tribunal finds that, given the inappropriate manner in which Hmood made physical contact with SD when performing the chest auscultation which was not clinically indicated nor necessary, it was performed for a sexual purpose.
2. The Tribunal accepts SD’s evidence given at the Tribunal hearing that the duration of chest auscultation spanned for approximately 40 seconds and that she felt uncomfortable by the physical contact made by Hmood, and the manner in which the examination was conducted:

… his hand felt like it was right between my breasts… my dress was pulled up all the way to just underneath my chest, so his body was up against my semi-naked body, and this was going on for a long time… I’ve not ever felt uncomfortable in the way that I felt in this room…

1. The Tribunal is satisfied to the *Briginshaw* standard that Hmood performed a chest auscultation on SD for a sexual purpose.

# Patient SW (Allegation 3)

1. The allegation concerning SW relates to a consultation she had with Hmood at the Kilmore Medical Practice on 15 March 2013.
2. On 21 May 2013, Hmood was interviewed by police, and denied the allegation put to him.
3. SW reported Hmood’s alleged conduct to another doctor at the Kilmore Medical Practice a couple of months after the 15 March 2013 consultation and made a written police statement on 20 November 2013 (approximately eight months after the alleged conduct occurred). This was after SW had seen an article in the Northern Central local paper regarding a local doctor being investigated for inappropriate behaviour. She later gave evidence at a committal hearing on 4 May 2015.
4. SW also signed a witness statement prepared by the Board’s solicitor on 19 June 2019.
5. On 9 September 2022, SW gave evidence at the Tribunal hearing.
6. The Tribunal accepts that in giving evidence at the Tribunal hearing on 9 September 2022, SW truthfully recollected to the best of her knowledge the events which occurred on 15 March 2013. Despite minor inconsistencies in her evidence which followed the initial police statement made 20 November 2013 (some eight months after the consultation), the Tribunal finds the fundamental aspects of SW’s evidence on which it bases its findings remained consistent.
7. The Board submits:
8. In early March 2013, she attended the ED with heart palpitations and trouble breathing. She was seen by Dr Hmood who conducted a consultation and some tests. He requested that she make a follow up appointment with him.
9. She saw him on a number of occasions.
10. On 15 March 2013, it was the first time she had attended an appointment with him on her own.
11. She gave a history of having difficulty breathing so he said he wanted to check her breathing.
12. She was wearing a halter neck dress and no bra. The top part of her chest and breasts, as well as her back, was exposed by her clothing.
13. He asked her to take off her top, so she undid the top of her halter neck and pulled it down exposing both of her breast
14. The dress she was wearing had a very low neckline and it would not have been difficult for him to examine her without removing the dress. She complied at the time because she thought it was a necessary part of the examination. She disagreed with the suggestion by counsel for Dr Hmood that it was necessary to expose her breasts for the purpose of the examination.
15. She does not remember any examination whilst lying on her back. In answer to a question from Member Mason she said that she could not recall an examination whilst sitting in a chair, or lying on the examination table, of the back of her chest.
16. He asked her to lie on the left side with her back facing him.
17. He kept asking her to move back towards the end of the bed.
18. She said:

While I was lying there I could feel him right behind me, pressed up against my behind, I thought I could feel him bumping his groin area into my backside. My dress was still down but my breasts were fully exposed. I felt like he was doing it for a couple of minutes. I felt very uncomfortable, and hyper aware of the situation I was in, it was not a normal situation. He didn’t say anything at all. After a while I asked him if he was finished and how much longer, because I was extremely uncomfortable and wanted to leave.

1. She disagreed with the suggestion that the stethoscope never touched her breast, and she is “sure” that his stethoscope touched her breast, at the top.
2. She could feel his groin area “bumping into my backside”. She deduced it was his pelvic area, based on the height of Dr Hmood and the height of the bed. The movements she felt were rhythmic, though not pounding. She has never had another doctor touch her like this on any occasion before or since.
3. The ‘examination’ felt like it went for a very long time and only ended after she said words to the effect “are we done”.
4. She disagreed that the examination took no longer that 40 seconds, “absolutely”. She explained:

“it was long enough for me to ask him whether or not he’d finished, and for me to prompt him”

1. She re-iterated that he only stopped the examination after she prompted him. She was not challenged on this evidence during cross examination.
2. After the examination he said to her that her chest was clear and he recommended she see a psychologist because he thought the symptoms were possibly a panic attack.
3. She reported her concerns to another doctor at the medical practice and her partner.
4. Hmood submits:
5. SW evidence was that she no longer had a recollection of what was discussed at the initial part of the consultation or whether Dr Hmood examined her prior to the event in question but she knew the reasons why she was there.
6. SW was concerned about her breathing and heart palpitations, and tingling in her arms and body as well as feeling light-headed and that these were concerning symptoms.
7. SW agreed that she mentioned her heart palpitations and breathing issues and that these were the reason she presented to Dr Hmood, this was also the reason for her previous attendance at the hospital and she was continuing to experience the problems.
8. SW was also a smoker, and agreed that this formed part of her clinical picture.
9. SW stated, “I’m sure he was aware of the concerns because we’d been speaking about it prior, but I would have brought it up again,” and she repeated her concerns.
10. SW agreed she would have informed Dr Hmood of her symptoms and concerns as they were sitting at Dr Hmood’s desk. After communicating her symptoms and concerns SW agreed that Dr Hmood informed her that he wished to examine her chest.
11. SW agreed, with the general proposition, that a doctor should be thorough.
12. SW agreed that Dr Hmood then asked her to lower the dress she was wearing and that this accompanied the request to listen to her chest, and that the dress, while lower remained on, along with all of her other clothing.
13. SW could not recall if she was first asked to lie down on her back first. SW did recall Dr Hmood saying to her, words to the effect, “can you please lie on your left side”? – Yes.
14. SW was responding to these requests because she understood that Dr Hmood was going to listen to her chest in that position.
15. SW also understood that Dr Hmood was going to use a stethoscope and what a stethoscope was and what it was used for.
16. While in the LLRP, SW recalled Dr Hmood asked her to move towards the edge of the bed towards him, and that she responded to the request by moving closer.
17. SW stated that Dr Hmood then leaned over the top of her and listened to her chest as she was in this position on her left side a few centimeters below her collarbone.
18. SW agreed that she was facing the wall away from Dr Hmood, on the treatment bed that was pushed up against it and it was a standard doctor’s bed that was not very wide.
19. As Dr Hmood was leaning over her, SW could not see Dr Hmood or what part of his body was making contact with her at the time, but that the contact was made while he was listening to her chest in this position. At the committal it was put to SW whether the rhythmic movement she felt was as a result of Dr Hmood’s breathing. SW was not able to say that the movement she felt was not as a result of his breathing.
20. SW disagreed that the examination in this position took no longer than 30-40 seconds, but could not say how long it was, and that she “couldn’t be sure of exactly how long it was”.
21. The examination concluded and SW put her halter neck dress back on, and Dr Hmood advised SW, “Um, I think he said that there wasn’t anything that he could do that would identify the problem”, and that he told her that her chest sounded clear, and he provided advice for further investigation of her reporting symptoms.
22. SW attended for a subsequent consultation to the one in question with Dr Hmood, and attended again with her family for some family vaccinations.
23. The clinical notes for SW confirm the hospital admission, ongoing cardiac concerns and attendances by SW for treatment. The clinical notes also confirm SW’s subsequent attendance upon Dr Hmood. The Tribunal can take this into account because it would be unusual for a patient to return to a doctor if they had any concerns about anything sexual or inappropriate. In fact the clinical notes show she subsequently attended on Dr Hmood on 22 March 2013 continuing to report cardiac concerns as well as ongoing psychological issues.
24. Dr Overton agreed that he had not been asked to have regard to SW’s smoking history and that he had no recollection of any of the pathology reports that formed part of the materials provided to him and he was not asked to have any regard to these results in forming his opinion.
25. Dr Overton agreed that SW’s pathology showed results outside of normal range.
26. Dr Overton agreed that a patient presenting with subjective concern about palpitations was something a doctor is entitled to take into account, and that a patient complaining of palpitations and breathing difficulties meant it was open for a doctor to perform a chest examination with the stethoscope.
27. Dr Overton also agreed that it would be appropriate to examine SW in the LLRP:

……. and that it would be appropriate also for the chest sounds to be examined in the left lateral position?---Okay, yes, it would be appropriate for a cardiac examination, it would also be appropriate for the doctor to record that in the patient's file.

1. Dr Overton agreed that he was not in the examination room at the time, and that there is a degree of subjective decision making that a clinician is entitled to engage in.
2. Dr Overton agreed that he had not been asked to have regard in his assumptions to shortness of breath, that he had not been asked to assume the length of time of the symptoms, had not been asked to consider SW’s smoking history. The fact Dr Overton did not have all relevant considerations as part of his assumptions lowers the weight that can be placed on the conclusion expressed in his report in relation to this patient.
3. Given the presenting complaint (as disclosed by the evidence and clinical records), SW’s understanding of the nature of the chest examination with the stethoscope including that it was going to include the LLRP, the fact, agreed to by Dr Overton, that the LLRP can be used to enhance the heart sounds themselves, and the evidence from Dr Overton that an LLRP was appropriate, together with the fact that incidental contact can occur in the performance of the examination, this allegation must fail.

### **Lack of informed consent**

1. The Tribunal is not satisfied that Hmood failed to obtain any or adequate consent from SW, or that he failed to give any or an adequate explanation for the chest auscultation.
2. The evidence establishes that after describing her symptoms to Hmood, SW complied with his request for her to lower the top of her halterneck dress (exposing her breasts). He said it was to check her breathing. The Tribunal considers this sufficient explanation. SW clarified in the police statement (which is consistent with the evidence before the Tribunal) that she complied with the request as she’d assumed it was a necessary part of the examination.
3. In circumstances where SW complied with Hmood’s request to lower the top of her halterneck dress to check her breathing and perform the chest auscultation, the Tribunal cannot be satisfied to the *Briginshaw* standard that Hmood failed to obtain any or adequate consent, or failed to give any or an adequate explanation for the chest auscultation.

### **Inappropriate and unnecessary physical contact**

1. The Tribunal is satisfied to the *Briginshaw* standard that Hmood performed a chest auscultation on SW in a manner that was not appropriate in the circumstances, and which involved inappropriate and unnecessary physical contact.
2. The Tribunal is satisfied that it was clinically indicated for Hmood to perform a chest auscultation on SW in the consultation, due to her heart and lung related symptoms. But it was conducted inappropriately.
3. The Tribunal accepts SW’s evidence regarding the contact Hmood made with her lower back/buttocks:

While I was lying there I could feel him right behind me, pressed up against my behind. I thought I could feel him bumping his groin area into my backside. My dress was still down but my breasts were fully exposed. It felt like he was doing it for a couple of minutes. I felt very uncomfortable and hyper aware of the situation I was in, it was not a normal situation. He didn’t say anything to me at all. After a while I asked him if he was finished and how much longer, because I was extremely uncomfortable and wanted to leave.

1. The Tribunal is satisfied to the *Briginshaw* standard that the examination involved inappropriate and unnecessary physical contact and was conducted in an inappropriate manner.

### **For a sexual purpose**

1. The Tribunal is satisfied to the *Briginshaw* standard that Hmood performed a chest auscultation on SW for a sexual purpose.
2. In her 19 June 2019 witness statement, SW clarified that due to her dress’ ‘very low neckline’ it would not have been difficult for Hmood to examine her chest area without exposing her breasts.
3. The Tribunal accepts SW’s evidence given at the Tribunal hearing that the duration of the chest auscultation spanned for at least 30 seconds. The prolonged breast exposure further indicates the sexual purpose of the chest auscultation, considering the manner in which Hmood performed the examination.
4. The Tribunal finds that the lack of a clinical record, as well as the manner in which the examination was conducted, and its duration, indicates that Hmood performed the examination for a sexual purpose.

# Patient NT (Allegation 6)

1. The allegation concerning NT relates to a consultation she had with Hmood on 1 October 2013.
2. KT, the mother of NT, reported Hmood’s alleged conduct to the police on 2 October 2013. On 17 October 2013, NT provided evidence to the police by way of a VARE in respect of the allegation. The VARE was not in evidence in this proceeding.
3. NT later gave evidence at the criminal trial, on 7 August 2015.
4. A witness statement was prepared by the Board’s solicitor, and signed by NT on 2 June 2019. NT also gave oral evidence in this proceeding.
5. The Tribunal finds NT to be honest in her recollections of the consultation, and takes into account that her evidence about the examination was largely consistent in accounts she gave over the years.
6. The Board submits:
7. There is an important clinical note of an earlier consultation on 17 July 2013…
8. This indicates that Dr Hmood did examine [NT], presumably in the left lateral recumbent position on an earlier occasion 17 July 2013 and recorded “no murmur can be heard”.
9. Importantly, NT gave evidence that:
   1. All previous attendance with Dr Hmood were with a parent (therefore including 17 July 2013);
   2. The inappropriate touching while she was lying on her left-hand side, was the first time she had attended alone.
10. Thus the 17 July 2013 note, provides context that further undermines any defence of Dr Hmood.
11. That is because:
    1. It dispels any notion that the bumping against the backside of the patient was an inevitable feature of how Dr Hmood conducts the examination. Only when NT attended alone did he touch her in the inappropriate way she describes;
    2. It dispels his claim that he does not record negative differential diagnoses or findings. It directly raises the question why no differential diagnosis was noted on this later occasion.
12. NT was not challenged on her evidence, that this was the first attendance without her parents, and that this was the first (and only) time she was touched by Dr Hmood in the manner she described.

…

1. NT’s evidence as to what she felt during the consultation was unchallenged in cross-examination. It is uncontradicted by any evidence. There is no evidence of any clinical basis for the examination. The contact was obviously unnecessary and improper. Tellingly, the conduct occurred on the first occasion she attended without a family member, at a consultation with a presenting issue that had nothing to do with the valves of her heart.
2. Hmood submits:
3. Given the presenting complaint (as disclosed by the evidence and clinical records), NT’s understanding of the nature of the chest examination with the stethoscope including that it was going to include the LLRP, the fact, agreed to by Dr Overton, that the LLRP can be used to enhance the heart sounds themselves and that rheumatic fever is a possible complication of a strep throat, plus the fact that incidental contact can occur during the performance of the LLRP this allegation must fail.
4. On 4 June 2018, and 10 December 2018, Dr Hmood via his solicitor .. responded to a request for information from Ahpra and denied breaching professional boundaries. His explanation in summary was as follows:

* Dr Hmood was acquitted of all charges
* He denied any deliberate physical contact
* Any contact that did occur was incidental to the examination
* He denied breaching any professional boundaries.

1. The denial of Dr Hmood must be given some weight
2. In addition to the matters above, having regard to Dr Hmood’s explanation, the allegation must also fail.

### **Lack of informed consent**

1. The Tribunal is not satisfied that Hmood failed to obtain any or adequate consent from NT, or that he failed to give any or an adequate explanation for the chest auscultation.
2. Critical to the issue of consent, NT gave consistent evidence that Hmood requested she sit up on the examination bed, told her he wanted to check her chest, asked her to turn on her left side (which NT did), requested she move closer to him (which NT did) and that she understood, or assumed, he was listening to her breathing.
3. In those circumstances, the Tribunal is not satisfied Hmood failed to obtain any or adequate consent from NT.
4. The first mention of Hmood failing to give an explanation for the chest auscultation was in the witness statement of 2 June 2019 (nearly six years after the consultation the subject of the allegation).
5. In that witness statement, and repeated in evidence given to this Tribunal, NT also describes discussing the rash on her face with Hmood. In her witness statement, NT states Hmood said he thought that the rash was rosacea and asked some questions about her breathing and if she had been sick.
6. The Tribunal is not satisfied that Hmood failed to give any or adequate explanation regarding the chest auscultation to Hmood, in circumstances where NT and Hmood discussed her presenting complaint and where Hmood directed NT, and NT complied, throughout the examination.

### **Inappropriate and unnecessary physical contact**

1. The Tribunal is satisfied, to the *Briginshaw* standard, that Hmood performed a chest auscultation on NT in a manner that was not appropriate in the circumstances, including in that it involved inappropriate and unnecessary physical contact with NT.
2. NT gave consistent evidence that she felt Hmood’s body (specifically, the area below his belly button to the top of his thighs) leaning against the region of her bottom and lower back throughout the examination in the LLRP.
3. NT described Hmood applying and releasing pressure in time with her breathing; ‘not pounding’ but applying ‘hard and then soft pressure’. She had previously described this, at the criminal trial, as a medium thrusting movement.
4. NT was 15 years old at the time of the alleged conduct.
5. In her witness statement, NT gave evidence that she had never been examined in the way Hmood examined her stating it, ‘had never happened before and has not happened since.’
6. The Tribunal is satisfied that at an earlier consultation on 17 July 2013, Hmood had previously examined NT’s heart (because he recorded in the notes ‘no murmur can be heard’). On that occasion, her parent was present. The Tribunal accepts that earlier test did not involve the bumping against NT’ backside that she describes.

### **For a sexual purpose**

1. The Tribunal is satisfied to the *Briginshaw* standard that Hmood performed the chest auscultation in the manner set out above for a sexual purpose.
2. Tellingly, Hmood performed the chest auscultation in a way that involved inappropriate and unnecessary physical contact on the first occasion when NT attended upon Hmood without a parent being present.

# Patient HM (Allegation 9)

1. The allegation concerning HM relates to a consultation she had with Hmood at the Kilmore Medical Practice in or around March 2013.
2. On 4 March 2019, AHPRA received a notification from HM regarding the conduct the subject of Allegation 9.
3. On 18 March 2019, the Board decided to commence an investigation into the notification of HM regarding the conduct the subject of Allegation 9.
4. On 24 October 2019, the Board decided to refer the matter regarding the conduct the subject of Allegation 9 to the Tribunal pursuant to s 193(1)(a)(i) of the National Law.
5. On 31 January 2020, the Board filed the Second Referral and Notice of Allegations (regarding this allegation) with the Tribunal pursuant to s 193(1) of the National Law.
6. HM signed a witness statement prepared by the Board’s solicitor on 19 February 2020.
7. On 13 September 2022, HM gave evidence at the Tribunal hearing.
8. The Tribunal accepts that she honestly gave evidence of events as she recalls them.
9. The Board submits:
10. HM was born on 3 May 1993, during her attendances upon Dr Hmood she was aged between 19 and 20 years.
11. Although HM could not recall the exact date that the incident with Dr Hmood occurred, her best recollection was that it related to her issue of recurring tonsillitis.
12. In respect to one of these consultations HM recalls Dr Hmood asking her to lie down on an examination table, on her left side facing the wall with her hips at the edge of the examination table. Dr Hmood explained this was to listen to HM’s heart sounds.
13. Dr Hmood then reached over her body with his arm and commenced listening to her chest with a stethoscope.
14. Whilst doing so HM felt Dr Hmood press his pelvis against her upper thighs and lower back. She also recalls Dr Hmood breathing heavily.
15. During cross-examination HM indicated that she felt that Dr Hmood was pressing up against her for a period of time that was longer than the actual examination.
16. This made HM feel uncomfortable and, although nervous, she spoke deliberately, clearly and at normal volume telling Dr Hmood ‘you’re too close.’ He initially did not respond to this.
17. In her evidence HM described the situation as follows:

And I think your evidence before to Mr Jellis was that it was mentioned in a not a particularly loud tone, a conversational type tone, did I get that right?---No, I said it - I was quite uncomfortable, so I said it in a clear voice, because I had to build myself up to say it, so there were enough moments there for me to consider this is making me uncomfortable, he's not moving, I'm going to say something, and then to say something out loud, and then for that to be ignored, and then to say it again a second time and then for him to move very slightly and still remain in contact with me, and remain in this more or less the same position, so there was a little shuffling, but not a movement away and not an explanation or a significant readjustment, and then to remain in that position.

1. After Dr Hmood did not respond, HM repeated herself. This saw Dr Hmood make a slight adjustment to his body position but nothing that could be viewed as significant.
2. She did could not recall the length of the examination and when it was put to her that is was likely to be 40 seconds or less she was unsure.
3. However, HM was of the view, conceding that her memory of the matter was not the best, that the examination lasted a ‘couple of minutes.’
4. Dr Hmood never explained to HM what the findings of the examination were.
5. In cross-examination HM accepted that she had been told that her tonsillitis could have caused a heart infection, however, no further explanation was sought of her or provided by her.
6. During other consultations Dr Hmood spoke with HM about topics such as
7. ‘have you been kissing boys’
8. ‘have you been smoking’
9. Do you go out partying and taking drugs.’
10. Dr Hmood also asked HM questions about her sexual and social life.
11. None of the above topics were relevant to her presenting complaint.
12. In response to a question from Member McNeill, HM could not recall if there were any other tests done that day or any questions surrounding issues of fevers or her temperature.
13. Hmood submits:
14. This allegation and particulars are now limited to a date in or around September 2013.
15. HM agreed that the LLRP examination only occurred on one occasion.
16. HM agreed that she had seen Dr Hmood for recurrent tonsilitis and that the “exact dates of the appointments are for the clinical records” and she could not recall exactly when it was but she knew she was treated throughout that time for recurring tonsilitis and she saw Dr Hmood on a number of occasions.
17. HM could not recall if her tonsilitis had arisen as a result of a strep throat and had no recollection of any specific pathology showing a strep throat.
18. HM could not recall if the LLRP had been preceded by Dr Hmood listening to her chest sounds while leaning forward but, “Absolutely it’s possible that he listened to my heart in one position and changed positions…”.
19. HM was taken to her statement that said that Dr Hmood said to her with words to the effect that the purpose of the exam was to listen to her heart sounds and it was easier or better to listen to the sounds whilst you were lying and better compared to her sitting up.
20. In relation to the LLRP HM explained, “I recall being told that the infection in my – my tonsilitis could have caused a heart infection and there was a need to listen to heart sounds, that’s as much as I recall, and what I was told.
21. HM also agreed that her statement … said that he, Dr Hmood, had also described that the purpose was to allow him to listen to her heart sounds in that position.
22. HM agreed that she understood Dr Hmood wanted to listen to her heart and that she moved into position based upon him saying that.
23. HM agreed she was lying on her left hand side, facing the wall and lying on a treatment bed pushed up against the wall and that it was a standard examination table. HM agree that Dr Hmood informed her that the tonsilitis could have a connection to a heart infection and that was why he wanted to listen to the heart sounds.
24. HM recalled being positioned on her side with her knees drawn up slightly toward her chest.
25. HM was fully dressed and only had to undo a button.
26. HM recalled Dr Hmood’s body across her body and he was holding a stethoscope and his right arm was over the top of her.
27. HM could not see Dr Hmood’s face as he was leaning across her but she was aware of pressure from his body on her lower back as the stethoscope was against her skin, HM could not recall the exact location of the stethoscope and she knew he was listening to her heart sounds as his hand was under her shirt as he held the stethoscope against her skin.
28. HM said that the contact to her body was occurring throughout the examination and her discomfort was as a result of the positioning of Dr Hmood’s body.
29. HM said, “I recall the body over my body, and the physical contact, and that’s the bulk of my recollection, so the exact timing of when the stethoscope was placed is difficult for me to recall. I feel that the presence of the body was there longer than the presence of the stethoscope, um, but that is the best of my recollection.
30. HM stated she had asked twice for Dr Hmood to move, but agreed that in her statement she said she believed Dr Hmood didn’t hear her because he had the stethoscope in his ears.
31. HM’s evidence was that she now believed Dr Hmood ignored the initial request and that she had to ask him to move a second time which only caused him to move very slightly and remain in contact with her.
32. HM’s initial thought at the time of the consultation was that Dr Hmood had not heard her request because the stethoscope was in his ears.
33. HM was unable to recall if the position was for approximately 30-40 seconds but that it was long enough for her to feel uncomfortable.
34. HM could not recall if Dr Hmood was asking her to take breaths as she was in the LLRP.
35. In relation to whether he explained the findings, HM’s recollection was that he possibly did.
36. In re-examination HM’s evidence as to whether the possibility of a heart infection had been ruled out was, “…all I know is that on that occasion he might have said that it’s fine or somethings fine, but I don’t know if there was any other follow up in regard to that.” The evidence here is sufficient to establish that a appropriate examination occurred and that the results were sufficiently communicated and that no follow up was required.
37. In relation to HM, Dr Overton agreed that there had been a complete blood work up for HM dated 25 March 2013, and that there had been a positive strep A finding.
38. Dr Overton agreed that his assumptions were not specifically directed toward these considerations.
39. Dr Overton agreed that the clinical records for 27 September 2013 contained a reference to chest pain sometimes with the query musculoskeletal.
40. Dr Overton agreed that the previous pathology showed a significant immune response and that the tonsilitis itself was caused by streptococcus.
41. The pathology report regarding streptococcus reported fairly heavy growth to which Dr Overton stated, “Well, it was positive yes”.
42. Dr Overton agreed that given the presenting features including significant immune response, report of chest pain a heart sounds examination was reasonably indicated.
43. Dr Overton disagreed that a LLRP position was a reasonable subjective clinical decision in this case.
44. Dr Overton expressed the opinion “…in a hospital practice you would be expected to do a full examination and general practice we would do an abbreviated examination”.
45. Dr Overton agreed that rheumatic fever is directly connected to streptococcus infection.
46. Dr Overton was unaware of outbreaks outside of disadvantaged communities, “but anything’s possible”.
47. Dr Overton attached a hyperlink to his report … about rheumatic fever.

http://conditions.health.qld.gov.au/HealthCondition/condition/14/33/160/acute-rheumatic-fever

1. Examining the information on that link reveals

Acute rheumatic fever (ARF) is a notifiable disease that can occur following an infection caused by the Group A Streptococcus bacterium (Strep). If untreated, a Strep infection (i.e. a ‘strep throat’ or skin infection) can lead to inflammation in other parts of the body, particularly the joints, brain and heart.  Without regular antibiotic treatment, further episodes of ARF can lead to serious damage of the heart valves. This is known as rheumatic heart disease (RHD).

1. The link identifies people in high risk categories – which includes indigenous communities. This was expressly referred to by Dr Overton in his report … However, Dr Overton did not make any reference to the website’s identification of people who “May be at high risk/additional considerations.” In this regard the website makes express reference to people “Aged 5 to 20 (peak years for ARF).” HM … was … 20 years of age at the time of the appointment.
2. Signs and symptoms listed as “typical initial symptoms include … chest pain”.
3. The website explained ARF requires hospitalisation and there “is no specific test to diagnose ARF. However, a number of tests will be done including an electrocardiogram or (ECG) to examine the rhythm of the heart and an echocardiogram (echo) which is a scan of the heart to check on the heart valves.”[[9]](#footnote-10)
4. Given the recorded and reported history the chest auscultation performed by Dr Hmood is plainly open.
5. Given the presenting complaint (as disclosed by the evidence and clinical records), HM’s understanding of the nature of the chest examination with the stethoscope including that it was going to include the LLRP, the fact, agreed to by Dr Overton, that the LLRP can be used to enhance the heart sounds themselves, and the that rheumatic fever is a possible complication of a strep throat, plus the fact that incidental contact can occur this allegation must fail.
6. On 4 June 2019, Dr Hmood via his solicitor responded to a request for information from Ahpra. His explanation in summary was as follows:
   * + He had no independent recollection of the incident
     + He denied any deliberate physical contact
     + Any contact that did occur was incidental to the examination
     + He denied breaching any professional boundaries.

### **Lack of informed consent**

1. The Tribunal is not satisfied that Hmood failed to obtain any or adequate consent from HM, or that he failed to give any or an adequate explanation for the chest auscultation.
2. The evidence establishes that after describing her symptoms to Hmood, he explained that he wanted to perform a chest auscultation on her and requested HM to lie down on the examination table in the LLRP.
3. The Tribunal accepts that HM complied with Hmood’s request, lying down in the LLRP after which Hmood performed the chest auscultation.
4. In circumstances where the consultation took place in March 2013, AHRPA received the initial notification from HM regarding the conduct the subject of Allegation 9 on 4 March 2019 and HM later signed a witness statement on 19 February 2020 (approximately six years after the consultation), the Tribunal cannot be satisfied to the *Briginshaw* standard that Hmood failed to obtain any or adequate consent, or failed to give any or an adequate explanation for the chest auscultation. In particular, it cannot be satisfied that HM recalled at the time she gave evidence everything that was said to her about the examination before she lay down in the LLRP.

### **Inappropriate and unnecessary physical contact**

1. The Tribunal is not satisfied that Hmood performed a chest auscultation on HM in a manner that was not appropriate in the circumstances, including that it involved inappropriate and unnecessary physical contact with HM.
2. HM gave consistent evidence regarding the physical contact Hmood made with her during the chest auscultation. As early as the 4 March 2019 AHPRA notification, HM stated:

He was looking down into my shirt, breathing heavily on me and pressing my body hard against his pelvis. After a couple of minutes I asked him if he could move his body away as it was making me feel uncomfortable. He adjusted slightly and continued to hold my body in place while standing over me. He said ‘oh that’s ok’ and continued the positioning for several minutes though I’d made it clear I was very uncomfortable. I was too afraid and felt too inferior to comment again. I was also positioned in a way that I couldn’t move away easily.

1. The Tribunal accepts that Hmood made physical contact with HM during the chest auscultation and that after she asked Hmood to move back, Hmood continued the chest auscultation in the LLRP for a period that she now recalls as approximately another minute.
2. However, a feeling of discomfort at the length of an examination does not establish, to the requisite standard, that Hmood performed the chest auscultation on HM with inappropriate and unnecessary physical contact.

### **For a sexual purpose**

1. The Tribunal is not satisfied to the *Briginshaw* standard that Hmood performed a chest auscultation on HM for a sexual purpose.
2. Importantly, a feeling of discomfort at the length of an examination does not establish the finding that Hmood performed the examination for a sexual purpose.

# Patient KT (Allegation 5)

1. The allegation concerning KT is alleged to have taken place during a consultation between Hmood and KT, at the Kilmore Medical Practice on 5 and/or 9 September 2013.
2. On 1 October 2013, KT reported Hmood’s alleged conduct to the police.
3. 17 October 2013, KT made a police statement.
4. On 4 May 2015, KT gave evidence at the committal hearing.
5. On 7 August 2015, KT gave evidence regarding her daughter, NT, at a criminal trial.
6. On 27 May 2019, KT signed a witness statement prepared by the Board’s solicitors.
7. On 13 September 2022, KT gave evidence at the Tribunal hearing.
8. The Tribunal finds KT was honest in giving evidence at the hearing as to her recollection of the events which occurred at the September 2013 consultations.
9. The Board submits:
10. At the consultation of 5 September 2013 KT told Dr Hmood she was having issues with a cough and chest infection.
11. KT agreed in her evidence that she had possessed the symptoms for some two weeks and they had not got better.
12. Dr Hmood asked her to lie on the consultation bed on her back.
13. After listening to KT’ upper chest with his stethoscope Dr Hmood then asked KT to roll onto her left side facing the wall.
14. Dr Hmood checked her back with the stethoscope – making her take deep breaths – whilst doing so he asked KT to move back to the edge of the bed. Whilst KT was moving backwards Dr Hmood placed his hand on her stomach between her hip and back.
15. KT could feel Dr Hmood’s crotch against her bottom.
16. She was unsure how long this lasted for.
17. KT gave evidence that Dr Hmood neither told her anything about the purposes of the examination or say anything to KT about her heart.
18. In relation to KT’s attendance on 9 September 2013 she confirmed in her evidence that the symptoms had not got better between the two appointments (these were the same symptoms as those presenting on 5 September).
19. Dr Hmood again asked KT to sit upon the consultation table initially asking her to lie on her back where he checked her chest.
20. As with the previous consultation Dr Hmood asked KT to turn upon her side and face the wall, where he checked back. Once again he both asked and manoeuvred her towards the end of the consultation bed, leaning over her and listening to her chest.
21. While standing behind KT he pressed his crutch up against her telling her to take deep breaths.
22. She could not be sure how long this lasted.
23. Hmood submits:

140. KT agreed that she had seen Dr Hmood on a number of prior occasions, and that she saw Dr Hmood on 5 September 2013 with a number of symptoms including a cough and shortness of breath. She believed she had a chest infection and that she had had the symptoms which had not resolved for two weeks prior to the consultation.

141. KT’s evidence at this hearing was that her symptoms deteriorated between the consultation on 5 September 2013 and her return on 9 September 2013.

142. KT also agreed that she was a smoker at the time and that at the commencement of the consultation she detailed the symptoms to Dr Hmood, and that this included a reference by her to Dr Hmood of a shortness of breath and a cough.

143. KT agreed that after telling Dr Hmood her symptoms that Dr Hmood told her he wanted to listen to her chest, that she understood that he was going to conduct an examination with a stethoscope and that she knew what a stethoscope was and that it was going to be used. KT was never asked to remove any item of clothing.

144. …

145. KT agreed that while in this position Dr Hmood asked her to take a deep breaths in and out and during the examination she became aware of contact between a part of his body and the back of her body.

146. The examination concluded and KT returned to the consultation chair she had been in for the initial part of the consultation, KT recalled that Dr Hmood informed her of what he believed she was suffering from, but could not recall if that was acute bronchitis.

147. The consultation concluded, prescriptions provided that were filled.

148. KT was not sure how long the stethoscope was placed and did not disagree that it could have been for a period of between 30-40 seconds. KT was not sure how long the stethoscope was in this position for, “it could have been under a minute, could have been a minute, I wasn’t counting”.

149. KT returned on 9 September 2013 and that it was in the context of advising Dr Hmood of a worsening of her persisting symptoms.

150. …

151. KT was asked to move to the edge of the bed and Dr Hmood provided assistance in moving her. KT was facing the wall and could not see his torso.

152. KT recalled Dr Hmood leaning over her, with the stethoscope in his hand, it was placed on her sternum between her breasts and she was asked to take deep breaths.

153. During the performance of the examination KT felt contact with her backside, she believed the contact was from Dr Hmood’s groin or crutch area.

154. The contact only took place whilst Dr Hmood was listening to her chest with the disc of the stethoscope placed on her sternum.

155. KT could not say how long this examination lasted and that it could have been under a minute.

156. The examination concluded and another script was provided with further advice about continuation of steroids and medications, “…I remember him giving me more, another antibiotic and told me to continue with the other medications that he had given me.”

157. KT then returned to Dr Hmood for a further, third consultation after the consultation on 9 September 2013.

158. In re-examination, while being examined in the LLRP, KT was unable to say whether the contact described occurred for a period of between 10 seconds or a minute.

159. In relation to KT, Dr Overton agreed that in relation to his assumptions he had not been asked to assume the length of time of KT’s symptoms, or her report of shortness of breath, or to the fact that she was a smoker.

160. Dr Overton agreed that smoking is a known cardiovascular risk, and that smoking elevates the risk of cardiovascular problems.

161. Dr Overton agreed that for a 43 year old female with a smoking history and her clinical presentation on 5 September 2013 that it was appropriate for a doctor to perform a heart sounds examination.

162. Dr Overton disagreed that the LLRP would be a reasonable exercise of subjective decision making. This Tribunal should reject this aspect of Dr Overton’s evidence. The LLRP is an accepted, recognised chest auscultation examination and there is nothing to suggest that it could not be performed here.

163. Given the presenting complaint (as disclosed by the evidence and clinical records), KT’s understanding of the nature of the chest examination with the stethoscope including that it was going to include the LLRP, the fact, agreed to by Dr Overton, that the LLRP can be used to enhance the heart sounds themselves, the fact that incidental contact can occur in the performance of the examination this allegation must fail for both dates alleged.

164. The highest Dr Overton’s evidence gets on the question of the LLRP in this allegation was that it was an “unreasonable exercise of subjective clinical decision making” this could not amount to evidence capable of supporting a conclusion that the performance of the “chest sounds auscultation” was for a sexual, inappropriate or non-clinical purpose. It is also noted that Overton was once again not provided all relevant facts in coming to his opinion. The fact Dr Overton did not have all relevant considerations as part of his assumptions lowers the weight that can be placed on the conclusion expressed in his report in relation to this patient.

165. Having regard to the Briginshaw standard as expressed in Anderson v Blashki the evidence is not capable of sustaining the allegation. The more improbable an event the stronger the evidence must be before it can be found to have occurred. Here it is not even clear how long the alleged contact occurred, let alone the part of the body that made contact to her. KT had attended on Dr Hmood on multiple occasions prior and subsequent to these consultations. The contact described occurred in connection to the request to perform a LLRP the examination. KT’s recollection was that she returned on 9 September 2013 with a worsening of symptoms. As Dr Overton agreed a doctor is entitled to take into account the reported concerns and their impact upon the patient. The Tribunal is also entitled to have regard to the fact that KT continued to attend upon Dr Hmood. This on its face seems inconsistent with the matters alleged. The Tribunal is entitled to take all of these factors into account and could comfortably conclude that the allegation is not made out.

### **Lack of informed consent**

1. The Tribunal is not satisfied that Hmood failed to obtain any or adequate consent from KT, or that he failed to give any or an adequate explanation for the chest auscultation.
2. KT has given consistent evidence since making the initial statement to police on 17 October 2013 that after describing her chest related symptoms to Hmood, he told her he wanted to complete a chest auscultation on her and requested KT lie down on the examination table. The Tribunal accepts this evidence and that KT complied with Hmood’s request.
3. In circumstances where KT complied with Hmood’s request to perform the chest auscultation and where the issue in contention regards the manner in which the examinations were conducted and the duration of them, the Tribunal cannot be satisfied to the *Briginshaw* standard that Hmood failed to obtain any or adequate consent, or failed to give any or an adequate explanation for the examination.

### **Inappropriate and unnecessary physical contact**

1. The Tribunal is not satisfied to the *Briginshaw* standard that Hmood performed the chest auscultations on KT in a manner that was not appropriate in the circumstances and which involved inappropriate and unnecessary physical contact.
2. KT was equivocal in her evidence regarding the physical contact made by Hmood at the consultations.
3. The Tribunal is not satisfied that the physical contact made by Hmood during the consultations was inappropriate and unnecessary. KT’s evidence of what occurred was not clear enough to lead to this conclusion.

### **For a sexual purpose**

1. The Tribunal is not satisfied to the *Briginshaw* standard that Hmood performed the chest auscultation on KT for a sexual purpose.

# Patient QC (Allegation 8)

1. The allegation concerning QC relates to a consultation she had with Hmood at the Kilmore Medical Practice on 31 May 2013.
2. QC reported Hmood’s alleged conduct to the police about eight months later, in January 2014, making a written police statement on 16 January 2014. She later gave evidence at a committal hearing on 5 May 2015.
3. The audio of that committal hearing was played at the Tribunal hearing, and the audio and transcript are in evidence (as discussed above). She did not give evidence at the Tribunal hearing.
4. QC also signed a witness statement prepared by the Board’s solicitor on 20 November 2019. The Tribunal accepts that it records matters as she then recalled them.
5. The Board submits:

224. At the time of her consultation on 31 May 2013, QC had just turned 18 years old.

225. Her presenting complaint was a sore throat.

226. Dr Hmood commenced by looking at the throat of QC before asking her to lie down on the consultation table facing the wall.

227. When on the consultation table Dr Hmood leant over the top of QC and placed his hand underneath her shirt and put the stethoscope on top of her left breast to listen to her heart.

228. Whilst doing this QC could feel Dr Hmood’s stomach or crutch pressing into the middle of her back. She could also hear him breathing.

229. QC conceded in cross-examination at the committal hearing that Dr Hmood probably put the stethoscope above her left breast.

230. She was, however, certain that it was Dr Hmood's crotch that pushed up against her – in contrast to her statement where she was equivocal. At the committal hearing she was certain.

1. Hmood submits:
2. At paragraph 47 of Ms Ashton’s affidavit she deposed that on 18 April 2019, “[QC] stated that the relevant conduct ‘happened when [she] was a kid really’ and that it was challenging for her to recall the details.

…

1. In regard to QC, the materials before the Tribunal contained in the clinical record showed that she presented with a sore throat for a few days and cough with phlegm. The clinical records on their face support the proposition that a chest examination and/or consideration of same was appropriate and at the very least it was an issue capable of exploration at this hearing. Should the Board seek to rely upon it, the evidence of QC at committal, with reference to the Briginshaw standard, is insufficient to find the allegation proven.

### **Lack of informed consent**

1. The Tribunal is not satisfied that Hmood failed to obtain any or adequate informed consent from QC, or that he failed to give any or an adequate explanation for the chest auscultation.
2. Critically, on the evidence before the Tribunal, the first time QC mentioned Hmood’s failure to explain what he was doing, or failure to obtain her permission, is in the witness statement prepared for this proceeding— nearly six and a half years after the events are alleged to have occurred.
3. When considered with her otherwise equivocal and changing evidence (discussed below), the Tribunal cannot be satisfied, to the *Briginshaw* standard, that Hmood failed to obtain any or adequate informed consent from QC, or failed to give any or adequate explanation to her for the chest auscultation.

### **Inappropriate and unnecessary physical contact**

1. The Tribunal is not satisfied that Hmood performed a chest auscultation on QC in a manner that was not appropriate in the circumstances, including in that it involved inappropriate and unnecessary physical contact with QC.
2. QC’s evidence differed over time as to how she remembered Hmood was placed during the examination. The Tribunal accepts her evidence that she felt uncomfortable with Hmood’s contact. However, what that contact was is too unclear to establish the allegation.
3. For example, in her police statement, she said she felt Hmood’s stomach or crotch pressed against the middle of her back. At the committal hearing QC said that she felt Hmood’s crotch pressing against her lower back. QC stated this change of position was because she ‘was scared’ at the time of giving the police statement in January 2014 but that she could ‘now…remember properly.’
4. In the witness statement prepared on 20 November 2019, QC said she did not know which part of Hmood was touching her, and conceded that it may have been his belt buckle.
5. The Tribunal accepts that QC could no longer recall what part of Hmood was touching her during the chest auscultation. In those circumstances, and when QC was not called to give evidence in this proceeding, the Tribunal cannot be satisfied to the requisite standard that examination involved inappropriate and unnecessary physical contact.

### **For a sexual purpose**

1. The Tribunal is not satisfied that Hmood performed a chest auscultation on QC for a sexual purpose.

# Patient TN (Allegation 7)

1. The allegation concerning TN relates to a consultation she had with Hmood at some point between February and July 2013.
2. TN reported Hmood’s alleged conduct to the police and made a statement to police on 29 January 2014. She later gave evidence at the committal hearing on 7 May 2015.
3. The audio of that committal hearing was played at the Tribunal hearing, and the audio and transcript are in evidence (as discussed above). She did not prepare a witness statement in this proceeding, nor appear to give evidence at the Tribunal hearing.
4. The Board submits:
5. TN attended upon Dr Hmood at least seven times between 12 November 2012 and 21 November 2013.
6. Her memory was she attended upon Dr Hmood sometime in June or July 2013 for a prescription in relation to gastroesophageal reflux disease. However, although the clinical records indicate that she did indeed attend Kilmore Clinic in June or July 2013 she saw Dr Hmood in January, February or November of that year.
7. When attending TN recalls Dr Hmood asking if she had any shortness of breath. TN told Dr Hmood she did not.
8. Dr Hmood told TN he wanted to check her heart and asked her to lie on the consultation table facing away from him.
9. He placed his stethoscope underneath her left breast and said words to the effect of ‘excuse where my hand is.’
10. It felt to TN that Dr Hmood listened to her chest for a period 5 to 10 minutes.
11. He was leaning against her back, it felt like his torso area. She could feel his belt buckle on her shoulder blades.
12. TN gave evidence at the committal hearing that initially she was not uncomfortable with Dr Hmood’s process but this changed as the listening with the stethoscope lingered.
13. Hmood submits:
14. TN in her police [statement] states that the incident [in] question occurred at an appointment in about “June or July 2013”. This is critical because with reference to the clinical records there is no recorded entry of TN attending.
15. In addition, the only issue identified by TN at her evidence given at committal does not support the allegation as alleged in the Notice. In her evidence at committal TN described her concern as follows,

So your concern as you’ve told us was the length of time and you started to feel strange when it went longer than you had anticipated? --- Yes

1. The clinical records, police statement and committal evidence on its face does not support the allegation and with reference to the Briginshaw standard, is insufficient to find the allegation proven.

### **Lack of informed consent**

1. The Tribunal is not satisfied that Hmood failed to obtain any or adequate consent from TN, or that he failed to give any or an adequate explanation for the chest auscultation.
2. In both her statement to police on 29 January 2014 and at the committal hearing on 7 May 2015, TN gave evidence that Hmood had asked her whether or not she suffered from shortness of breath, told her he wanted to check her heart, asked her to get on the bed facing the wall, and during the examination had said words to the effect of, ‘excuse where my hand is’.
3. The Tribunal is not satisfied to the *Briginshaw* standard that Hmood failed to obtain any or adequate consent, or failed to give any or an adequate explanation for the examination.

### **Inappropriate and unnecessary physical contact**

1. The Tribunal is not satisfied that Hmood performed a chest auscultation on TN in a manner that was not appropriate in the circumstances, including in that it involved inappropriate and unnecessary physical contact with TN.
2. The Tribunal is not satisfied as to how long the consultation lasted. In her police statement, TN said:

It felt like he was listening to my chest for about five to ten minutes, he was leaning against my back, it felt like his torso area. I could feel his belt buckle on my shoulder blades, I thought this behaviour was strange… It seemed to take a really long time and he kept asking me to take deep breaths.

1. TN’s evidence at the committal was that she felt uncomfortable after the examination lasted longer than the ‘about a minute’ she had anticipated, and that Hmood said something like ‘excuse where my hand is’.
2. A feeling of discomfort at the length of an examination, and feeling ‘a belt buckle’ on shoulder blades, does not establish, to the requisite standard, that Hmood performed the chest auscultation on TN with inappropriate and unnecessary physical contact.

### **For a sexual purpose**

1. The Tribunal is not satisfied that Hmood performed a chest auscultation on TN for a sexual purpose.

# Patient FM (Allegation 4)

1. The allegation concerning FM relates to a consultation she had with Hmood on 29 July 2013.
2. FM made a statement to the police regarding Hmood’s alleged conduct on 2 November 2013. She gave evidence at the committal hearing on 4 May 2015 and at the criminal trial on 7 August 2015.
3. The audio of FM’s evidence at the committal hearing was played at the Tribunal hearing, and the audio and transcript are in evidence (as discussed above). The transcript from her appearance at the criminal trial is also in evidence.
4. FM did not make a witness statement in this proceeding, nor give oral evidence at the Tribunal hearing.
5. Although FM was not called to give evidence, the Tribunal was satisfied that she was honestly recalling events in the evidence she had previously given of the matters set out below. Louisa Ashton’s affidavit gave an explanation for her not being called.
6. The Board submits:
7. FM attended upon Dr Hmood a number of times in 2013.
8. The clinical notes from FM’s attendance on 29 July is as follows:

…

1. FM states that she attended in relation to an ongoing issue she and her partner were having (the clinical notes make clear what the issue is from).
2. On her third visit in respect of this issue Dr Hmood asked FM to sit on the consultation bed so he could listen to her chest. He then directed her to lay down on her left side and face the wall.
3. Dr Hmood then put his hand over FM’s waist and onto her hip, he pulled her lower hip so that her bottom ‘pop[ed] out even more towards the doctor.’ This made FM uncomfortable.
4. FM was unsure what was happening until Dr Hmood told her he was going to check her chest.
5. Dr Hmood then placed his stethoscope into the breast area of FM, this continued for a long time.
6. When challenged about her recollection of where the stethoscope had been placed, at the trial FM was adamant in her evidence:

Dr Hmood was using the stethoscope, correct? -- -Yep, yep . You say it was principally on or around your left breast, correct? ---Correct.

What I'.m saying

MS PIGGOTT: Well the witness has in fact said on her breast, not principally? - --On. It's on, I've said it

HIS HONOUR: Yes, she did say on her breast, that's correct?

---I've said it a few times

MS FOX: So do you agree it was around and on or you're saying just on? ---On, on.

And are you saying that within - well there was more than one position that it was placed on your breast? ---Yes

And one of those positions was, I'd suggest, underneath your left breast. Do you agree with that? - --I'm not agreeing with that. It was on my boob. If that's what you mean, then yes but if that's not what you mean, I'm not going to agree with that.

1. Whilst doing this FM felt Dr Hmood push his body against her bottom. She was of the view that she could feel his penis pushing into her.

…

1. Unlike TN or QC she was cross-examined at both a committal hearing and a trial. She has therefore been tested twice in respect of her account. There is a resolute consistency through her account in terms of which she gave evidence of recalling. She was challenged directly on her account and remained true to it.
2. The Tribunal is well placed to assess the clinical indication for the purported examination, including by reference to the clinical notes and the opinion of Dr Overton.
3. The Tribunal is well-placed to assess whether the contact described by FM was unnecessary and/or inadvertent.
4. It can undertake this task, even if it ultimately decides that it is unable to be satisfied, on the evidence, of the particular factual allegation by FM that she felt his penis against her.
5. Hmood submits:

262. Should it be necessary, in regard to the materials before the Tribunal, the clinical record for FM recorded that on 29 July 2013 that she attended for amongst other things headache and dizziness and SOB. This was in conjunction with a recorded smoking history, and a sexually transmitted infection, and recorded psychiatric issues and medications. The clinical records on their face support the proposition that a chest examination was appropriate or at the very least it was an issue capable of exploration. The ability to explore this has been denied to the Tribunal and Dr Hmood.

263. The evidence of FM itself is unsafe. For example, at the County Court trial FM stated that she could feel Dr Hmood’s erect penis up her arse, and that it was pushed and held there for a period estimated to be 5 minutes. Her evidence was inconsistent with reports of the incident to her then partner…who stated FM said to her that Dr Hmood was grinding his genitals against her buttocks for what she reckoned was in excess of 10 minutes.

264. Given the gravity of this allegation there must be a weight of evidence that is commensurate with the gravity of the allegation. In light of the exaggeration and inconsistencies this evidence could be used to conclude that the allegation is[[10]](#footnote-11) made out.

### **Lack of informed consent**

1. The Tribunal is not satisfied that Hmood failed to obtain any or adequate consent from FM, or that he failed to give any or an adequate explanation for the chest auscultation.
2. After describing her symptoms to Hmood at the initial stage of the consultation, FM complied with his request for her to get onto the examination table in the LLRP so that he could check her breathing and perform the chest auscultation.
3. In the circumstances, the Tribunal cannot be satisfied to the *Briginshaw* standard that Hmood failed to obtain any or adequate consent, or failed to give any or an adequate explanation for the chest auscultation.

### **Inappropriate and unnecessary physical contact**

1. The Tribunal is satisfied to the *Briginshaw* standard that Hmood performed a chest auscultation on FM in a manner that was not appropriate in the circumstances which involved inappropriate and unnecessary physical contact.
2. During the performance of the chest auscultation while she was in the LLRP, FM felt Hmood place his hand on her hip and pull her body back so that her backside made contact with Hmood’s groin or crutch area:

…When I was facing the wall my legs were straight out. Dr Hmood put his hand over my waist onto my hip which was on the bed. He used his hand to pull my lower hip further around on the bed. This made my arse pop out even more towards the doctor. This made my back twisted and I was uncomfortable. I thought he could have asked me to move around further. I was uncomfortable with him grabbing me on the hip the way he did.

… While he had the stethoscope on my chest he had pushed his body against me arse. I could feel his dick pushing into me. It was hard and against my arse…It was just held hard against my arse…

1. Although some details as to how the contact occurred changed from FM’s initial police statement, to the committal hearing and then criminal trial, FM’s evidence regarding fundamental aspects and critical issues such as that she felt Hmood’s hard penis pressed against her backside for the length of chest auscultation was consistent. The Tribunal accepts her evidence.
2. Her estimates of timing that the penis was against her, varied in her County Court evidence. She said ‘probably five minutes’, then, in cross examination said ‘a couple…maybe more, five, three, four…’. The Tribunal is satisfied that the contact occurred for at least two minutes (and may well have felt like much longer).
3. The Tribunal is satisfied that the physical contact Hmood made to FM’s backside area during the examination while having his hand on her hip was inappropriate and unnecessary, accepting the evidence of Dr Overton:

… it is not clinically necessary or appropriate for a doctor’s groin area to be touching a patient in the manner described, or have his hand touching her hip, while performing a left lateral recumbent chest examination.

### **For a sexual purpose**

1. The Tribunal finds that the inappropriate manner in which Hmood made physical contact with FM when performing the chest auscultation which was not clinically indicated or necessary suggests that it was performed for a sexual purpose.
2. The Tribunal accepts FM’s evidence that the duration of the chest auscultation was performed in the manner described for at least two minutes and that she felt uncomfortable with the physical contact made by Hmood which resulted in her leaving the consultation in a state of shock:

… After he stopped (the chest auscultation examination) I can’t remember what he said to me. I just wanted to get out of there. I don’t remember anything at all that was said. I needed to leave…

1. The finding that there was a sexual purpose is supported by the fact that Hmood failed to provide FM with a sufficient explanation of results after completing the chest auscultation, and there was no record of the examination in the clinical notes.
2. The Tribunal is satisfied to the *Briginshaw* standard that Hmood performed a chest auscultation on FM for a non-clinical and sexual purpose.

# CONCLUSION

1. The Tribunal has found some, but not all, of the allegation, are established.
2. The parties are directed to now consider the further orders that should be made in this hearing, so that the matter can proceed to a hearing in relation to whether the found conduct constitutes professional misconduct, or unprofessional conduct, and what determination should be made.
3. Proposed orders and submissions are to be provided to the Tribunal by the Board by 4pm on 30 January 2023, and by Hmood by 4pm on 24 February 2023.

|  |  |  |
| --- | --- | --- |
| **Judge Marks**  **Vice President** | **Dr Robyn Mason**  **Health practitioner member** | **Dr Peter McNeill**  **Health practitioner member** |

1. Chest auscultation involves using a stethoscope to listen to a patient’s respiratory system, and interpreting the lung sounds heard). [↑](#footnote-ref-2)
2. In the course of the hearing, the Board submitted that the Tribunal should be satisfied that each examination was done for a sexual purpose (rather than some other unspecified inappropriate or non-clinical purpose). The Tribunal’s findings as to purpose therefore relate to whether it is satisfied the examinations were done for a sexual purpose. [↑](#footnote-ref-3)
3. Hmood’s patients are identified by pseudonyms, due to a suppression order made in this proceeding. [↑](#footnote-ref-4)
4. Allegations 1-9 are as set out in the two Notices of Allegation (a consequence of the consolidation of proceedings Z485/2019 and Z74/2020). [↑](#footnote-ref-5)
5. Extracts have been included from the parties’ final written submissions. They have been reproduced with Tribunal Book and Transcript references redacted. [↑](#footnote-ref-6)
6. As indicated earlier, in the course of the hearing, the Board submitted that the Tribunal should be satisfied that each examination was done for a sexual purpose (rather than some other unspecified inappropriate or non-clinical purpose). The Tribunal’s findings as to purpose therefore relate to whether it is satisfied the examinations were done for a sexual purpose. [↑](#footnote-ref-7)
7. The sole exception is patient HM who gave some evidence as to being told by Hmood to the effect that her tonsilitis could have caused a heart infection. See particular (iii)(D). [↑](#footnote-ref-8)
8. [2017] NSWSC 53. [↑](#footnote-ref-9)
9. Dr Overton link at TB [116] <http://conditions.health.qld.gov.au/HealthCondition/condition/14/33/160/acute-rheumatic-fever>. [↑](#footnote-ref-10)
10. The Tribunal assumes this sentence is missing the word ‘not’ at the end, and should finish with ‘to conclude that the allegation is *not* made out’. [↑](#footnote-ref-11)