Draft Solicitor's Assessment — Verhoeven v Epworth HealthCare

LEGAL ASSESSMENT — VERHOEVEN v EPWORTH HOSPITAL & DR MICHAEL PIPEROGLOU

Prepared for: Foris AG, Bonn, Germany Date: [DATE] Prepared by: [FIRM NAME, ADDRESS] Author: [PARTNER NAME], [QUALIFICATIONS]

1. INSTRUCTIONS

We have been asked to provide a preliminary legal assessment of a medical negligence claim by Mr Patrick John Verhoeven (DOB 28/03/1980) arising from electroconvulsive therapy (ECT) administered at Epworth Hospital, Camberwell, Victoria in August 2018. This assessment is prepared for the purposes of Foris AG's internal review of a proposed litigation funding facility.

2. FACTUAL SUMMARY

Mr Verhoeven was admitted to Epworth Hospital (Ward MHUB) on 1 August 2018 as a voluntary psychiatric inpatient under the care of Dr Michael V Piperoglou, psychiatrist. He received six bilateral ECT sessions between 8 and 20 August 2018 using a Thymatron System IV device.

Prior to ECT, Mr Verhoeven had a documented Full Scale IQ of 121 (Superior range, WAIS-IV, December 2017), was employed as a quantitative analyst at Phillip Capital managing approximately $16 million in funds under management at an income of approximately $250,000 per annum, and held three degrees from Monash University (LLB, BEco, BCom).

Mr Verhoeven is now in receipt of a Disability Support Pension. Three successive Commonwealth assessments (2023, 2024, 2025) have documented progressive deterioration to total incapacity, with baseline work capacity assessed at 0-7 hours per week and suitable work classified as "Not Applicable."

3. PROPOSED DEFENDANTS

a. Dr Michael V Piperoglou — treating psychiatrist, administered the ECT course
b. Epworth Hospital — institutional defendant, vicarious liability, duty of care as treating facility

Additional defendants under consideration include the referring psychiatrist, the treating anaesthetist, and the outpatient psychiatrist whose treatment was modified on non-clinical direction prior to the ECT admission. All are expected to hold professional indemnity insurance.

4. LEGAL BASIS

The claim is brought in negligence under the common law of Victoria, subject to the Wrongs Act 1958 (Vic), Part XI (Civil Liability). The cause of action arises from breaches of the duty of care owed by the

treating psychiatrist and the hospital to the patient during the administration of ECT.

5. IDENTIFIED BREACHES OF DUTY

a. Failure to respond to a life-threatening cardiac event

The Thymatron machine printout from Treatment 5 (17 August 2018) records a heart rate of 23 beats per minute. Normal resting heart rate is 60-100 bpm. Below 40 bpm constitutes clinically significant bradycardia. Pre-ECT nursing observations taken on the ward that same day recorded a normal pulse of 76 bpm.

No documentation in any record released by Epworth indicates that this bradycardia was recognised, treated, or discussed. Treatment 6 proceeded three days later without any documented clinical adjustment. A competent practitioner would be expected to investigate, document, and respond to a near-asystole event, and to reassess the appropriateness of continuing the ECT course.

b. Excessive dose escalation with declining seizure quality

The electrical stimulus was tripled between Treatment 1 and Treatment 5: - Charge delivered: 51.1 mC to 152.8 mC (+199%) - Frequency: 30 Hz to 50 Hz (+67%) - Stimulus duration: 0.9 sec to 1.7 sec (+89%)

Despite this escalation, seizure quality deteriorated: - Seizure Energy Index: 12,549 to 3,239 uV2 (-74%) - Max Sustained Power: 21,815 to 5,117 uV2 (-77%) - EEG seizure duration: 65 sec to 50 sec (-23%)

The progressive decline in seizure quality despite increasing stimulus indicates the brain developing tolerance, a finding that should prompt a competent practitioner to reassess the treatment approach, consider changing electrode placement, or discontinue the course. Higher charge and frequency are associated in the literature with greater cognitive side effects.

c. Failure to obtain or maintain adequate informed consent

The ECT consent form (document MR3NN per the hospital’s own MR40H checklist) was not included in the records released to Mr Verhoeven. Consent was obtained during a period of acute psychological instability, shortly after cessation of effective ADHD medication on non-clinical direction. No evidence of an independent capacity assessment has been produced.

d. Failure to provide a discharge plan

On 20 August 2018, a family member emailed both Dr Piperoglou and the outpatient psychiatrist requesting a post-discharge plan, stating no plan had been prepared despite prior requests. Mr Verhoeven was discharged the following day. No discharge care plan has been located in the released records.

6. MISSING RECORDS

Mr Verhoeven submitted a Medical Record Access Request Form on 25 January 2026 requesting his complete medical record. The hospital’s own MR40H checklist confirms the following documents existed. None were released:

- MR22: Anaesthetic charts (all 6 sessions)
- MR3NN: ECT consent form
- MR2B: ECT referral
- MR80: Medication chart and alert card

- Psychiatrist clinical notes, admission notes, progress notes, discharge summary
- Any cognitive assessment performed before, during, or after the ECT course

A section 17 preservation notice was served on Epworth on 23 December 2025. Epworth acknowledged receipt. The standard seven-year retention period for these records would have expired approximately January 2026.

The absence of these records is significant both substantively (they would contain evidence of the clinical response to the 23 bpm event and the clinical rationale for dose escalation) and procedurally (the hospital's inability to produce records it was obliged to maintain may give rise to adverse inferences at trial).

7. CAUSATION

Mr Verhoeven's treating general practitioner, Dr Christopher Mulroney, independently placed the onset of the disabling condition at 2019, post-ECT.

A neuropsychological assessment with Dr Robert Bourke at Eastern Neuropsychology has been referred and funded by Maurice Blackburn (who act on related insurance claims). This assessment will provide an objective before-and-after cognitive comparison against the 2017 WAIS-IV baseline and is expected to establish the nature and extent of cognitive decline.

The causal hypothesis is that the ECT course, and in particular the undocumented 23 bpm cardiac event at Treatment 5 (with possible associated cerebral hypoperfusion), caused or materially contributed to an acquired brain injury resulting in progressive executive dysfunction.

Mr Verhoeven's employment termination in 2023 (documented grounds: task abandonment, impulsive actions, systematic procedural non-adherence) is consistent with frontal lobe executive dysfunction.

8. LIMITATION

The ECT was administered in August 2018. The standard limitation period under the Limitation of Actions Act 1958 (Vic) is three years from the date of discoverability.

The neurological character of the injury and its causal connection to ECT were not reasonably discoverable until late 2025 when (a) an independent psychiatric assessment by Dr Michael Maloney found the conditions for which ECT was ostensibly administered were in remission, mischaracterised, or not present; and (b) forensic analysis of the Thymatron readouts in early 2026 identified the 23 bpm cardiac event, which had never been disclosed to the patient.

It is our assessment that the limitation period has not expired, on the basis that the date of discoverability is no earlier than late 2025. The pending neuropsychological assessment will further support this position by establishing the objective cognitive deficit that was not previously identified.

9. QUANTUM

The principal heads of damage are:

a. Loss of earning capacity: pre-injury income of approximately $250,000 per annum from age 38 to retirement, reduced by DSP income of approximately $31,000 per annum.

b. Past and future treatment and care costs: to be quantified following the neuropsychological assessment.

c. Non-economic loss: to be quantified.

On a preliminary assessment, total claim value is estimated in the range of $7.5 million to $10 million.

10. PROSPECTS OF SUCCESS

The claim presents reasonable prospects of success, having regard to:

a. The documented 23 bpm cardiac event with no evidence of clinical response;
b. The aggressive dose escalation pattern with declining seizure quality;
c. The absence of key clinical records from a “complete records” request;
d. The significant pre-injury and post-injury functional gap (IQ 121, $250,000 income to DSP);
e. Bill Madden (Senior Legal Counsel, Carroll & O’Dea, Accredited Specialist in Personal Injury, co-author of Australian Medical Liability) has reviewed the clinical materials and stated in writing that “the proposed claim may have merit”;
f. Maurice Blackburn has accepted instructions on related insurance claims, indicating their independent assessment of the underlying injury claim.

The principal risk areas are limitation (addressed above) and causation (dependent on the pending neuropsychological assessment). These are manageable risks that can be addressed through the evidence-gathering phase of proceedings.

11. RECOMMENDATION

We recommend that Foris AG consider funding this claim. The combination of documented clinical breaches, missing records, a significant damages quantum, insured institutional defendants, and the involvement of reputable Australian law firms on related claims presents a favourable risk-return profile for a litigation funder.

[FIRM NAME] [PARTNER NAME] [DATE]