# SPSO decision report

**Case:** **202303473, Tayside NHS Board**
**Sector:** Health
**Subject:** Clinical treatment / diagnosis
**Decision:** upheld, recommendations

## Summary

C complained about the care and treatment provided to their late parent (A) by the board. A, who had a history of breast cancer, was admitted to hospital with pain and vomiting. Tests were carried out and A underwent a liver biopsy. Following the biopsy, their condition deteriorated and they died a few days later. C felt that A's death was premature and was hastened by the actions of the board.

The board said that CT scans showed that A had an abnormal liver and an MRI was requested. This wasn't completed until eight days later due to high demand. The liver biopsy was undertaken the same day. When A began to deteriorate, an urgent CT scan showed that A was bleeding from an injury to the branch of the cystic artery from the biopsy site. The board said that this is a known complication of a liver biopsy. The bleed was successfully treated but A deteriorated further and died. A had shown signs of potential infection and was commenced on antibiotics. The post-mortem stated that the cause of death was 'complications of liver biopsy and metastatic breast cancer in liver', and could not conclude to what extent the infection contributed to A's death.

We took independent advice from a consultant general and colorectal surgeon. We found that the MRI did not appear to have been reviewed prior to proceeding to biopsy and the breast team were not notified of the CT scan results. We also noted that A was not referred to the breast cancer multidisciplinary team (MDT). We found that antibiotics should ideally have been administered within one hour of deterioration and sepsis considered as a main cause of A's deterioration. A was also given a cystic artery embolization (a minimally invasive procedure that blocks or closes the blood vessel) and two units of blood despite having a normal blood count and no evidence of significant bleeding. Therefore, we upheld this part of C's complaint.

C complained about communication with A and A's family, stating that A was not given sufficient information about their condition or results from tests. A's family were unaware of test results until after A's death. We found that communication with A and A's family was unreasonable and that there had also been an absence of communication with the breast team and MDT, which was a missed opportunity. We upheld this part of C's complaint.

C complained that the board unreasonably failed to undertake a Significant Adverse Event Review. We found it was unreasonable for the board not to have undertaken a Significant Adverse Event Review. This was a missed opportunity to reflect on A's care and treatment, and identify learning from these events. We upheld this part of C's complaint.

## Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failure to provide reasonable care and treatment to A, the failure to communicate to a reasonable standard and the failure to undertake a Significant Adverse Event Review. 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:

- Plans for investigations, especially of an invasive nature, should be adequately discussed with the patient, including where there is a suspicion of malignancy.
- Relevant clinical teams should be involved, especially where investigations were initiated prior to admission. Sepsis should be appropriately considered as a reason for deterioration, and wherever possible, antibiotics be administered within an hour of deterioration. Appropriate treatment should be given based on clinical signs and symptoms.
- Significant Adverse Event Review’s should be completed in line with the national framework and the board’s own protocols.

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.