Madden Briefing — Verhoeven v Epworth HealthCare

BRIEFING – VERHOEVEN ECT MATTER

Prepared for Bill Madden, Carroll & O'Dea

Call: Tuesday 7 April 2026, 10:00am

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1. PATIENT SUMMARY

Patrick John Verhoeven, DOB 28/03/1980. Admitted to Epworth Hospital (Ward MHUB) on 01/08/2018 for electroconvulsive therapy under the care of Dr Michael V Piperoglou, psychiatrist. Received 6 bilateral ECT sessions between 8 and 20 August 2018 using a Thymatron System IV device (S/N 42863, program DGX). UR: 2442987.

Patrick was 38 years old at the time of treatment. He was a voluntary psychiatric inpatient. His brother, Michael Verhoeven, emailed both Dr Piperoglou and Dr Joel Aizenstros (Cognicare, outpatient psychiatrist) on 20/08/2018 requesting a post-discharge plan. No plan had been prepared despite prior explicit requests. Patrick was discharged the following day.

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2. THREE CRITICAL FINDINGS

A. Severe bradycardia – 23 bpm at Treatment #5

The Thymatron machine printout from Treatment #5 (17/08/2018, 11:21:55) records a Base Heart Rate of **23 beats per minute**. Normal resting heart rate is 60-100 bpm. Below 40 bpm is clinically significant bradycardia. At 23 bpm, patients are at immediate risk of syncope, hypotension, and cardiac arrest.

The pre-ECT nursing observations for that same session record a normal pulse of **76 bpm**, taken on the ward before transfer to the ECT suite. The 23 bpm reading was captured by the Thymatron's cardiac monitor during the procedure itself. There is **no documentation in any released record** of this bradycardia being recognised, treated (e.g. with atropine), or discussed. Treatment #6 proceeded three days later without any documented adjustment.

B. Energy escalation pattern

Parameter	Treatment #1 (8/8/18)	Treatment #5 (17/8/18)	Change
% Energy	10%	30%	+200%
Charge delivered	51.1 mC	152.8 mC	+199%
Frequency	30 Hz	50 Hz	+67%
Stimulus duration	0.9 sec	1.7 sec	+89%

Treatment #1 was a standard low-dose titration that produced a robust 65-second seizure. By Treatment #5, the stimulus had been tripled across every parameter. Higher charge and frequency are associated in the literature with greater cognitive side effects.

C. Seizure quality collapsed despite tripling the stimulus

Metric	Treatment #1	Treatment #5	Change
Seizure Energy Index	12,549 uV2	3,239 uV2	**-74%**
Max Sustained Power	21,815 uV2	5,117 uV2	**-77%**
EEG seizure duration	65 sec	50 sec	-23%
Time to peak power	16 sec	32 sec	+100%

The brain’s seizure response deteriorated dramatically despite tripling the electrical dose. The seizures became shorter, weaker, and less organised. This pattern indicates the brain developing tolerance to the stimulus – a finding that should prompt clinical review of whether to continue, change electrode placement, or stop treatment.

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3. MISSING RECORDS

Patrick submitted a Medical Record Access Request Form on 25/01/2026 requesting his **complete medical record** via secure email. The MR40H checklist in the released records confirms the following documents existed and accompanied the patient to each ECT session. **None were released:**

- **MR22 – Anaesthetic Charts** (all 6 sessions). These record drugs administered (propofol, suxamethonium, atropine if given), doses, vital signs during the procedure, and adverse event documentation. This is where any response to the 23 bpm bradycardia would be recorded.
- **MR3NN – ECT Consent Form**. Documents informed consent, risks explained, patient understanding.
- **MR2B – ECT Referral**. Who referred Patrick for ECT, clinical indication, treatment justification.
- **MR80 – Medication Chart & Alert Card**. All medications administered during admission.
- **Admission notes, progress notes, discharge summary**. No psychiatrist clinical notes were released.
- **Any cognitive assessment** performed before, during, or after the ECT course.

What was released: MR40H checklist (1 page), ward recovery checklist (1 page), recovery room observation sheets (1 page), and Thymatron EEG thermal printout strips. This is the procedural

paperwork only – the clinical decision-making record is entirely absent.

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4. BEFORE AND AFTER

Before ECT (as at August 2018): - WAIS-IV Full Scale IQ: 121 (Superior range), assessed December 2017 - Employed as quantitative analyst at Phillip Capital, ~$250k/year, managing ~$16M FUM - Three Monash University degrees - Active co-parent to two daughters

After ECT (current): - Unable to sustain employment since ECT - Disability Support Pension recipient - Persistent cognitive complaints: memory, executive function, processing speed - Suspected acquired brain injury – unconfirmed, pending formal neuropsychological assessment with **Dr Robert Bourke at Eastern Neuropsychology** - Lost custody, now self-represented litigant in family law proceedings (MLC8366/2025)

The 43-point gap between a documented pre-ECT IQ of 121 and Patrick's current functional capacity is the damage narrative. Dr Bourke's assessment will quantify this.

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5. KEY QUESTIONS FOR MADDEN

1. **The missing MR22 anaesthetic charts** – what do they likely show about the clinical response to the 23 bpm bradycardia? If atropine was administered and documented there, the negligence argument shifts from "failure to treat" to "failure to reassess and communicate." If atropine was NOT given, this is a straightforward breach of duty. Either way, the absence of these charts from a "complete record" request is itself a concern.

2. **Does the energy escalation pattern with declining seizure quality support a negligence argument?** Tripling the stimulus while seizure quality dropped 74% – at what point does a competent practitioner stop, reassess, or change approach?

3. **Preliminary assessment of claim viability and quantum?** The combination of: (a) undocumented severe bradycardia, (b) aggressive dose escalation with declining efficacy, (c) incomplete records release, and (d) a patient who went from IQ 121 and $250k/year to DSP – what does this look like from a med-neg perspective?

4. **Limitation period** – ECT was August 2018. Under the Limitation of Actions Act 1958 (Vic), what is the relevant date of discoverability given Patrick only obtained these records in early 2026?

5. **Next steps** – should a formal complaint to Epworth for the missing records precede or accompany the legal claim? Should the Health Records Act 2001 (Vic) s.35 complaint pathway be used to force release of MR22, MR3NN, MR2B, and MR80?

Prepared from Epworth ECT records (released ~March 2026), Thymatron System IV printouts, MR40H checklist, recovery observations, and discharge correspondence. All clinical values sourced from original scanned documents.