Moorfields Eye Hospital NHS Foundation Trust

NHS

Root Cause Analysis (RCA) Investigation Report (Concise)

Incident investigation title:	Investigation into the potential mis-diagnosis of a patient
Incident date:	N/A
Incident form number:	N/A
Author(s) and job titles:	Mark Maynard, Quality Partner Moorfields South
Investigation report date:	14 June 2022
Sign-off date:	17 June 2022 By Louisa Wickham, medical director
Version:	FINAL APPROVED, version 1.0

Version history

Version	Date	Change	Author
1.0	14 June 2022	New document	Mark Maynard

Contents

Incident description and consequences

Brief incident description:
A complaint letter was received from a patient's mother following the untimely death of her daughter at University College London Hospital (UCLH) in July 2021. The patient had been seen twice by Moorfields Eye Hospital, once at a neuro-ophthalmology clinic on 4 December 2019, and then in Accident & Emergency (A&E) on 18 December 2019. The patient was appropriately discharged from each service after these appointments.

The patient was admitted for treatment by UCLH in July 2021 but sadly passed away whilst being treated.

Detection of the incident:
The trust was alerted to concerns of the deceased patient's mother on 25 April 2022, when a letter was received via e-mail.

Incident date:
Not applicable as no incident has been identified in relation to the care provided and/or the clinical decisions that were made. An incident has been reported retrospectively, dated 18 December 2019, regarding an error that was made in the A&E discharge letter.

Incident type:
See comment above. The incident that has been reported retrospectively recognises the error in clinical documentation.

Speciality and sub-specialty:
Ophthalmology - Neuro-Ophthalmology.

Actual effect on the patient/service:
Not applicable, as the investigation has confirmed that there were no shortcomings in respect of the ophthalmic care and treatment afforded to the complainant's daughter at Moorfields.

Actual incident severity:
Although the eventual outcome for the patient was catastrophic, a clinical review of the care provided to the patient by Moorfields Eye Hospital has found that there is no connection between the care provided at either appointment and the patient's untimely death.

Terms of reference:
To investigate the care provided to the patient on her two attendances at Moorfields Eye Hospital and to answer the questions posed by the patient's mother in her request for a formal complaint investigation.

Investigation team

Name	Job title
Mark Maynard	Quality Partner, Moorfields South

Scope and level of the investigation:
Concise RCA

Investigation type, process and methods used
RCA

Involvement and support of the patient, relative(s) or carer(s)
A letter from the patient's mother, dated 21 April 2022, was sent to the trust via e-mail on 23 April 2022. Also included in the e-mail were the following attachments:

- Record of Inquest
- Record of Inquest (narrative determination) on 14.02.22
- UCLH SI report 2021/15713 (dated 7 February 2022)

The patient's mother asked the four questions below. The trust response to each of these questions is shown in *italics* beneath each question:

1) On the OCT images I received from Moorfields the optic disc margins seem blurred and the optic discs elevated in both eyes. If "OCT imaging confirmed no oedema of the optic discs or signs of optic disc drusen", what do they think was the reason for the raised / swollen nerve? The results letter is unclear and does not go into enough detail regarding the images in order to understand the diagnosis of "no abnormality".

   A consultant ophthalmologist specialising in neuro-ophthalmology, and who works within a different part of the organiastion, reviewed the OCT images that were taken on 4 December 2019. Confirmation was provided that there "was no evidence of optic disc swelling at the time they were seen and the management was appropriate".

2) My daughter had for 2yrs+ headaches when she was seen at Moorfields by Ms Braithwaite. Hence she was not "asymptomatic" as referred to by Ms Braithwaite. These headaches continued. There is no mentioning of headaches in the results letter. Why not? Did she enquire about those headaches?

   There is no evidence in the handwritten clinical record from 4 December 2019 that the history of headaches was discussed between the patient and the doctor who saw her. As the images of the optic discs showed that there was no swelling there would not have been a link between the optic discs and the headaches.

3) I understand that Moorfields together with Birmingham was part of the first phase of the IIH:Life Registry databank founded by Professor Dr Sinclair to be used by

Neurologists / Neuro Ophthalmologists in order to raise awareness and understanding of IIH (Idiopathic Intracranial Hypertension). If a young woman of childbearing age gets referred because of long-term headaches and blurred optic disc margins, should this not have rung alarm bells and certainly given reason for a call back instead of an immediate discharge?

As there was no evidence of swollen optic discs at the appointment of 4 December 2019, discharge of the patient was appropriate.

4) Why was my daughter called a "frequent attender of Emergency Department" by Dr Taha Soomro after seemingly only 1 time? Gaia had attended Moorfields A&E Department 18 Dec 2019 with an eye injury in her right eye.

A review of the trust's appointment booking software has shown that the patient only attended the A&E department once. The doctor who saw the patient on the day is no longer employed by the trust, so it has not been possible to speak with them regarding this entry. A review of the drop down menu to populate the letter has shown that "frequent attender of emergency department" is below the option for "no safeguarding concerns identified" and it is thought that the incorrect option was selected in error. An incident has been reported retrospectively by the head of risk & safety to acknowledge this error. The trust apologises to the family for the distress that this has caused.

Involvement and support for staff involved in the incident

Not applicable as no incident has been identified in relation to the care provided and/or the clinical decisions that were made. The doctor that wrote the discharge in A&E no longer works at the trust, so further engagement has not been possible.

Information and evidence gathered

- Review of complaint letter
- Review of SI report completed by UCLH
- Review of care by Neuro-Ophthalmology consultant
- Review of care by Urgent Care service lead
- Review of paper and electronic health records

Chronology of events

See appendix 1.

Notable practice

Notable practice is ordinarily recognised as points in the incident or patient journey where care and/or practice had an important positive impact. The investigation, as informed by documentation in the patient's health record, has not identified any notable practice. This may be because of the time that has passed since the patient's appointment with the neuro-ophthalmology service and therefore the likely poor recollection of specific details that have

not been documented. The investigation has confirmed that the patient received the care and treatment that would have been expected given her presentation, specifically:

- A review of the care provided at the Neuro-Ophthalmology appointment on 4 December 2019 was undertaken by a Neuro-Ophthalmology consultant on 10 May 2022. The consultant, who routinely works at other Moorfields locations, provided the opinion that the patient was seen by a qualified doctor who was acting as a locum consultant at the time of the appointment. In their opinion and following a review of the OCT images and health record, all necessary investigations were undertaken, and these were acted on appropriately. Discharge of the patient was appropriate.
- A review of the care provided at the A&E presentation on 18 December 2019 was undertaken by an ophthalmic consultant and service director of the Urgent Care service at Moorfields St George's. In their opinion the treatment provided for the corneal abrasion was appropriate and no other investigations were clinically indicated. Discharge of the patient was appropriate.

Care and service delivery problems

Not applicable, as the investigation has confirmed that there were no shortcomings in respect of the ophthalmic care and treatment afforded to the complainant's daughter at Moorfields.

Contributory factors

Not applicable, as the investigation has confirmed that there were no shortcomings in respect of the ophthalmic care and treatment afforded to the complainant's daughter at Moorfields.

Other issues identified

It was recorded on the letter following the A&E appointment on 18 December 2019 that the patient was a "frequent attender of emergency department". It is believed that this was a human error as the investigation has confirmed that the patient had only attended A&E on 18 December 2019.

Root causes

Not applicable, as the investigation has confirmed that there were no shortcomings in respect of the ophthalmic care and treatment afforded to the complainant's daughter at Moorfields.

Lessons learned

Not applicable, as the investigation has confirmed that there were no shortcomings in respect of the ophthalmic care and treatment afforded to the complainant's daughter at Moorfields.

Recommendations

Not applicable, as the investigation has confirmed that there were no shortcomings in respect of the ophthalmic care and treatment afforded to the complainant's daughter at Moorfields.

Arrangements for shared learning

Not applicable, as the investigation has confirmed that there were no shortcomings in respect of the ophthalmic care and treatment afforded to the complainant's daughter at Moorfields.

Distribution list

- Family of patient
- Serious Incident Panel
- City Road divisional management team (via the head of nursing)

APPENDIX 1: Chronology

Date & Site	Event
27 September 2019 City Road	Referral received from the patients GP, Ritchie Street Group Practice asking for a review of the patient's optic discs bilaterally due to blurriness seen by Optician. Referral from SpecSavers to GP states that the patient has been having headaches for 2+ years. Appointment booked in General Ophthalmology clinic for 26 November 2019 via Choose and Book.
30 September 2019 City Road	Referral uploaded to Cito.
4 October 2019	Referral diverted to neuro-ophthalmology. Suggested 'urgent 2-4 weeks'
7 October 2019 City Road	Referral scrutinised by Neuro-Ophthalmolgy consultant as for appointment in three months.
11 October 2019 City Road	Appointment booked in Neuro Ophthalmology clinic for 4 December 2019. General Ophthalmology clinic appointment for 26 November cancelled.
4 December 2019 City Road	Patient attends for booked appointment. Examination finds no abnormality. Visual Acuity is recorded as 6/5 in both eyes with full colour vision, normal pupil reactive, no RAPD, full movement, no double vision, full fields to confrontation and a healthy appearance of the optic nerve, macula and retina. OCT imaging confirmed no oedema of the optic discs or signs of optic disc drusen. Patient discharged from the Neuro-Ophthalmology service.
18 December 2019 City Road	Patient presents to A&E and is diagnosed with a right eye (RE) corneal abrasion (struck eye with the edge of a container). Prescribed Chloramphenicol and discharged with advice to return if symptoms worsen.