# SPSO decision report

**Case:** **202209844, Lothian NHS Board - Acute Division**
**Sector:** Health
**Subject:** Communication / staff attitude / dignity / confidentiality
**Decision:** some upheld, recommendations

## Summary

C complained about the care and treatment provided to their late parent (A) by the board. A was under the care of another board and investigations undertaken were suggestive of cancer in the bile drainage system, which was initially thought to be operable. A was referred to the board and admitted to hospital for a percutaneous transhepatic biliary drain (a procedure to drain bile to relieve pressure in the bile ducts caused by a blockage) and biliary biopsies. This was carried out and the three biopsies taken were sent back to the ward with A.

The duty consultant and the clinical nurse specialist met with A and relayed the findings of the multi-disciplinary team discussion the previous day. The specialist radiologists felt that there was a thickening of the lining of the abdomen that may suggest the disease had spread and that the nature of the tumour was unresectable. A check tubogram (a dye test to check whether the stent had opened up) indicated that the stent inserted had not fully drained the bile ducts and a second stent was inserted, with the external component of the biliary drain removed.

A was discharged shortly afterwards. At a multi-disciplinary team discussion less than two weeks later, it was highlighted that there were no biopsies currently in the pathology laboratory. Further investigation found that A's biopsies had been disposed of. Four months on, A was made aware by the referring board that the biopsies had not reached the laboratory. A died after a short period.

We took independent advice from a general and colorectal surgeon. We found that whilst A had been given sufficient information regarding their care and treatment and the need for a biopsy, the board unreasonably lost biopsy samples and failed to inform A that they had been lost. We also found that the communication between departments, wards and with another board was unreasonable. We upheld the complaint.

## Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the specific failings identified in respect of the complaint. The apology should meet the standards set out in the SPSO guidelines on apology available at www. spso. org. uk/information-leaflets.
- Apologise to C for the specific failings in communication with them, between departments and with another board. The apology should meet the standards set out in the SPSO guidelines on apology available at www. spso. org. uk/information-leaflets.

What we said should change to put things right in future:

- The treating hospital should ensure all outstanding results are reviewed and subsequent forward planning is done. The episode of care should not be viewed as complete until all results are reviewed rather than the discharge status.
- Biopsy samples should have the correct form, details of the responsible clinician on the form and should be sent from the originating area. There should be a process in place to correct errors in specimen

direction.

- The treating clinician should be responsible (directly or delegated) for notifying a patient as soon as is reasonably possible regarding a biopsy loss.
- Investigation of a datix incident should be thorough and ensure appropriate and adequate learning from the events.
- There should be clear communication between departments and wards regarding planned procedures. Patients should be informed without delay of any cancellation, and where appropriate a prompt apology made to reduce distress.

We have asked the organisation to provide us with evidence that they have implemented the recommendations we have made on this case by the deadline we set.