IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

**COR 2022 004773**

**FINDING INTO DEATH WITHOUT INQUEST**

*Form 38 Rule 63(2)*

*Section 67 of the **Coroners Act 2008***

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| Findings of: | Coroner Catherine Fitzgerald |
| Deceased: | Michael James Batten |
| Date of birth: | 22 February 1979 |
| Date of death: | 20 August 2022 |
| Cause of death: | 1(a) Complications of valvular heart disease |
| Place of death: | 42 Randall Crescent, Moe, Victoria, 3825 |

## INTRODUCTION

1. On 20 August 2022, Michael James Batten was 43 years old when he was found deceased at his home. At the time of his death, Mr Batten lived at Moe, Victoria, with his father.

2. Mr Batten's medical history included an intellectual disability, schizophrenia, depression and aortic valve replacement (**AVR**) for aortic regurgitation in 2008. His father was his full-time carer. Mr Batten was under the care of Northern Health's (**NH**) Cardiology Outpatient team since 1999 for congenital aortic valve disease and aortic regurgitation. Following his AVR in 2008, Mr Batten was reviewed annually by the NH Cardiology Outpatient team from 2009 to 2017, inclusive. In 2018, Mr Batten's family requested a referral to a cardiologist closer to home and were referred to another service. Due to a change in circumstances, Mr Batten was referred back to NH in July 2019.

## THE CORONIAL INVESTIGATION

3. Mr Batten's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

4. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and the circumstances in which the death occurred. The circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

5. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

6. This finding draws on the totality of the coronial investigation into the death of Michael James Batten. Whilst I have reviewed all the material, I will only refer to that which is directly

relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

## MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

### Circumstances in which the death occurred

7. On 2 August 2021, Mr Batten underwent a transthoracic echocardiogram (**TTE**) at NH. The results showed "*a mean gradient across the prosthetic aortic valve of 56.3 mmHg, which had increased from a mean gradient of 27.9 mmHg shown on a TTE performed on 15 January 2021*". This suggested that Mr Batten's prosthetic valve was narrowing.

8. Following the TTE, on 16 September 2021, NH Cardiologist, Dr Vivek Mutha, referred Mr Batten for a transoesophageal echocardiogram (**TOE**), following a telehealth consultation with Mr Batten's father, Alan Batten. Dr Mutha also wrote to Mr Batten's general practitioner (**GP**) to inform them of his plan and stated that if Mr Batten's condition were to deteriorate in the interim, he should be sent to a local hospital for treatment.

9. Mr Batten underwent the TOE at NH on 14 June 2022. The procedure was performed by (then) NH Cardiology Registrar Dr Sheran Vasanthakumar, under the supervision of the NH Cardiology Consultant. Dr Vasanthakumar's review of the TOE imaging showed "*severe aortic stenosis*", which he verbally conveyed to Mr A Batten at the time. However, no follow up appointment was scheduled, and Mr Batten did not receive any further contact or further medical management by NH following the TOE procedure.

10. On 19 August 2022, Mr Batten was reportedly fine and did not appear to be unwell according to Mr A Batten, who last saw his son watching television at about midnight on 20 August 2022. At about 3.30am on 20 August 2022, Mr A Batten was woken up by noises coming from his son's bedroom. He thought the television may still have been on or perhaps his son was moving furniture around in his bedroom, which he often did. Mr A Batten knocked on his son's bedroom door but did not receive a response. He tried to open the door but was unable to move it. Eventually, Mr A Batten was able to reach inside a small gap in the door

[1] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

and he felt Mr Batten pushed up against it, blocking the doorway and preventing it from opening. He called triple zero, requesting emergency services.

11. Paramedics and police attended and confirmed Mr Batten was deceased. Police investigated the scene and did not identify any suspicious circumstances or signs of third-party involvement in the death.

**Identity of the deceased**

12. On 20 August 2022, Michael James Batten, born 22 February 1979, was visually identified by his father, Alan Batten.

13. Identity is not in dispute and required no further investigation.

**Medical cause of death**

14. Forensic Pathologist Dr Joanne Ho, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external post-mortem examination on 23 August 2022 and provided a written report of her findings dated 1 September 2022.

15. The post-mortem examination was unremarkable. Toxicological analysis of post-mortem samples was not indicated and therefore not performed.

16. Dr Ho provided an opinion that the medical cause of death was "*1(a) Complications of valvular heart disease*."

17. I accept Dr Ho's opinion.

**FURTHER INVESTIGATIONS AND CPU REVIEW**

18. It was unclear what occurred in relation to the medical management of Mr Batten following the TOE procedure, and I directed further investigations and review regarding this issue. Statements were obtained from NH, clinicians, Mr Batten's GP and his father about the procedure. I also referred this matter to the Coroner's Prevention Unit (**CPU**)[2] for an

[2] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

independent review of the medical care provided to Mr Batten, and for advice on whether his death was preventable.

**Absence of follow up after the TOE procedure**

19. Mr A Batten recalled that the TOE procedure had demonstrated his son's prosthetic valve had deteriorated and likely required replacement. His understanding was that NH did not book another appointment at the time, as they "*all have a panel and discuss whether they would go ahead with a further procedure*". His impression was "*they would get back to me*". Mr A Batten stated that he did not receive any paperwork or any other documents relating to the procedure, or any future procedures. Mr Batten's GP similarly did not receive any paperwork from NH.

20. The TOE proceduralist, Dr Vasanthakumar, could not specifically recall Mr Batten's procedure due to the passage of time, however he believed that the usual process post-TOE was for the "*Cath Lab Resident*" to submit an electronic referral for a follow-up outpatient cardiology appointment.

21. Dr Mutha, who referred Mr Batten for the TOE, stated that he did not receive either verbal or written results of the procedure. According to Dr Mutha, it was NH standard procedure at the time to notify the cardiologist if the TOE results were time critical and organise admission of the patient the same day. If the results were not time critical, a follow-up appointment would be organised by the discharging team or the cardiology unit, following completion of the TOE. However, Dr Mutha could not find any records of follow-up, referrals, or further investigations following Mr Batten's TOE.

22. NH's Head of Echocardiography, Associate Professor Nagesh Anavekar, explained that a copy of Mr Batten's TOE results could not now be located, despite reasonable searches being undertaken by NH staff. This appears to have hindered the ability of NH to provide an explanation regarding what specifically occurred in Mr Batten's case. On behalf of NH, the Director of Cardiology, Professor William Van Gaal, indicated that both the procedure and the follow up appointment are ordinarily scheduled at the same time, and NH cannot confirm how or why a follow up appointment was not scheduled in Mr Batten's case.

**CPU review**

23. The CPU explained that Mr Batten was experiencing progressive stenosis of his prosthetic aortic valve from January 2021 until at least June 2022, when the TOE procedure confirmed that he had "*severe aortic stenosis*". The CPU advised that progressive narrowing of the prosthetic aortic valve required repair or replacement of the valve to prevent death, and the failure to follow-up and monitor or treat Mr Batten's valve stenosis was a missed opportunity to prevent his death. The CPU opined that this represented a significant shortcoming in Northern Health's processes, particularly considering the serious complications associated with aortic valve stenosis.

24. The CPU noted that Dr Vasanthakumar provided verbal preliminary findings to Mr A Batten at the completion of the procedure, and the CPU therefore assumed that the findings were not considered 'time critical' such that Mr Batten required admission that same day. Whilst Dr Vasanthakumar stated that it was usually the "*Cath Lab Resident*" who made the request for a further appointment, it was noted that Dr Mutha stated it was normally the responsibility of the discharging team or the cardiology department to make this referral.

25. The CPU also noted Mr A Batten's statement regarding his understanding following the TOE, and that there needed to be further discussion amongst clinicians about what would occur next. The CPU explained that it is common for complex cases to be reviewed at a team or multidisciplinary meeting to seek input from other clinicians and form a management plan. However, the CPU was unable to find any reference to a multidisciplinary meeting in Mr Batten's medical records after the TOE.

26. Whilst the CPU noted that it is often the referring doctor who is ultimately responsible for following up results, having regard to the significant delay between the referral in September 2021 and the procedure in June 2022, the referring doctor (Dr Mutha) may not have been aware that the procedure had occurred.

27. Whilst the Cardiology Checklist[3] completed after Mr Batten's procedure stated that discharge information was provided and that the patient had a "*clear*" understanding of the discharge instructions, the checklist does not provide any specific information about the discharge plan

[3] Northern Health Medical Records, 73.

or a request for outpatient follow-up. It provides no assistance in determining which clinician or team was responsible for scheduling the follow up appointment.

28. Ultimately, the CPU review was not able to ascertain which clinician or team was responsible for scheduling a follow up appointment with Mr Batten, or the planning regarding his further management.

29. The CPU review also noted that it was unclear why the TOE was first requested in September 2021, but the procedure did not occur until June 2022, representing a 9-month delay. NH has subsequently advised that this delay was due to the impacts of COVID-19 pandemic, and that NH have since appointed additional TOE specialists which has increased capacity to perform TOE investigations. It therefore appears that delays to these procedures are not an ongoing issue.

**Conclusions**

30. I am satisfied that an outpatient appointment was not scheduled for follow up of the TOE results with Mr Batten as it should have been. NH has been unable to provide an explanation why a follow up appointment was not scheduled but concede this should have occurred.

31. Having regard to the varying accounts provided about the processes which should have ensured a follow up appointment was scheduled, I have not been able to determine why this did not occur, or who was responsible for following up the clearly concerning results with Mr Batten. In my view, it is possible that internal uncertainty at NH about this process contributed to the failure to schedule an outpatient appointment.

32. Given the available evidence, I am satisfied that Mr Batten's valve stenosis was continuing to deteriorate from September 2021, ultimately resulting in his death from "*Complications of valvular heart disease*". He required repair or replacement of the prosthetic aortic valve, but this was not appropriately followed up with him or his father, who was his carer. I accept the CPU's advice that Mr Batten's death may have been prevented if he received an appropriate referral and follow-up after the TOE in June 2022.

33. The failure to schedule an outpatient appointment therefore represents a significant shortcoming in this case, particularly given the obvious possibility of serious complications occurring from not treating the valve stenosis.

34. Having been provided an opportunity to respond, NH have accepted that Mr Batten's condition was deteriorating and that he required appropriate referral, follow-up and timely treatment after the TOE results. It was also noted by NH that the remedial procedure Mr Batten required was "*a significant undertaking in and of itself carrying its own risks*." Whilst I accept that repair or replacement of the valve was not without risk, it may well have succeeded and prevented Mr Batten's death. I am therefore satisfied that the failure of follow up and further medical management in his case resulted in a missed opportunity to prevent his death.

35. I also note that Mr Batten was a vulnerable patient. He had an intellectual disability and schizophrenia, and he was being cared for in the community by his father. The failure of follow up in this case is therefore of particular concern. Whilst Mr A Batten was given some verbal information at the conclusion of the TOE, I am satisfied that he believed NH would make contact at an appropriate time for follow up, and he was not aware of the serious complications which would arise from an absence of further, timely, medical intervention for his son. Had he been made aware of this, he would have been better placed to advocate for his son, and to make enquiries about what needed to occur following the TOE procedure. By way of comment, NH may wish to consider whether current policies and procedures appropriately account for the vulnerability of patients with disability, and their carers.

## FINDINGS AND CONCLUSION

36. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was Michael James Batten, born 22 February 1979;

    b) the death occurred on 20 August 2022 at 42 Randall Crescent, Moe, Victoria, 3825, from complications of valvular heart disease; and

    c) the death occurred in the circumstances described above.

## RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendations:

i) I recommend that NH update its 'Cardiology Checklist' document to ensure that required follow up appointments are scheduled by the responsible clinician/team.

ii) I recommend that NH review its Cardiology policies and procedures, to ensure sufficient clarity regarding which clinician/team is responsible for scheduling follow up appointments with patients who undergo a diagnostic procedure, following referral from a Cardiologist.

I convey my condolences to Mr Batten's family for their loss.

I direct that a copy of this finding be provided to the following:

Alan Batten, Senior Next of Kin

Northern Health

Senior Constable Cameron Docherty, Victoria Police, Notifying Member

Signature:


Coroner Catherine Fitzgerald

Date : 04 March 2025

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.