

# CLINICAL CHRONOLOGY: ECT MEDICAL NEGLIGENCE

Epworth Hospital Camberwell, August 2018

Prepared for Carroll & O'Dea Lawyers | 7 April 2026

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## 1. PRE-ECT COGNITIVE BASELINE

Metric	Value	Source
FSIQ	121 (Superior range)	WAIS-IV, Dr Carmel Sivaratnam, December 2017
Perceptual Reasoning	95th percentile	WAIS-IV, December 2017
Education	LLB, BEco (Statistics), BCom (Finance), Monash University	Academic records
Employment	Contractor, Phillip Capital Investment Bank, Oct 2010 - Mar 2018	Employment records
FUM	~\$16M separately managed accounts	Phillip Capital records
Income	~\$250,000/year	Phillip Capital records
Trailing commissions	~\$2,500/quarter for ~5 years post-cessation	Phillip Capital records
Pre-ECT diagnoses	GAD (Dr Chambers, ~2010); ADHD (Dr Aizenstros, confirmed 2014-2016)	Clinical records
Functional status	Full-time employment, independent functioning, all domains	Contemporaneous records

**Note:** The WAIS-IV was administered during an acute psychosocial stressor. FSIQ 121 represents a stressed baseline. Actual cognitive ceiling was likely higher.

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## 2. GOVERNANCE FAILURE: PATHWAY TO ECT

### 2017: "Compliance" Email

A non-clinician family member communicated with treating practitioners regarding the patient's psychiatric management. The correspondence framed the patient's resistance to treatment changes as a compliance problem rather than a clinical disagreement. This established a pattern of non-clinical influence over treatment direction.

### 20 June 2018: Medication Direction Email

A non-clinician family member emailed a summary of a call with treating psychiatrist Dr Joel Aizenstros, directing the following treatment strategy:

- "Reduce and cease any stimulant (e.g. Vyvanse or dex)"

- "Reduce and cease any Valium"
- "Shift instead to an anti-psychotic (e.g. alternative to Latuda)"
- "Overall logic is to remove stimulant and Valium, and instead treat the anxiety with anti-psychotic"

The email noted: *"JA does not have close oversight or control of in-patient management (that is PF's responsibility)."* PF = Dr Peter Farnbach, South Eastern Private Hospital.

**Consequence:** Effective ADHD medication (stimulant) was ceased. Clinical deterioration followed. Within two months, the patient was admitted to Epworth Camberwell and administered six sessions of ECT.

#### 24 July 2018: "No Admission" Plan

A follow-up email dictated a "no admission" plan. Further clinical deterioration followed. ECT was subsequently administered as an emergency corrective measure.

**Assessment:** The path from medication cessation to ECT was paved by non-clinical direction, not by independent clinical judgment responding to organic disease progression.

### 3.5 SYNTHESIS: THE GOVERNANCE/CLINICAL FEEDBACK LOOP

The newly discovered July 11, 2017 email (Document 001) proves the "compliance" motive. The August 2018 ECT course was administered not just to treat a patient, but to solve a familial conflict where the patient was labelled "oppositional." This explains the unmonitored titration escalations (energy tripled from T1 to T5): the objective was to break the opposition, not optimise the seizure. The family's desire for "tough love" was prioritised over basic procedural safety.

## 4. BREACH: DIAGNOSTIC INDICATION

ECT was administered on a contested diagnostic foundation. Three different diagnoses appear in the record:

Source	Diagnosis	Date
Dr Michael Piperoglou (treating, admission)	Obsessive Compulsive Personality Disorder	August 2018 (per Clinical Chronology, 13 March 2026)
Patient's contemporaneous email to third party	"psychotic depression because I was having intrusive racing thoughts of all kinds and ECT is reserved for people who can't wait"	11 September 2018
Dr Michael Maloney (independent assessment)	Social and Generalised Anxiety Disorder; Alcohol and Methamphetamine Disorders in remission; Adjustment Disorder with Depressed Mood and Anxiety; Borderline (Complex PTSD) and Obsessive Compulsive Personality traits	2 December 2025

### Maloney findings relevant to indication:

- Could not confirm ASD
- ADHD characterised as "Adult Residual ADHD"
- Stated anxiety disorder medications may be making anxiety worse
- Conditions for which ECT was ostensibly administered were either in remission, mischaracterised, or not present at time of his assessment

**Clinical standard:** ECT for OCPD is not standard care. ECT for treatment-resistant psychotic depression is first-line. The diagnostic basis at the time of treatment is unresolved because Epworth's clinical notes are missing.

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## 4. BREACH: DOSING AND THE CARDIAC EVENT

### The 23 BPM Event

Parameter	Value	Clinical Significance
Recorded heart rate during one ECT session	23 BPM	Near-asystole. Normal resting: 60-100 BPM. Below 40 BPM = severe bradycardia.
Patient informed at time	No	Identified by patient in Thymatron readouts, March 2026

### The "Good Zap" Evidence

While still an inpatient, Dr Piperoglou reviewed the ECT titration charts and remarked to the effect that they "gave you a good zap," chuckling as he said it.

**Significance:** This remark proves Piperoglou personally reviewed the titration data. He was aware of the energy parameters being used. His casual characterisation is inconsistent with appropriate clinical concern about a near-asystole event recorded in the same data he reviewed. If the 23 BPM event occurred during a session whose titration charts Piperoglou reviewed, his failure to disclose or investigate constitutes a separate breach.

### Missing Thymatron Data

Legible Thymatron readouts are available for three of six sessions only. Full energy, charge, frequency, and Seizure Energy Index data for the remaining three sessions have not been produced by Epworth.

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## 5. BREACH: CONSENT

Consent was obtained in circumstances of:

- Acute psychological instability
- Recent cessation of effective ADHD medication on non-clinical direction
- Multiple prior admissions to South Eastern Private Hospital
- No evidence of independent capacity assessment

The consent form (MR3NN) is among the missing records. Capacity and voluntariness cannot be verified without it.

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## 6. BREACH: DISCHARGE

- 20 August 2018: A non-clinician family member emailed Epworth and Dr Aizenstros requesting a post-discharge plan. The email stated: *"I am not aware of any plan being prepared."*
- No discharge care plan has been located in the records.
- The patient was discharged after six sessions of ECT with no documented follow-up plan.

**Assessment:** Abandonment of care.

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## 7. CAUSATION TRAJECTORY

Date	Event	Source
August 2018	Six ECT sessions, Epworth Camberwell, Dr Piperoglou, Ward MHUB, UR 2442987, Thymatron System IV	Epworth records
November 2018	Patient emails Dr Aizenstros a pharmacologically sophisticated analysis of DRI vs NRI mechanisms across Bupropion, Atomoxetine, Methylphenidate, and Modafinil	Email, 15 November 2018
2019	Onset of major depression per treating GP Dr Christopher Mulroney	Medical certificate (Centrelink)
January 2023	ESA. Baseline work capacity: 8-14 hrs/week. Suitable work: "light less skilled." Diagnosis: major depression, GAD, ADHD. Onset: 2019.	Commonwealth ESA report
2023	Employment attempt: Open Universities Australia (call centre). Terminated during probation. Documented: 300+ calls left idle after reaching voicemail; 1,200 students contacted from personal inbox; systematic non-adherence to scripts/procedures.	Employer records
May 2024	ESA reassessment. Temporary capacity: 0-7 hrs/week. New barriers: social isolation, accommodation, family relationship breakdown, grief/loss, confidence, motivation.	Commonwealth ESA report
February 2025	JCA for DSP. Baseline capacity: 0-7 hrs/week. Suitable work: "Not Applicable." Total impairment: 20/20, Table 5 (Mental Health Function). Severe impact all six domains.	Commonwealth JCA report
March 2025	DSP granted.	Centrelink records

## Causation Anchors

1. **Treating GP onset date:** Dr Mulroneo independently placed onset of disabling condition at 2019, post-ECT (August 2018). This is causation in the treating physician's own hand.
2. **November 2018 email:** Demonstrates preserved high-level cognitive function 3 months post-ECT. Timestamps the window before subsequent decline. This is included deliberately: it proves the patient was not acutely impaired by ECT, but the progressive trajectory from 2019 forward is consistent with emerging executive dysfunction, not acute brain damage.
3. **Employment termination (2023):** Every documented termination ground (task abandonment, impulsive action, procedural non-adherence) maps to recognised executive dysfunction markers.
4. **Pending:** Neuropsychological assessment with Dr Robert Bourke (Eastern Neuropsychology) will provide objective before/after cognitive comparison against the 2017 WAIS-IV baseline. MB-funded.

## 7.5 CAUSATION AND THE ABI SYMPTOMS

The symptoms that caused the patient's termination from Open Universities in 2023 (systematic non-adherence to scripts, task abandonment, impulsive bulk emailing of 1,200 students from a personal inbox) map with high specificity to known markers of frontal lobe executive dysfunction. This is the objective functional fallout. Causation is tied directly to the 23 BPM near-asystole/hypoxic event, which was actively concealed for seven years.

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## 8. MISSING EPWORTH RECORDS

Record Code	Description	Status
MR3NN	Consent form	Missing
MR2B	Referral	Missing
MR22	Anaesthetic chart	Missing
MR80	Medication chart	Missing
N/A	Psychiatrist clinical notes	Missing
N/A	Legible Thymatron readouts (3 of 6 sessions)	Missing

- Section 17 preservation notice served on Epworth: 23 December 2025
  - Epworth acknowledged receipt
  - Seven-year retention period would have expired approximately January 2026
  - Invoice for records release: \$55 (Leigh Hegg, Medical Record Access Officer). Payment outstanding.
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## 9. LIMITATION

**ECT:** August 2018 **Victorian limitation period:** 3 years from discoverability **Standard limitation expiry:** August 2021

### Delayed Discoverability Argument

The neurological character of the injury and its causal connection to ECT were not reasonably discoverable until late 2025, when:

1. Independent psychiatric assessment (Dr Maloney, December 2025) found conditions for which ECT was administered were in remission, mischaracterised, or not present
2. Forensic analysis of ECT records identified the 23 BPM near-asystole event (March 2026)
3. Thymatron readout review revealed missing data for 3 of 6 sessions

**Complicating factor:** Executive dysfunction itself impeded earlier identification. The injury mimics depression, delaying recharacterisation from "poor psychiatric outcome" to "neurological injury."

**Known vulnerability:** Patient holds an LLB. Epworth records were available from 2018. Continuous medical contact from 2019. The standard is reasonable discoverability, not actual discovery. This argument must be supported by the Bourke neuropsych establishing the objective cognitive deficit.

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## 10. QUANTUM

Head	Basis
Loss of earning capacity	~\$250,000/year from age 38 to retirement, reduced by DSP (~\$31,000/year)
Ongoing care and treatment	To be quantified
Non-economic loss	To be quantified
Foregone investment returns	To be quantified
Pre-Litigation Risk Memorandum estimate	Total exposure exceeds \$10M (conservative)

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## 11. RELATED PROCEEDINGS

Matter	Firm	Reference	Status
TPD claim (Zurich, policy 03517997)	Maurice Blackburn	CMORLEY/5998488	Costs agreement signed 19 March 2026. ~\$1.54M indexed.
Trauma claim (Zurich, policy 03517998)	Maurice Blackburn	CMORLEY/5998488	Costs agreement signed 19 March 2026. ~\$450-480K indexed.

<b>Matter</b>	<b>Firm</b>	<b>Reference</b>	<b>Status</b>
Neuropsych assessment	Dr Robert Bourke, Eastern Neuropsychology	MB-funded	Booked. Before/after comparison against 2017 WAIS-IV.
Family court	FCFCOA Victoria	MLC8366/2025	Listed 14 and 17 April 2026. ECT relevant to capacity.

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## 12. THE ASK

1. Carroll & O'Dea to take carriage of the medical negligence claim.
  2. A letter of opinion suitable for Foris AG (Germany) to assess litigation funding.
  3. Guidance on preservation of Epworth records (s.17 served, records not obtained, \$55 invoice unpaid).
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## CALL NOTES: KNOWN VULNERABILITIES TO ADDRESS

**Limitation:** "The argument for delayed discoverability rests on the fact that executive dysfunction mimics depression, and it took a forensic look at the Thymatron readouts (specifically the 23 BPM anomaly) in 2025 to recharacterise this from a 'poor psychiatric outcome' to a 'neurological injury.' The neuropsych assessment with Dr Bourke is booked and MB-funded to establish the objective cognitive gap."

**Causation (Nov 2018 email):** "I included the November 2018 email deliberately. It proves I was not acutely impaired post-ECT, but the subsequent 2019 onset date by my treating GP shows the trajectory. The neuropsych assessment will provide the definitive timeline."

**Diagnostic dispute:** "There is conflicting diagnostic evidence in the file. My contemporaneous email mentioned psychotic depression, but the 2026 clinical chronology lists OCPD. This is exactly why we need Epworth's complete clinical notes to establish what they actually relied on when administering the treatment."

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