[redacted]

INQUEST INTO THE DEATH OF MR DAVID SELMAN

Regulation 28: Report to prevent future deaths

This report is being sent to: Chief Executive, South Central Ambulance Service

1. **Coroner**

   I am Nicholas Graham, Assistant Coroner, for the Coroner Area of Oxfordshire.

2. **Coroner's Legal Powers**

   I make this report under paragraph 7, Schedule 5, of the Coroner's & Justice Act 2009 and Regulations 28 and 29 of the Coroner's (Investigations) Regulations 2013.

3. **Investigation and Inquest**

   On 13 February 2013 an Inquest was opened into the death of DAVID LESLIE SELMAN, then aged 38. The Inquest concluded at a hearing on 25 September 2013. The conclusion of the inquest was a narrative verdict, a copy of which I attach, the medical cause of death being multiple drug toxicity.

4. **Circumstances of the death**

   4.1 Mr Selman had a history of mental illness and suffered from schizophrenia and epilepsy for which he took prescription drugs. He also had a history of taking "legal highs". Just prior to his death on 11 February 2013 Mr Selman had consumed a large amount of legal highs which had an adverse reaction with the prescription drugs that he was then taking.

   4.2 In the early evening of 11 February 2013 he had a drink at All Bar One, a public house on High Street, Oxford, when the staff at All Bar One noted unusual behaviour on the part of Mr Selman, including shaking and

spasms. The bar staff were sufficiently concerned that they called for an ambulance at 17:51 hours.

4.3 As I understand is usual practice, because Mr Selman was in a public house, and the ambulance service were not given assurances that it was safe to attend, the police were called and attended at All Bar One at 18:05.

4.4 At the same time the ambulance crew who were originally notified were told to stand back. Unfortunately, that message reached the crew but they thought the control room had told them to stand down and they therefore returned to the hospital. (The ambulance engaged was sub-contracted by South Central Ambulance Service to Surrey Ambulance Service.)

4.5 At 18:08 the police officers attending contacted their control room to say that they were on the scene to confirm that an ambulance was required. Effectively, that it was safe to approach. That was relayed to the control room for the ambulance service at 18:17 and the crew were then notified to attend the scene. As they had deployed back to the hospital it took them a further ten to twelve minutes to attend to Mr Selman at 18:33 hours. The total time from the original call until the ambulance arrived was, by my calculation, 42 minutes.

4.6 Because of the delay in the ambulance arriving a further call was made and further information given to the control room as regards Mr Selman's state. That information was not passed on. Had it done so I understand there could have been a reassessment of whether a paramedic should have been deployed as opposed to the ambulance technician who attended. A paramedic may have been in a position to provide an advanced level of care.

5. Coroner's concern

During the course of the Inquest the evidence revealed matters giving rise to a concern as defined by the above regulations. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you.

The matters of concern are as follows:

5.1 There was a miscommunication, or misunderstanding, between the control room and the ambulance staff as regards to whether they were required to stand down or stand back.

5.2 If they had stood back as instructed then I understand they would have been only a matter of two to three minutes away from the scene as opposed to ten to twelve minutes. In addition to the slight delays in communication between the police and the ambulance control room, this exacerbated a problem.

5.3 It is clearly important that a continual assessment of the patient's presenting symptoms are relayed to the ambulance crew and how best to deploy resources given the circumstances of any individual case. The evidence at the Inquest was that no such assessment was undertaken.

I should make it clear that I found no evidence that an earlier attendance by the ambulance crew would have resulted in a different outcome for Mr Selman who sadly went into cardiac arrest just prior to arriving at the John Radcliffe Hospital and, despite the best efforts of the staff at the hospital, he could not be revived.

I would also say that [redacted], on behalf of your service, provided me with a helpful report which assisted my inquiry and gave a very open and honest account of his assessment of the circumstances of this case.

6. Action should be taken

6.1 In my opinion action should be taken to prevent future deaths and I believe your service has the power to take such action.

6.2 Such action should include:

(a) reviewing the communication arrangements between the control room and the ambulance staff to ensure that they fully understand the request to stand down as opposed to any request to stand back;

(b) ensuring that staff continually assess the patient's presenting symptoms to ensure the attendance of appropriate resourced ambulance crew.

7. Your Response

7.1 You are under a duty to respond to this report within 56 days of the date of this report, namely by 26 November 2013. I, the Coroner may extend the period.

7.2 Your response may contain details of action taken, or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.

8. Copies and publication

8.1 I have sent copies of my report to the Chief Coroner and to [redacted] who was the representative of the family.

8.2 I am also under a duty to send the Chief Coroner a copy of your response.

8.3 The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest.

8.4 You may make representations to me, the Coroner, at the time of your response, about the release or publication of your response by the Chief Coroner.

Nicholas Graham
Assistant HM Coroner for Oxfordshire