LEGAL ASSESSMENT AND CASE DESCRIPTION

Verhoeven v Epworth HealthCare / Dr Michael V. Piperoglou

Medical Negligence: Electroconvulsive Therapy

Prepared for Foris AG | 8 April 2026

Independent Legal Assessment: Bill Madden, Senior Legal Counsel, Carroll & O'Dea Lawyers (Sydney). Accredited Specialist in Personal Injury. Co-author, *Australian Medical Liability* (LexisNexis, 4th ed). Fellow, Australian Academy of Law. Doyle's Guide 2024 Preeminent Practitioner, Medical Negligence (Plaintiff). He reviewed the clinical chronology and Thymatron data. On 7 April 2026 he stated: *"The proposed claim may have merit, but it will be necessary to obtain all of the relevant records and then an opinion from an independent medical expert."*

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1. Parties and Jurisdiction

Claimant: Patrick John Verhoeven (DOB 28/03/1980). LLB, BEco (Statistics), BCom (Finance), Monash University. Quantitative fund manager, Phillip Capital (contractor, October 2010 to March 2018), ~$16M FUM, ~$250,000/year. Currently on the Disability Support Pension (~$600/week).

Respondents: Epworth HealthCare (major not-for-profit hospital, medical indemnity insured) and Dr Michael V. Piperoglou (treating psychiatrist). Jurisdiction: Supreme Court of Victoria. Wrongs Act 1958 (Vic), Part X.

2. Facts

2.1 Pre-Injury Baseline

WAIS-IV Full Scale IQ 121 (Superior range, Perceptual Reasoning 95th percentile), December 2017, assessed during acute psychosocial stress. Three degrees. Eight-year career managing $16M in client funds. Pre-existing GAD and ADHD, both effectively managed with stimulant medication. Fully functional across all domains: employment, parenting, independent living.

2.2 Non-Clinical Pathway to ECT

On 20 June 2018, Michael Verhoeven (the claimant's brother, Partner at Bain & Company, Melbourne) emailed a strategy for the claimant's psychiatric management: cease all stimulant medication (Vyvanse/dexamphetamine), cease Valium, shift to antipsychotics. The email stated: *"Alternative diagnosis of bi-polar would not change this path"* and acknowledged the treating psychiatrist (Dr Aizenstros) *"does not have close oversight or control of in-patient management."* The medication changes were predetermined regardless of diagnosis.

Effective ADHD medication was ceased. The claimant deteriorated. A 24 July 2018 email dictated a "no admission" plan. Further deterioration followed. The claimant had three or four admissions to South Eastern Private Hospital for Transcranial Magnetic Stimulation (a non-invasive, low-risk treatment). Despite the availability of this conservative pathway, the claimant was then admitted to Epworth and administered six sessions of ECT, an invasive neurological procedure, as an emergency corrective measure. The escalation from TMS to ECT followed directly from the non-clinical medication cessation.

The Phillip Capital contracting arrangement was wound up by a family member while the claimant was hospitalised for ECT, eliminating his primary income source and ~$2,500/quarter in trailing commissions.

2.3 Contested Diagnostic Basis

Dr Piperoglou recorded Obsessive Compulsive Personality Disorder. The claimant was told psychotic depression (contemporaneous email to ex-spouse, 11 September 2018). An independent psychiatric assessment (Dr Michael Maloney, Consultant Psychiatrist, Honorary Fellow, University of Melbourne, 2 December 2025) found the conditions for which ECT was administered were in remission, mischaracterised, or not present at time of his assessment. No published guideline (RANZCP, APA, NICE) supports ECT for OCPD.

2.4 The 23 BPM Cardiac Event

Treatment 5 (17 August 2018, 11:21:55): the Thymatron System IV recorded a Base Heart Rate of 23 BPM. Pre-procedure ward observations showed a normal pulse of 76 BPM. At 23 BPM, cardiac output drops to approximately one-quarter of normal. ACLS protocols require immediate atropine 1 mg IV for symptomatic bradycardia below 50 BPM; ANZCA PG18 mandates continuous cardiac monitoring and immediate intervention. No released record documents this event being recognised, treated with atropine, or disclosed to the patient. Treatment 6 proceeded three days later with no documented adjustment and no prophylactic atropine. The claimant discovered this event in March 2026 through forensic analysis of the Thymatron thermal printouts.

2.5 Piperoglou Reviewed the Data and Did Nothing

While the claimant was still an inpatient, Dr Piperoglou reviewed the ECT titration charts and remarked words to the effect of *"they gave you a good zap,"* chuckling. This is a party admission proving: (a) Piperoglou personally reviewed the treatment data; (b) what he saw surprised him; and (c) he failed to investigate, document, or disclose. His reaction eliminates any future defence that the Thymatron data was clinically unremarkable.

2.6 Energy Tripled, Seizure Quality Collapsed

Treatment 1 used 10% energy (51.1 mC) and produced a robust 65-second seizure. By Treatment 5, energy had been tripled to 30% (152.8 mC), frequency increased 67%, and stimulus duration increased 89%. Despite this, the Seizure Energy Index fell 74% (12,549 to 3,239 mV^2), maximum sustained power fell 77%, and time to peak power doubled. The first treatment worked at low dose. The response deteriorated as the dose was tripled. Every major guideline (RANZCP, APA, NICE) requires reassessment or cessation when this occurs. The Inquest into the Death of Gerard Helliar [2018] VicCorCResp (Coroner Peter White, Victoria) found a death preventable where ECT was escalated without adequate review.

2.7 Discharge Without Care

On 20 August 2018, the claimant's father emailed Epworth and Dr Aizenstros requesting a discharge plan. The email stated: *"We have requested this in the past"* and *"I am not aware of any plan being prepared."* The claimant was discharged the following day after six ECT sessions with no documented follow-up, no outpatient plan, and no post-ECT cognitive monitoring.

2.8 Six Categories of Missing Records

Despite a formal access request (25 January 2026) and a s.17 preservation notice (served 23 December 2025, days before the seven-year retention period expired, acknowledged by Epworth), six categories of records have not been produced: consent form (MR3NN), referral (MR2B), anaesthetic charts for all six sessions (MR22), medication chart (MR80), psychiatrist clinical notes, and legible Thymatron readouts for three of six sessions. The MR40H checklist in the released records confirms these documents existed and accompanied the patient to each session. Only procedural paperwork was released. The entire clinical decision-making record is absent.

3. Six Independent Grounds of Breach

(a) Failure to manage a cardiac emergency. 23 BPM under general anaesthesia requires immediate atropine (ACLS) with continuous cardiac monitoring (ANZCA PG18). No record of intervention. Without the MR22 anaesthetic charts, the respondents cannot demonstrate atropine was administered.

(b) Failure to disclose an adverse event. Wighton v Arnot [2005] NSWSC 637: duty to disclose adverse events is a necessary part of reasonable aftercare. Rogers v Whitaker [1992] HCA 58: all material risks must be disclosed. The 23 BPM event was never disclosed. This is a standalone breach (Wighton) and vitiates informed consent for subsequent sessions (Rogers v Whitaker). Wrongs Act s.60 excludes the duty to warn from the s.59 peer opinion defence.

(c) Negligent dose escalation. Energy tripled while seizure quality collapsed 74%. Treatment 1 produced a therapeutic seizure at low dose; the escalation was unnecessary and contrary to RANZCP, APA, and NICE guidelines. Helliar coronial finding: direct Victorian precedent.

(d) Failure to investigate a known clinical concern. Piperoglou reviewed the titration data, reacted with surprise, and took no clinical action. His duty upon observing an anomaly was to investigate, document, and disclose.

(e) Unsupported diagnostic indication. ECT for OCPD has no published guideline support. The patient was told a different diagnosis (psychotic depression) from what was recorded (OCPD). Either the treatment lacked indication (if OCPD) or the records are inaccurate (if psychotic depression). Both create liability.

(f) Non-clinical interference in clinical decision-making. A management consultant directed cessation of effective medication on a predetermined path regardless of diagnosis. The hospital accepted and treated a patient whose clinical trajectory was shaped by non-clinical interference without independent reassessment.

Adverse Inference

Jones v Dunkel [1959] HCA 8: unexplained failure to produce evidence within a party's control supports an inference unfavourable to that party. Six categories of missing records across consent, referral, anaesthesia, medication, clinical notes, and treatment data. Without MR22: no proof of atropine. Without MR3NN: no proof of informed consent. Without clinical notes: no proof of independent clinical judgment.

4. Causation

Treating GP observation (Dr Mulroney, signed referral, 13 March 2026): After 10 years of continuous treatment, Dr Mulroney identifies a dissociation between preserved verbal and analytical ability and significantly impaired executive function, and states this pattern is not consistent with the claimant's pre-existing conditions (anxiety, ADHD, depression), which would produce generalised cognitive impairment rather than specific executive dysfunction with preserved intellectual capacity.

Onset date: Dr Mulroney independently places onset of the disabling condition at 2019, post-ECT.

Preserved post-ECT cognition (15 November 2018): An email to Dr Aizenstros demonstrates pharmacological analysis of DRI vs NRI mechanisms across four medications and frontal lobe dopamine receptor subtypes. This timestamps preserved high-level cognition three months post-ECT and anchors the pre-decline window.

Progressive decline: Three independent Commonwealth assessments: work capacity 8-14 hrs/ week (January 2023), temporary capacity 0-7 hrs/ week (May 2024), maximum impairment 20/ 20 Table 5 Mental Health Function with suitable work "Not Applicable" (February 2025). Employment terminated during probation at Open Universities Australia (2023) for task

abandonment, impulsive action, and systematic non-adherence to procedures: recognised executive dysfunction markers.

Government determination: DSP granted March 2025. The Australian Government independently determined the claimant cannot work. This is the prospects assessment.

Pending: Neuropsychological assessment with Dr Robert Bourke (Eastern Neuropsychology) will provide the objective before-and-after cognitive comparison against the 2017 WAIS-IV baseline. This is the key evidence unlock. The 23 BPM event provides a specific physiological mechanism (cerebral hypoperfusion) for acquired brain injury, independent of general ECT cognitive effects. Causation will be strengthened or clarified by this assessment.

5. Estimated Quantum

Head of Damage	Estimate (AUD)
Past loss of earnings (2018-2026, ~$220,000 net loss p.a.)	$1,760,000
Future loss of earnings (to age 67, discounted)	$3,000,000 - $4,000,000
Forced sale of investment property (2019) + foregone capital growth	To be quantified
Lost trailing commissions (wound up during hospitalisation)	~$50,000
General damages (pain, suffering, loss of amenity, loss of children)	$400,000 - $600,000
Future care, treatment, rehabilitation	To be quantified
Total estimated quantum	AUD $7,500,000 - $10,000,000

At current exchange rates this exceeds EUR 4.5 million, well above the EUR 1 million international threshold. The respondent hospital is a major insured institution with capacity to satisfy judgment. Parallel Zurich insurance claims (combined indexed value ~$1.92 million, managed by Maurice Blackburn) represent an additional recovery source from the same disabling event.

6. Limitation

ECT was administered in August 2018. Under the Limitation of Actions Act 1958 (Vic), the standard period is three years from discoverability (s.27D). The neurological character of the injury and its causal connection to ECT were not reasonably discoverable until 2025/2026 for three reasons.

First, the injury mimics depression. Every clinician who assessed the claimant between 2018 and 2025 characterised his condition as psychiatric (depression, anxiety, personality disorder), not neurological. Dr Mulroney's March 2026 referral for suspected acquired brain injury was the first clinical identification of a neurological framing.

Second, the claimant's own understanding evolved in real time. As late as December 2025, his litigation briefs (available on file) framed the claim as systemic diagnostic failure and C-PTSD, not ECT-related brain injury. The recharacterisation occurred only after forensic analysis of the Thymatron printouts identified the 23 BPM cardiac event in March 2026.

Third, the executive dysfunction caused by the injury itself impeded earlier identification. In December 2024, the claimant was evicted following a VCAT hearing because he was, in his words, "mentally paralysed and unable to respond to a Notice to Vacate despite understanding the consequences." The cognitive impairment that prevented him from investigating his own medical records is a documented consequence of the injury.

Known risk: The claimant holds an LLB and had theoretical access to records from 2018. This argument requires expert evidence establishing that the injury was not reasonably discoverable

without specialist forensic analysis. This is addressed directly because funders identify limitation as the primary procedural risk.

7. Funding Request

Total facility sought: up to AUD $250,000, comprising:

Legal costs and expert evidence (~$80,000-$120,000): Independent medical expert opinion on breach and causation, neuropsychological assessment (Dr Bourke, partially funded by Maurice Blackburn), supplementary expert reports as required, legal costs of commencing proceedings in the Supreme Court of Victoria, and disbursements.

Claimant stabilisation (~$80,000-$130,000): The claimant is on the Disability Support Pension with ~$150/week margin after rent. He cannot fund housing, basic living expenses, or participation in proceedings without support. Stabilisation funding is a litigation necessity: if the claimant becomes homeless during proceedings, the case collapses. The need for stabilisation is itself a direct consequence of the injury.

8. Related Proceedings

Maurice Blackburn (costs agreement signed 19 March 2026) manages TPD and Trauma claims against Zurich (combined indexed value ~$1.92 million). These are factually related but legally independent. A neuropsychological assessment with Dr Bourke (MB-funded) will serve both the insurance claims and this negligence matter. Family court proceedings (MLC8366/2025, FCFCOA Victoria) are listed 14 and 17 April 2026. ECT is relevant to capacity in those proceedings.

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Documents available: Clinical chronology with Thymatron analysis, Madden briefing, Thymatron printouts, MR40H checklist, contemporaneous emails (June/July/August/September/November 2018), three Commonwealth assessment reports, Dr Mulroney signed referral letter (13 March 2026), Dr Maloney independent psychiatric assessment (2 December 2025), Zurich policy documents, s.17 preservation notice and acknowledgment.