



JUDICIARY OF
ENGLAND AND WALES

In the Central Criminal Court

R v David Sellu

5 November 2013

Sentencing remarks of Mr Justice Nicol

You may remain seated for the time being.

David Sellu the jury have found you guilty of the manslaughter of Jim Hughes because of gross negligence while he was in your care and you were his consultant surgeon.

Between the time that you first saw him, just after 9.0pm on the evening of 11th February 2010 and the time that he came into the operating theatre just after 10.00pm the following day, there were numerous occasions when your care fell far below that which could reasonably be expected of a consultant colorectal surgeon. Like the jury, I have heard all the evidence, including your own testimony. The jury's verdict means that, taken as a whole your conduct was grossly negligent. It would be open to me to distinguish between the different matters on which the Crown relied, as long as my overall conclusion was consistent with the verdict of the jury.

I have reflected on one matter in particular: whether you did instruct the Resident Medical Officer to prescribe antibiotics for Mr Hughes. You and the RMO gave conflicting evidence on that matter. On the expert evidence I have heard, it would have been an obvious step to take. But as the prosecution have commented, it is not a step to which you referred in your first witness statement for the coroner, made by you about 3 weeks after the death of Mr Hughes. To the internal investigation set up under Professor Empey a short time later, you said you had instructed the RMO to start antibiotics and then, when you said you spoke to him later that night, to continue with the antibiotics. That is different to the account which you gave to the jury. Although you did make a record of other elements of your care plan for Mr Hughes in your medical notes, there is no reference to antibiotics. Overall, for whatever reason, I am sure that you omitted to give instructions to the RMO at any stage to prescribe antibiotics for Mr Hughes.

That was but one of a whole series of omissions in your care of Mr Hughes. On 11th February you did identify the possibility of free gas in Mr Hughes' abdomen from the X rays. You are not a radiologist and your uncertainty on this matter was no fault. However, as Mr Kelly, the expert surgeon called by the Crown, put it whether there was free gas or not really mattered. The Clementine Churchill Hospital had a radiologist on call who could and would have given you a definitive answer. You did not take that step.

I have said you did not instruct the RMO to start antibiotics on the Thursday night, but, even if you had, the failure to record this in the medical notes also really mattered. It meant that the nursing staff were not alerted to the need for Mr Hughes to have this important part of his treatment.

You wanted a CT scan of Mr Hughes' abdomen. That was not unreasonable, but you did not make use of the facility, which was also available at the hospital, to have a scan like this done that same night. Instead you instructed it to be done the following morning with a predictable delay of about 12 hours. On the expert evidence called by the Crown which the jury must have accepted, that was simply far too laid back for someone with a suspected perforated bowel.

The following day you said that you visited Mr Hughes. You made no record of that visit and, if it happened at all, you were, as you put it in evidence, in a rush because you had another patient who was undergoing a pre-booked procedure. You did not speak to any of the nurses, the RMO or anyone else who had been caring for Mr Hughes during the night. I am sure that there was not the careful assessment of your patient which you were required to give him. There was then further delay in chasing up the CT scan and arranging an operation once the scan confirmed that Mr Hughes' illness was due to a perforated bowel.

In summary, I am satisfied that the Crown has proved to the necessary standard, each of the aspects of gross negligence which they alleged.

Even if you had acted more speedily, there was a chance that Mr Hughes would have died anyway. There is always such a risk with major abdominal surgery of the kind which he needed. But the chance would have been very, very much smaller if you had acted as a reasonable surgeon would have done on the Thursday night. The risks would have increased if the operation had not taken place until Friday morning and would have got progressively larger as the day went on, but at each stage the chances of his survival would still have been better than when he finally did get to the operating theatre late in the evening of Friday 12th February.

All of this means that this was not a single isolated act of negligence. There were several. Nor were they committed in the pressured circumstances of an acute NHS hospital where the stress of dealing with very many patients in an emergency condition can be particularly challenging. You have observed, without seeking to cast blame elsewhere, that others caring for Mr Hughes that others in the hospital may have missed opportunities to help Mr Hughes or notice that he was deteriorating. But you were his consultant surgeon. It was you who was responsible for determining his treatment. It is your several failures in that regard which amounted to gross negligence. I am afraid that it means your culpability is high.

And that negligence contributed significantly to the death of Mr Hughes. You have heard this afternoon the grief and anguish that has caused the members of his family. He was a kind, generous, hard-working and energetic man. His death has left a void for his immediate and extended family and others who knew him.

You are 66 and a man without previous convictions or cautions and, of course, I take that into account.

I have heard the evidence of Dr Whitehead who praised your ability and dedication as a surgeon. I have read the references from your many colleagues in the NHS and private practice who speak equally highly of your skill and care for patients. This case is completely at odds with that picture. There is no explanation as to why it should have been so.

Your conviction will, no doubt, bring your career to a halt. It will have been a tragedy for you and your family. Surgeons sometimes have the opportunity to save lives. I have heard that you sometimes saved lives. But their decisions or defaults can also have the opposite effect. Sadly, that was the case with Mr Hughes.

I have considered the cases and statutory provisions which the prosecution have drawn to my attention. I accept that in your case there was no alteration of medical records which would have been a significantly aggravating factor. However, in your witness statements for the coroner and your answers to Professor Empey's investigation you made numerous errors. All of them put you in a better light. It is true, as your counsel has said that you were charged with no offence in relation to these matters and the jury has acquitted you of count 2 on the indictment. However, at the very least they show a lack of candour with those responsible for investigating Mr Hughes' death.

Your counsel realistically accepts that the only sentence I can pass is one of custody. He has asked that I suspend the sentence. He says, rightly that you will be no danger to the public or patients because you will not practice again. However, I am afraid that in all the circumstances I do not consider that would be right.

The sentence will be the shortest which is appropriate. You will serve half. You will then be released on licence, but may be recalled if you offend again or otherwise breach the terms of your licence.

Stand up

David Sellu for the offence of unlawfully killing James Hughes you are sentenced to 2 ½ years imprisonment.