

**Report, dated 27th February 2006, of the
Review into the events leading up to
and following the death of
Christopher Alder on 1st April 1998**

**by the
Independent Police Complaints Commission**

*Return to an Address of the Honourable the House of Commons
dated 27th March 2006
for the*

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This report has been published by the Home Office in its entirety save for some small redactions in the text which the IPCC has asked should be made and which are indicated in the body of the report. Those redactions relate to material that the IPCC has seen and which it has relied on in reaching some of its conclusions but which enjoy third party legal professional privilege and therefore cannot be published.

One paragraph in Appendix 31 which contains personal information about Mr Alder's family has also been redacted at the request of the IPCC.

SUMMARY

HOME SECRETARY

Your predecessor, the Rt Hon. David Blunkett MP, wrote to me on 20 April 2004, requiring the Independent Police Complaints Commission (IPCC) to undertake a Review of the events leading up to and following the death of Christopher Alder.

Mr Alder died while in police custody at Queen's Gardens police station in Hull during the early hours of Wednesday 1 April 1998.

The Review was carried out under Section 79(1) of the Police Act 1996. The terms of reference of the Review were:

- to identify and take account of the concerns of the family of Christopher Alder in respect of his death;
- to consider the circumstances surrounding his death;
- to produce a report on the evidence surrounding his death that will include a view on whether or not the approaches taken at the criminal and disciplinary proceedings may, or may not, have been different had the investigation been conducted in a different way; and
- to make any recommendations for the benefit of policing that may arise from the Review.

I was responsible for the Review and was assisted by a team of permanent and seconded IPCC staff. I sought the assistance of the Healthcare Commission (HCC) in assessing the standards of medical care Mr Alder received. A summary of their conclusions is attached as an appendix to the IPCC report, and the HCC full report will be published simultaneously with this report. I am grateful to the HCC for their cooperation.

I have set out a summary of my findings below.

Overview

Christopher Alder, a black man aged 37, died on the floor of the custody suite at Queen's Gardens police station in Hull during the early hours of 1 April 1998. His last minutes of life were captured on CCTV. They are shocking and distressing pictures. The grief and anger occasioned by his death stands in contrast to the manner of it – unnecessary, undignified and unnoticed.

Since that time there has been a lengthy inquest, a criminal trial and a police disciplinary hearing. The inquest verdict was subject to judicial review and an

appeal was heard against one of the rulings in the trial. Mr Alder's death was the subject of a criminal investigation by Humberside Police and a West Yorkshire Police investigation supervised by the Police Complaints Authority (PCA). Seventeen doctors and pathologists considered the cause of his death. There has been one civil action heard before the County Court. I understand other civil actions and a case before the European Court of Human Rights are pending.

The Review was announced following the BBC documentary *Death on Camera*, which highlighted serious concerns about the circumstances of Mr Alder's death.

The whole process has taken eight years since Mr Alder's death.

There is no doubt in my mind that the events leading to and following Mr Alder's death represent very serious failings by many of the individuals and organisations involved – but the process that followed did not hold any individual responsible for these failings. No individuals have been held responsible – yet all of those involved, family and police officers alike, have, to a greater or lesser extent, been punished by the process itself.

I do not want there to be any doubt about my findings. The most serious failings were by four of the police officers involved: Police Constable (PC) Barr, PC Blakey, PC Dawson and Police Sergeant (PS) Dunn. I believe they were guilty of the most serious neglect of duty. In the case of PS Dunn, the duty placed upon him as a custody officer was greater than that of his colleagues. I do not believe, as has been alleged by some, that any of these officers assaulted Mr Alder. Nor can it be said with certainty, such are the contradictions in the medical evidence, that their neglect of Mr Alder, as he lay dying on the custody suite floor, caused his death. However, all the experts agreed that, at the very least, the officers' neglect undoubtedly did deny him the chance of life. It appears that the process that has since followed has not allowed the officers to accept their failings and offer any apology for their actions.

It has been put to me – on occasion by senior officers – that the actions and inactions of these officers were typical of what many of their colleagues would do – and have done – faced with similar circumstances in other custody suites on other nights up and down the country. Any officer might have done the same, it is said. That this incident ended the way it did was a tragedy for Mr Alder and simply unlucky for the officers. I have had the advice of a number of experienced police officers in conducting this Review. They share my shock and distress at what the CCTV shows.

Superintendent Bates, the Humberside Police Senior Investigating Officer, described during his interview with my team the moment he first saw Mr Alder's death on tape:

- A. I remember John saying, I was on the phone, "Yes, it is, you should see it." I then made certain I had a viewing of the tape, a

copy of the tape, not the original, brought over and I sat and watched it with my team. I remember the silence in the room as we watched it. Every minute that went by that he was laid on the floor, I was actually willing, I remember mentally willing someone to go and look at him. Eventually they did, but it seemed an age. I remember being shocked.

- Q. Did that in any way change your perception of the events or the focus of the investigations, yours and West Yorkshire's?
- A. I knew, having viewed the tape, that the question of who may or may not be charged and found responsible for Christopher's death would be very, very unclear.

If the lack of common sense and common decency displayed by the officers who watched Mr Alder die is typical of how any police officer would react, it is a disturbing comment on the police service as a whole. However, I do not believe this is the case. There is no excuse. Far from being typical of most police officers, their behaviour has disgraced police officers and the police service as a whole. The failures of Barr, Blakey, Dawson and Dunn were personal and individual.

In addition to these primary individual failings, there were other mistakes. Acting Police Sergeant (A/PS) Ellerington was involved, but to a lesser extent than the other officers, in the events leading to Mr Alder's death. The HCC has criticised the medical care Mr Alder received in their report. Mr Gordon Clark, then Deputy Chief Constable (DCC) of Humberside Police, declined to establish a disciplinary tribunal. When forced to do so by the Police Complaints Authority, he severely restricted its powers. These were very serious errors of judgement for a senior officer responsible for force discipline to make. Ironically, the failure of the discipline process meant that many of the most serious allegations hung over the officers' heads for far longer than necessary. Mr Sean Price, Chief Constable of Cleveland, presided over the disciplinary tribunal but was denied legal advice during the hearing. This placed him in an impossible position and he now accepts that as a result he made errors in his handling of the tribunal.

There were also significant failings in the two police investigations into Mr Alder's death.

The Humberside police investigation focused on Jason Paul who had been involved in a fight with Mr Alder on the night he died. Humberside Police was allowed to take too much of the initiative in the investigatory process and undertook tasks that should have fallen to West Yorkshire Police. A jury at Sheffield County Court found, on the balance of probabilities, that Mr Paul had been unlawfully arrested and charged to divert attention away from Humberside Police's own failings with regard to Mr Alder. I have not seen evidence that suggests this was a deliberate intention. Mr Paul was arrested and charged before any of the investigators had seen the devastating content of the Queen's Gardens custody suite tapes. However, whatever the intention, the effect of the Humberside investigation was indeed to marginalise the

enquiry carried out by West Yorkshire. It is also clear, largely with the benefit of hindsight, that Superintendent Holt of West Yorkshire Police, who carried out the Police Complaints Authority-supervised investigation into Mr Alder's death, made some significant errors in his investigation. Some of these errors contributed to the suspicion and myths that have bedevilled this case for so many years.

There were also three major systemic failures that go beyond the responsibilities of the individuals involved. All of these have been the subject of other reviews and inquiries. Much has changed since that time but the same problems still reoccur too often.

1. I believe the failure of the police officers concerned to assist Mr Alder effectively on the night he died were largely due to assumptions they made about him based on negative racial stereotypes. Lord Macpherson describes this as 'unwitting racism' and I believe his analysis and many of his recommendations are directly relevant to this case. Lord Macpherson's recommendations need continued attention and powerful leadership in all police forces.
2. The HCC report identifies a number of failings in the medical care Mr Alder received. Critical amongst these was the lack of information and advice about his condition passed from the medical staff to the police officers. You have previously indicated your support for a national protocol between health and police services to ensure that such transfers of responsibility for care are more effective in future. I hope a high priority will now be given to establishing that protocol, together with local audits of existing arrangements and the implementation of appropriate training and operating procedures in both services to ensure the best possible working practices.
3. The case of Mr Alder represents a major failure of the police discipline system. It cannot be right that the police service still labours under a discipline system based on the court martial system in place at the time of the Indian Mutiny. It saps the morale, effectiveness and resources of the police service. It has no defenders that I know of. I think the public would be appalled if they knew how inadequate and old fashioned the system is. Last year, Bill Taylor set out widely supported recommendations for the reform of the police disciplinary system. I urge that his recommendations are acted on with all possible speed.

I want to give a very clear message to Humberside Police.

In my view, Humberside Police must show they accept several simple truths of the case:

- The acquittal of the officers in the trial and disciplinary hearings did **not** amount to an endorsement of their actions.

Executive Summary

- Right-minded people watching the videotape of Mr Alder's death are quite properly appalled by what they see.
- Even if the officers did not cause the death of Mr Alder, their behaviour was not acceptable, and fell seriously short of the standards that are expected of police officers.
- The officers were not the victims in this case.
- Humberside Police still owes the Alder family an apology.

Humberside Police may argue that they are unwilling to offer any apology while civil litigation is ongoing. I do not accept this view. Other forces have taken a different stance in similar circumstances. The Chief Constable should offer an unreserved apology for the force's failings in relation to the death of Christopher Alder and he should do it now.

I am disappointed that the police officers directly involved in Mr Alder's death refused to cooperate with the Review. I was finally notified of their refusal by a letter dated 17 October 2005. I made every effort to enable them to participate. Most of the delays in completing the Review were a consequence of their refusal. In my view, there is no possibility of any further criminal or disciplinary action against them and so they had no good reason for failing to speak to my team. Indeed, I think they owed it to Mr Alder's family, their colleagues in the police service, and the wider public on whose behalf they served, to account fully for their actions on the night of Mr Alder's death. They have not done so and any future justification or comment they make will be less credible because of it. The failure of these officers to cooperate with the Review is in disappointing contrast to the cooperation received from other officers, police staff, the forensic science service and the health professionals involved – all of whom knew they were potentially subject to criticism but nevertheless gave full and frank accounts of their actions.

I have carried out a **Review** in line with the terms of reference your predecessor gave the IPCC – not a **reinvestigation**. I do not believe a further investigation would add anything of substance. I have largely relied on the extensive material gathered over the last eight years. However, where appropriate and possible, my team has interviewed those most closely involved to clarify their accounts and answer some of the new questions that have arisen. In addition, some of the original evidence has been reanalysed using techniques that were not available at the time.

Inevitably I have had the benefit of hindsight in considering these matters and the passage of time has clouded the memories of those we spoke to. However, I believe that my team and I have been able to construct a detailed and accurate account of all the circumstances surrounding the death of Mr Alder. What is missing is an account from the officers of why they acted, or failed to act, as they did. Some of what we found will be unwelcome to the police service. I know the family of Mr Alder will find other aspects difficult to accept.

The first point of the terms of reference for the Review enjoins me to take account of the concerns of Mr Alder's family. As you know, they wanted a public inquiry, not a review. Nevertheless, I have had considerable contact with Janet Alder in particular by phone and e-mail during the course of the Review. I have also met with the solicitor representing Mr Alder's sons. I understand the key concerns of Mr Alder's family to be:

- Why was Christopher Alder arrested at the hospital?
- Following his arrest, was he assaulted by police en route to the police station?
- Why was he unconscious on arrival at the police station, and why was he incontinent, with his trousers coming down and his belt missing?
- Why was he offered no assistance as he lay dying on the floor of Queen's Gardens police station?
- Was the investigation into his death adequate, and was there an attempt to cover up the cause of his death?
- Were his treatment by the police and the investigation into his death influenced by Mr Alder's race?
- Why was nobody held accountable for his death, despite an inquest verdict of unlawful killing?

It is the aim of my report to set out a full, impartial and independent answer to these questions.

Christopher Alder and the events of 1 April 1998

Mr Alder was born in Hull on 25 June 1960. His parents were from Nigeria. He joined the Parachute Regiment aged 16 and served his country in that capacity for six years. His service included a tour of duty in Northern Ireland. On leaving the army, he moved between Andover and Hull before returning to Hull permanently in 1990. He had family living in the city including a brother, Richard. He had a sister Janet, who lived in Lancashire. In the 1980s he had two sons.

Mr Alder was knocked unconscious by Jason Paul during a fight outside the Waterfront Club in Hull on 1 April 1998. It was a serious injury. He may have been unconscious for up to 11 minutes. He was treated with great kindness and care by the nightclub staff and some of his friends. He was taken by ambulance to Hull Royal Infirmary. The symptoms of his injury, a historic fear of hospitals and the not-excessive amount of alcohol he had drunk combined to make him aggressive and uncooperative with the medical professionals

who tried to treat him. Nevertheless, the HCC have found that the medical care he received was inadequate.

PCs Dawson and Blakey were assigned to deal with the incident. They attended the club and then the hospital. At the request of hospital staff, they removed Mr Alder when he did not cooperate with treatment. There was an inadequate handover from the medical staff to the police officers. The police officers dragged him outside the building where he was arrested for a breach of the peace. A/PS Ellerington collected Mr Alder by van and drove him to Queen's Gardens police station while Dawson and Blakey followed in their car. The van was called from Queen's Gardens at 03.34 and was back at Queen's Gardens, having collected Mr Alder, at 03.46. That is a period of 12 minutes, which would include the time taken to place Mr Alder in the back of the van and take him out again at Queen's Gardens police station.

It has been alleged that CS spray was used on Mr Alder. I have found no evidence to support this. It is also alleged that he was subject to an assault by the officers. I am satisfied that this did not occur. I am confident that the timings of the journey preclude assault as a possibility and there is no forensic evidence at all to support any aspect of this allegation. Reconstructions of Mr Alder's position in the van carried out on my behalf by Control Risks Group using the position of the blood smears as reference points show no evidence of a struggle or significant changes in Mr Alder's position. Furthermore, I do not believe the demeanour of the officers shown on the CCTV both before and after Mr Alder's death in the custody suite is consistent with the allegation that they had just carried out an assault which led to the death of the man in the custody suite in front of them.

However, what did happen was disgraceful. On arrival at Queen's Gardens police station Mr Alder was found slumped in the back of the van. The officers believed he was faking sleep or illness. He was dragged from the van to the custody suite. At some stage, as he was dragged outside the hospital and later from the van, his jeans, which he had probably not been able to refasten after he urinated at the hospital and which probably did not have a belt, had come down round his knees. He was doubly incontinent.

Events in the custody suite were recorded on CCTV. He lay on the custody suite floor watched by PS Dunn, the custody sergeant, PC Barr, the jailor, Blakey, Dawson and, for a short while, Ellerington. A civilian 'matron' named Bridget Winkley was also on duty (Matron Winkley was not a qualified nurse).

The officers all claim that they believed he was faking his condition. He lay largely disregarded on the custody suite floor for 11 minutes. At one point, his handcuffs were removed. He remained motionless and unresponsive throughout. The tapes record the desultory conversation of the officers and Mr Alder's guttural last breaths.

The officers noticed Mr Alder had stopped breathing at about 03.57. They and the ambulance crew who arrived shortly afterwards (the same crew who had

attended Mr Alder at the Waterfront Club) made determined but ineffectual attempts to resuscitate him. Mr Alder was officially pronounced dead at 07.20.

Up to the arrival of Mr Alder, it had been a normal night in the custody suite. It had not been exceptionally busy. PC Barr even had time for a few jokes. At 01.34 he made one, possibly two, calls to what appeared to be other police stations. He claimed to be a reporter from the *Hull Daily Mail* enquiring about a death in custody. It was an April Fool's joke. I do not suggest that this had any direct relationship with subsequent events – but it speaks volumes about his state of mind.

Other earlier events in the custody suite also raise grave concerns about the attitudes of the officers. At 23.52 on the evening of 31 March, a white woman prisoner was being brought into the custody suite and making loud, drunken protests. In my view, and that of my team, the CCTV clearly shows PS Dunn making monkey noises and gestures towards her. I should record that this view of what occurred during this early part of the shift is not shared by the consultant, Ms Elizabeth McClelland, commissioned on our behalf by Control Risks Group to analyse this portion of the tapes.

This behaviour is significant because of its obvious connection to the events that were recorded at 05.45 on 1 April while Mr Alder lay dead on the floor of the custody suite and which have been the source of considerable controversy.

In 2002, nearly four years after Mr Alder's death, lawyers preparing for the trial of the officers identified remarks and noises on the tape which appear to be monkey imitations, references to 'banana boats' and hoods with eyehole slits. The possible racist connotations of these sounds made while Mr Alder, a black man, lay dead on the floor, were obvious. However, different experts took different views of what the tapes revealed (one of those experts was Ms McClelland, who on this occasion believed the tape **did** reveal monkey noises and references to banana boats and slitted hoods). The Crown Prosecution Service (CPS) and the PCA believed the words used were 'banana boots', not 'banana boats', and the references were to the yellow forensic overshoes and other over-clothing that the officers thought they might be asked to wear. The yellow overshoes, which I have seen, were known in the Humberside Police Force as 'banana boots'.

I have had a new forensic analysis conducted on this section of the tape using techniques that were not available at the time the original analysis was done. I am satisfied that the CPS and the PCA were correct and that the references were to the yellow forensic overshoes and other forensic clothing used by the forces and so was not intentionally racist or offensive. However, I think there were monkey noises being made both at the beginning of the shift and after Mr Alder's death. I do not think these noises were directed specifically at Mr Alder. If the racist connotation of these noises was not obvious to the officers, they should have been. The banter and casual attitude displayed both before Mr Alder arrived, while he lay dying in the custody suite, and before he was eventually removed was grossly insensitive in the extreme.

The two investigations and contact with the family

The death of Mr Alder triggered two separate investigations: the first of these by Humberside Police, as the local force responsible for investigating whether the blow he sustained outside the Waterfront Club was an unlawful assault and whether it had led to his death. The second investigation, triggered by the fact that he died in police custody, was conducted by West Yorkshire Police under the supervision of the PCA. The Humberside investigation was lead by Superintendent Bates, the West Yorkshire investigation by Superintendent Holt. Both have cooperated fully and frankly with the Review.

The initial view taken by both police forces was that the Humberside investigation was the priority. That assumption led to a number of errors that were compounded by a lack of rigour in establishing the independence of the West Yorkshire investigation – its *raison d'être*. I do not suggest that the West Yorkshire investigation was obstructed in any way but the assumption that it was the blow struck in the fight outside the Waterfront Club that killed Mr Alder appeared to have excluded other possibilities.

Mr Paul went to the police with his solicitor of his own volition on the morning of 1 April 1998. He was arrested for murder and detained. However, as early as the first post mortem on the evening of 1 April it became clear that the blow was not the cause of death. This was recognised in the decision to de-arrest Mr Paul for murder and to arrest and charge him for Grievous Bodily Harm with Intent the next day. On the day after that, 3 April, the tapes showing the dreadful events at Queen's Gardens Police Station were seen for the first time by the investigators. At that point at least, the balance between the two investigations should have changed.

However, the inquiry run by Humberside Police was still being described as a murder investigation, and run as such until 29 April, when Dr Clark, the pathologist, formally reported to the police that Mr Alder had not been killed by the blow.

The Humberside investigation received a damning verdict from the jury that considered Jason Paul's claim against Humberside Police in January 2006.

The jury in that trial returned verdicts in which they found that it was more likely than not that:

- The instruction to arrest for murder was given to deflect potential criticism of the circumstances surrounding Mr Alder's death
- DC Wade had not considered the lawfulness of the the arrest before his initial arrest of Mr Paul for murder

Executive Summary

- DCI Davison did not rely upon the statement of Richard Hillyard when he decided to charge Mr Paul with causing grievous bodily harm, and that
- Mr Paul was charged with causing grievous bodily harm to deflect potential criticism of the circumstances surrounding Mr Alder's death

I am most concerned about the lack of clarity in planning and the failure to divide responsibilities on the correct lines between the two forces. Although both sides needed a clearer approach, I find more fault with West Yorkshire Police for sitting back and allowing Humberside Police to take the initiative.

Humberside Police was initially investigating a potential murder, and therefore should have been looking for culprits. West Yorkshire Police, however, should have been considering:

“How and why did this man die in the circumstances that he did?”

Those were the questions the family were likely to ask, and West Yorkshire Police should have been answering them.

The West Yorkshire investigation clearly reflected the lower priority it was given and the early erroneous assumptions that had been made. Humberside took the lead on all important lines of inquiry. The West Yorkshire investigation was inadequately resourced and Superintendent Holt lacked experience of this sort of investigation. The recording processes were poor. The early assumption that the officers were not at fault meant that their notebooks and duty statements were not secured as a matter of priority and their clothing was returned to save their feelings without a clear rationale regarding the evidential consequences. Regulation 7 (now 9) notices, which advise the recipient that they are subject to an investigation, were not issued in a timely way.

The Humberside investigation was pursued with vigour. Nevertheless, insufficient attention was given to establishing a forensic strategy, with the consequence that a number of forensic opportunities, particularly at Queen's Gardens police station, were missed. This was not the responsibility of the forensic personnel involved but of their senior officers. The West Yorkshire investigation compounded these errors. Blood samples and a recovered tooth were not subject to analysis and were destroyed, as was Mr Alder's clothing. The officers' clothing was not tested. These tests might have provided an opportunity to definitively rule in or out some of the hypotheses that have subsequently emerged. These opportunities were missed.

One is therefore faced with a curiously lopsided approach to the investigation. On the one hand, the two police forces both failed to follow up on basic tests that should have been carried out on the blood stains in the police van and passageway and on the tooth recovered from the scene of the initial fracas.

By way of contrast, the cause of Mr Alder's death was examined in close detail and at great length by the cream of UK pathology expertise.

There were significant shortcomings in the family liaison strategy. PC Beatrice Smith from Humberside acted as family liaison officer to Richard Alder. PC Smith was black and Janet Alder regarded her as a token appointment. I do not accept her view. It seems to me that PC Smith carried out her duties effectively and appeared to be appreciated by Richard Alder, Christopher's brother, the initial family contact. She did not receive the support she deserved at the time and I am concerned that she may not have done so since.

Superintendent Holt had a different strategy. He believed families needed time to "come to terms with their grief" before being informed of the nature of the PCA inquiry. PC Smith was removed from the inquiry and there were a number of very insensitive early contacts between officers of various ranks and Janet Alder. These ranged from getting vital dates and facts wrong to a senior officer chewing gum as he explained the circumstances of her brother's death to Janet Alder in the first meeting anyone from Humberside Police had with her. I accept that Janet Alder was not always easy to deal with – but in these circumstances it is possible to see why her suspicion and hostility grew.

Around the time of these events the PCA Supervising Member, Jim Elliott, was pioneering a new PCA approach. Very unusually for the PCA at that time, he dropped other business to attend the scene immediately he was informed of the death and went on to attend the post mortem. He attempted to take on much of the family liaison role himself (and may thereby have created some confusion). Ultimately he had neither the resources, time nor access to the professional advice he needed to effect a different outcome. However, the fault was with the system – not with Mr Elliott.

Medical history and post mortem medical evidence

Seventeen eminent doctors and pathologists have considered the cause of Mr Alder's death. Different individuals gave evidence at different stages of the process. Some of these individuals have changed their views as new evidence emerged or in response to the arguments put forward by others.

I have not sought to make my own assessment of the medical evidence – but I am grateful to Dr Richard Shepherd for his help in understanding the views of the other experts and his very helpful suggestions about how such complex cases could be handled in future.

The post mortem evidence does not support the allegation that Mr Alder was assaulted by the police. Some small injuries were identified at the post mortem that were not noted when Mr Alder was treated at Hull Royal Infirmary. I believe these are best explained by the very different circumstances in which the two examinations took place. However, the post mortem did not identify any injuries – such as marks on the wrist that would

have occurred on a man in handcuffs defending himself from attack – that give credence to the allegation that such an assault took place.

It is important to be clear that the blow that knocked him unconscious was ruled out as the immediate cause of Mr Alder's death. It is also clear that there was no evidence of a pre-existing medical condition that might have caused his death. No trace of drugs was found in his body. Two questions then arise – what caused his collapse in the van, and whether events in the custody suite contributed to his death?

A number of factors were cited as possible causes of his collapse in the van. These included whether the alcohol he had drunk, concussion, a panic attack or excited delirium had affected his heart or brain functions. The majority of experts agree that the position he was placed in caused positional asphyxia but disagree as to whether prompt and effective emergency assistance would have saved him or whether, by that stage, his condition was such that he would have died whatever action had been taken.

The dilemma facing the jury at the inquest and the judge at the trial was summed up by the coroner, Mr Saul:

“I suggest you ask yourselves this question, members of the jury, as you wrestle with this difficult concept of causation: If the experts cannot be sure that his condition was survivable come what may when he arrived at the custody suite, can you in turn be sure, as a jury, that any hastening of the death you may find by omitting to place him in the recovery position and check his airway, etcetera, caused his death more than minimally, trivially or negligibly?

His death may have been hastened by his position but can you say that caused his death more than minimally if, because we do not know the cause of his unconsciousness, we cannot rule out as a reasonable possibility that he might have died shortly anyway?”

The coroner's jury and the judge at the trial approached the issue from different positions and came to different conclusions about this. Evidence was available to the judge that was not available to the jury. Having studied all the medical evidence, I do not believe that the evidence available **for the trial** proved causation beyond reasonable doubt. However, the very uncertainties mean that Mr Alder was denied at least the chance of life.

Dr Shepherd's report is reproduced in full as an appendix to the main report. I highlight here two of his main recommendations, which I believe would provide a real opportunity in future to deal with such unusually complex cases more productively:

“1. In the more complex cases of sudden unexplained deaths and in particular deaths associated with restraint, a team of experts should be convened; the exact composition will vary from case to case (for instance, a toxicologist may be essential in some cases but of no value

in others). The core medical members should be an experienced forensic pathologist, a forensic physician (police surgeon) and an A&E consultant and they should be able to co-opt individuals with additional skills as they see necessary.

2. Confidential Inquiry

- a. In a number of areas of medicine (maternal deaths, post-operative deaths, etc) it has been found beneficial to establish a Confidential Inquiry system, whose remit it is to consider each death in confidence. The confidential format allows for the presentation and discussion of controversial factors that might remain hidden in legal proceedings.
- b. These Confidential Inquiries produce annual reports and recommendations based on their deliberations and experience but do not comment on individual cases.
- c. I would strongly recommend the establishment of such a Confidential Inquiry Panel for Deaths in Custody (Police and Prison) so that there can be an attempt to understand these deaths with a view to developing police procedures and practices so that further deaths can be prevented or the risks can, at least, be minimised.”

The hearings

Three hearings were held to investigate and adjudicate upon the death of Mr Alder. These were an inquest in 2000, a trial of the five officers in 2002, and a disciplinary hearing in 2003. In addition, there was a judicial review hearing of the inquest in 2001 and an appeal on one of the legal rulings in the trial heard in 2004. The approach in each of these hearings was different, and the outcome of each also varied. The purpose of the inquest was to seek to determine the cause of death for Mr Alder, without seeking to allocate blame. The trial was to establish whether the five officers were, individually, guilty of the charges brought against them, these being manslaughter and misconduct in public office. The disciplinary hearing was to establish whether they had, individually, been guilty of neglect of duty.

The coroner, Mr Saul, decided that the inquest should take place before the trial. The inquest started on 3 July 2000. It was unusually long and lasted 33 days.

Much of the evidence used in this Review was originally considered at the inquest. It is clear to me that some of this evidence has subsequently been forgotten by those with an interest in the case, and issues have been reopened that the inquest closed.

Executive Summary

The atmosphere of the inquest was tense and emotions often ran high. In view of their impending trial, the officers reserved their right to refuse to answer questions.

At the close of evidence, the coroner summed up over three days in what was described by Mr Justice Jackson, who considered the subsequent judicial review, as “a model of clarity”. The coroner left four verdicts open to the jury:

- unlawful killing on the basis of possible involuntary manslaughter;
- accidental death;
- natural causes; and
- open verdict.

The coroner explained carefully what he meant by ‘unlawful killing’:

“Now what is ‘unlawful killing’?”

In this case it would mean that you are sure that the death of Mr Alder was as a result of manslaughter, a crime of homicide. It would be as clear-cut and severe as that. The kind of manslaughter involved, and there are different varieties of manslaughter in the criminal law, the kind involved here is something called ‘involuntary manslaughter’, perhaps more helpfully called ‘manslaughter by gross negligence’, and would centre on events in the custody suite.

If you are to make such a finding, you must be satisfied so that you are sure that the act, or omission, of at least one single person, whom on no account must you name, was so grossly negligent as to amount to criminal conduct which caused the death into which we inquire.

Now the separate failures of a number of individual people cannot be added together to justify a gross failure amounting to gross negligence manslaughter, and although you must not publicly declare the identity of any such single person you find you are sure has unlawfully killed Mr Alder, although you must not publicly declare the identity, his or her identity must be agreed by you all.”

On 24 August 2000, the jury returned with their verdict – which was ‘unlawful killing’.

Allegations were subsequently made that one of the jurors was improperly influenced by her relationship with one of the male barristers. This matter and others, including the argument that the jury was misdirected by the coroner, particularly by leaving a verdict of unlawful killing open to them, were the subject of a judicial review. This was heard and rejected by Mr Justice Jackson.

The inquest verdict was received with jubilation by Mr Alder's family, who were naturally dismayed that the trial judge reached a different conclusion.

The trial commenced on 15 April 2002 in front of Mr Justice Evans at Teesside Crown Court. It was to end in the judge directing the acquittal of the officers on all charges.

In my view, the case was prosecuted vigorously but ethically by the CPS, which went to considerable lengths to meet the family's concerns. The CPS met the family's expenses to attend the trial, and one member of the prosecuting team was appointed to liaise with them.

Nevertheless, relations between Janet Alder and the CPS deteriorated. I can imagine her frustration at the two different verdicts. Janet Alder subsequently argued that the CPS had approached the case in a racist way and that individuals involved had previously been found to have behaved in a racist way in other matters. I have seen no evidence to support these allegations. I do not believe them to be correct.

The CPS did have a real difficulty in deciding how to deal with the conflicting evidence in the case. In January 2002, as a result of late medical evidence they had received, the CPS had submitted a 'voluntary bill of indictment' to add manslaughter to the existing charges. This procedure necessitated placing all the evidence before the judge – even where it was contradictory. The CPS felt that in those circumstances they had no alternative but to do the same for the jury. In any case, they reasoned, all the evidence would come out in due course and their presentation would be weakened if the jury believed they were withholding the full picture. This was the main issue of dispute between the CPS and the Alder family. In my view, it was a finely balanced decision but there were sound legal and presentational arguments for the decision the CPS made.

Following the prosecution case, submissions were made for the defence. Mr Justice Evans gave his ruling on Friday 21 June 2002. He stated the law to be that the Crown, to prove manslaughter, would need to show that: (a) each defendant owed a duty of care to the deceased man; (b) the defendant breached that duty; (c) the negligence caused the death; and (d) the negligence amounted to gross negligence, being so bad as to amount to a criminal act or omission. The defence, for the purpose of the submission, conceded that there was sufficient evidence for a jury to consider on points (a) (b) and (d), but argued the causation of death was not supported by the evidence.

On 21 June 2002, the judge ruled that there was insufficient evidence to leave the charge of manslaughter before a jury. He went on to rule that, while there would be sufficient evidence to form a case to answer against the officers if negligence were the basis for misconduct in public office, the required level was that recklessness had to be proven, and he found that the evidence presented was insufficient to allow that to be safely left to the jury. He ordered the officers to be acquitted.

The issue of negligence **was** central to the disciplinary process that followed.

Regulation 7 (now 9) notices were served on the five officers on 8 and 9 April 1998. Each notice stated that:

“Superintendent Holt has been appointed to investigate a matter concerning you from which it appears that you may have committed an offence against the Discipline Code”

and each stated that:

“Initial enquiries reveal that you may have neglected your duty in relation to the care and treatment of Mr Alder whilst he was in your custody.”

The discipline issues were considered after the trial ended. The discipline procedures in place at that time have since been subject to considerable amendment – although very major problems of principle remain. Under the rules of the time, the PCA was responsible for conducting a misconduct review to consider whether it was appropriate to bring any misconduct charges against the officers. Sally Hawkins was the PCA member responsible for the misconduct review. DCC Clark was responsible for discipline within the Humberside force.

***10 lines redacted
Legal and Professional Privilege***

In September 2002, DCC Clark produced a memorandum for the PCA which accepted that, although the officers were in breach of their duty, it was not serious enough to merit disciplinary action. He argued:

“For an act or omission to amount to a disciplinary neglect, it is not a necessary requirement to establish a wilful neglect of duty. However, in my view to proceed to a charge of neglect there should be a ‘conscious’ act or omission. Or, put simply, an officer who is aware they could have done more and chooses not to is very different from an officer who could have done more but does not.”

DCC Clark also dismissed the issue of racism, on the basis of the evidence given to him of the analysis by Dr French.

In respect of PS Dunn, he stated that he was not recommending a disciplinary tribunal on the basis that the officer had been suspended for four years and had been through a coroner's inquest and trial. DCC Clark gave as a separate reason the fact that PS Dunn had stood trial, that the evidence under consideration was essentially the same, and that he had been acquitted of the charges. He also stated the pursuit of disciplinary charges might be an abuse of process, and was not in any event in the public interest. Finally he stated that there was "no irrefutable evidence" that any neglect of duty by the sergeant contributed to the death of Mr Alder. He recommended that PS Dunn be admonished by the Chief Constable and attend a custody officers' training course, that PC Barr attend a custodian's training centre, and that all five officers be given "duty of care" advice by an Assistant Chief Constable.

Sally Hawkins response was scathing:

"We are agreed that all of the officers present in the custody suite owed a duty of care to Mr Alder and that they were in breach of that duty. However, you have said that for this to be a disciplinary neglect, there would need to be a conscious act or omission. You say that the fact that the officers could have done more but did not is not the same as choosing not to. Your assessment of the officers' actions is therefore based on an analysis of whether there is any evidence that they were aware that they should have behaved differently.

I take a different approach. I start with the standard of care that the public can reasonably expect from police officers. I go on to ask if this standard is within the competence of the officers. If officers fail to meet this reasonable standard, and this is not through lack of competence, then this is a disciplinary neglect."

She went on to outline the reasons for her view of the evidence, and said that:

"I have watched the video recording of events in the custody suite with great care, and each time I am struck by the lack of ordinary humanity with which the officers respond, or fail to respond, to Christopher Alder lying inert on the floor. They show no interest in him or his welfare; they assure themselves he is faking when they have no evidence of this; they focus entirely on 'processing' him. They needed no special expertise to attempt to rouse him or to focus on his welfare or to at least attempt to place him in the recovery position."

In each case she recommended formally that the officers should face a disciplinary hearing. She observed that:

"I do not accept that the public interest has been fully served by the criminal trial. The public can be satisfied that any evidence of a crime has been tested in court; however, the public should also be satisfied that the officers' actions, whilst not criminal, have been judged against the high standards that should be expected of public servants."

The letter ended by asking whether DCC Clark could:

“outline for me the lessons that the force has learned from the tragic death of Christopher Alder. Have there been any significant changes in practice, policy or training?”

DCC Clark wrote again to the PCA on 11 November 2002, taking issue at length with the analysis of Ms Hawkins. He maintained his position that he did not regard disciplinary proceedings as appropriate. He rejected her ‘recommendations’ and declined to follow them.

Sally Hawkins took further advice, and as a result the PCA decided to direct Humberside Police to pursue disciplinary proceedings. Formal notice of the direction was sent by the PCA under cover of a letter of 17 December 2002 from the Chairman of the PCA, Sir Alistair Graham, to DCC Clark.

DCC Clark then informed the PCA that none of the officers would be afforded legal representation and that the case would be presented by the Head of Professional Standards, Chief Superintendent (C/Supt) Everett. The consequence of this decision, as everyone knew, was to limit the sanctions available to the tribunal to a fine, a reprimand, a caution, or no action at all. It successfully frustrated the PCA direction.

On one matter DCC Clark and Sally Hawkins could agree – much to the concern of Janet Alder. They both agreed that the tapes did not reveal evidence of overt racism by the officers, although they had acted with great insensitivity.

DCC Clark’s successor, DCC Steve Love, noted later that in his handover meeting with Clark the (unattributed) comment had been made that:

“The officers had suffered enough.”

It summed up the Humberside position at that time.

DCC Clark may have won his battle with Sally Hawkins but it was a pyrrhic victory. The reputation of Humberside Police was hugely damaged as a result. Furthermore, the consequence of DCC Clark’s decision was that the discipline process was inconclusive, the campaign of the Alder family went on, and the officers were subject to many more years of scrutiny and pressure than they would otherwise have endured. In the long run, everyone lost.

The discipline tribunal eventually took place at Scunthorpe Police Station on 19 June 2003. It was chaired by Chief Constable Price of Cleveland Police. Incredibly, once the hearing began, Chief Constable Mr Price had no access to legal advice. C/Supt Everett made his opening statement presenting the evidence against the officers. The Federation representative challenged this, reading a submission of no case to answer that C/Supt Everett believed had been prepared with the benefit of legal advice. Chief Constable Mr Price

accepted the defence submission and gave his reasons in a lengthy judgement that was unsurprisingly wrong in important areas of law and fact.

In discussion with Chief Constable Price, my team pointed out to him that his ruling at the close of the presenting side's case was made under a misapprehension. To his credit, Chief Constable Price conceded that he now recognised it as such. He expressed frustration with the lack of legal representation, and with the fact that he had not received legal advice beyond the first two days of the hearing. He made it clear that he had been anxious to have advice, but that despite an approach he had made to Humberside Police, they were not prepared to reverse their decision to deny legal representation to the officers. For this reason, the view taken was that legal advice was also not available to the tribunal. Chief Constable Price has given full and frank assistance to the Review. I am grateful to him. In many respects, he was placed in an impossible position.

Was racism a factor in the death, or in the handling of the case, of Christopher Alder?

I have considered carefully the extent to which racism may have been a factor in the death of Mr Alder and the subsequent handling of his case. Many of these events took place before the publication of the Stephen Lawrence Report in 1999, but the report and later work by the PCA on investigating allegations of racially discriminatory behaviour provide very helpful assistance in understanding the Alder case.

In particular, I have drawn on the definitions of 'unwitting' and 'institutional' racism as set out in Lord Macpherson's report into the death of Stephen Lawrence:

"Unwitting racism can arise because of lack of understanding, ignorance or mistaken beliefs. It can arise from well intentioned but patronising words or actions. It can arise from unfamiliarity with the behaviour or cultural traditions of people or families from minority ethnic communities. It can arise from racist stereotyping of black people as potential criminals or troublemakers. Often this arises out of uncritical self-understanding born out of an inflexible police ethos of the 'traditional' way of doing things. Furthermore, such attitudes can thrive in a tightly knit community, so that there can be a collective failure to detect and to outlaw this breed of racism. The police canteen can too easily be its breeding ground."

Lord Macpherson goes on to define racism in general terms and 'institutional' racism as follows:

"'Racism' in general terms consists of conduct or words or practices which advantage or disadvantage people because of their colour,

culture or ethnic origin. In its more subtle form it is as damaging as in its overt form.” [6.4]

“‘Institutional racism’ consists of the collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantage minority ethnic people.” [6.34]

This definition provides a standard against which the treatment of Mr Alder can be considered. I use Lord Macpherson’s discussion of these issues to consider the actions of the officers who were in contact with Mr Alder on that night. It was not within my terms of reference to consider to what extent these behaviours were typical of the force as a whole either then or now.

I have also used the formula contained in the PCA guidelines for dealing with allegations of racism from the case of *King v. Great Britain-China Centre of 1991*, which suggested the criteria against which the existence of racist attitudes could be assessed. These were:

- difference in treatment;
- difference in race;
- detriment for the complainant; and
- no explanation for these differences being available.

It appears to me that there are a number of aspects of the behaviour of the officers that suggest that unwitting racism, as described by Lord Macpherson, may have influenced the way in which Mr Alder was treated. Addressed singly, all of these matters might have a reasonable explanation; taken together, in my view they amount to a pattern of “processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping” that further stacked the odds against Mr Alder that evening. This pattern included:

- the assumption that the man at the hospital was suffering from the effects of amphetamines, steroids or alcohol and the way in which this view persisted despite evidence to the contrary while the effects of the head injury were not given sufficient weight;
- the willingness to believe that he was unhurt despite having been severely struck;
- the willingness to attribute his problems to a ‘bad attitude’ on his part rather than to any physical injury;
- the reluctance to touch or rouse him once at the police station;

- the language used: “coloured” – “of negroid appearance”; and
- the monkey imitations, which were directed to a white prisoner and were, I believe, repeated as Mr Alder’s body lay on the floor, the reference to a hood with slits, and banana boots, which referred to the forensic over-clothing – none of which were directed way to Mr Alder yet all of which show at best, gross insensitivity.

I believe these factors reflect a set of stereotypical assumptions and attitudes based on Mr Alder’s colour and these assumptions and stereotypes are likely to have influenced the care – or lack of it – with which Mr Alder was treated.

I have not, of course, had the opportunity to question the officers concerned directly about these matters. In these circumstances, I can do no more than draw the conclusions that seem most likely to me on the evidence I have available.

I conclude that the treatment of Mr Alder did indeed reflect the definitions of ‘unwitting’ racism described by Lord Macpherson. There is evidence of the “lack of understanding, ignorance or mistaken beliefs” and “well intentioned but patronising words or action” that Lord Macpherson describes. I believe we can see in the treatment of Mr Alder “processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantage minority ethnic people” and I believe this did lead to a failure to “provide an appropriate and professional service” to Mr Alder because of his “colour, culture or ethnic origin”.

Applying the test set out in the PCA guidelines, I believe there was “difference in race”, “detriment” for Mr Alder and “no explanation for these differences being available”. I cannot say for certain that a white prisoner with similar injuries would have been treated differently and better. Indeed, it has been suggested that the treatment of Mr Alder was typical of what might be found in many custody suites. This is a disturbing conclusion and not one supported by the police investigators who have viewed the CCTV footage and advised me. On balance, I think the treatment of Mr Alder was not typical. There was “difference” in his treatment.

I cannot say for certain that Mr Alder would have been treated more appropriately had he been white – but I do believe the fact he was black stacked the odds more heavily against him.

The PCA and Humberside Police recognised that the attitudes of the officers were unacceptable in their assessments. I have gone further in my own conclusions. However, ultimately events overtook the proposed “advice” that would have been given to the officers concerned.

I have also considered to what extent the dealings of the police and other agencies with the family of Mr Alder were influenced by racism in any way.

This was alleged by Janet Alder of both the PCA and the CPS. As I have described, there were clearly difficulties in the relationship between Janet Alder and the police, the PCA and the CPS. However, I have not found any evidence to support her allegations of racism.

It is not my intention, nor within the terms of reference of this Review, to cover ground that has already been thoroughly covered by Lord Macpherson's report into the death of Stephen Lawrence or to consider the performance of Humberside Police as a whole in this regard. However, there are enough causes for concern arising from the events surrounding the death of Mr Alder and other matters identified in the course of this Review to suggest that, even after the passage of several years, that report still deserves consideration and has many lessons that are still to be learnt.

Conclusion

The grim conclusion I have reached is not that Mr Alder mattered enough to those who dealt with him on that night nearly eight years ago for them to conspire to kill him – but that he did not matter enough for them to do all they could to save him.

His death may not have mattered then but it matters now. It matters to his family, to me, and to all those who have worked with me on this Review and previously to establish the truth of what happened.

Most of all it matters because of the importance of ensuring what happened to Mr Alder does not happen again. I hope this report makes some contribution to achieving this goal.

Nick Hardwick
Chair
IPCC

27 February 2006

RECOMMENDATIONS FOR THE BENEFIT OF POLICING

Introduction

In this chapter, I seek to address the lessons to be learnt from the case of Mr Alder. I have sought to divide these recommendations into different categories, since some of the issues relate solely to Humberside Police and others are more general. I am conscious that much work has been undertaken over the years since the tragic death of Mr Alder, and that it would be unreasonable not to acknowledge the progress already achieved.

I am also aware that inquiries and reports in the intervening years have made a number of valuable and important recommendations. Perhaps most prominent among these is the Stephen Lawrence Inquiry. I am reluctant to repeat recommendations that have already been made, but it is crucial that police forces should regularly review the progress made in implementing the recommendations made by such reports.

My recommendations fall into the following categories:

- substantive recommendations for policing;
- steps towards concluding the process;
- specific recommendations for Humberside Police; and
- a review of previous recommendations.

Recommendations for policing

- i. When a person has attended hospital for any medical reason, and that person leaves hospital under police escort (whether or not under arrest), the responsible doctor should provide a report confirming fitness for detention and instructions for the custody officer.
- ii. Consideration should be given to changing the PACE Codes of Practice to clarify the custody officer's duty when considering fitness for detention. Such a change should create a presumption in favour of taking a person to hospital whenever there is any doubt as to that person's fitness.
- iii. In all cases of death in custody, where there is no clearly determined cause of death, a case conference should be held

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between the SIO, the IPCC, the Forensic Science Service, the crime scene manager, the pathologist and other relevant bodies.

- iv. All police Professional Standards Departments should be properly equipped and trained to provide a critical incident response to death in custody. There should be recognised minimum standards for such a response.
- v. Police forces should review the carriage of detainees in caged vans and ensure that detainees in transit are monitored at all times
- vi. The dangers of positional asphyxia should be well known. However, all police forces should ensure that officers and other staff involved in detention are reminded of this danger and understand how it can be avoided.
- vii. In all IPCC-directed misconduct cases, where the IPCC is presenting the case, the IPCC should have discretion to require that the accused officer(s) are offered legal representation if this is necessary to ensure that all appropriate sanctions be available to the tribunal. The presiding officer should always have access to legal advice if s/he believes that this would be of assistance.

The following two recommendations were made by Dr Shepherd as part of his advice to the IPCC. I wish to thank him for his assistance and careful consideration of these matters. I have paraphrased the recommendations, and I adopt and endorse them:

- viii. In cases of sudden unexplained deaths in custody, and in particular deaths associated with restraint, a team of experts should usually be convened and the make-up of that team should be tailored to reflect the nature of the death. The core medical members should be an experienced forensic pathologist, a forensic physician (police surgeon), an A&E consultant and such other experts as they deem necessary. This team would be available to provide guidance to the original pathologist, the coroner, the police and the CPS throughout the investigations.
- ix. In particularly complex cases, a Confidential Inquiry Panel for Deaths in Custody (Police and Prison) should be established so that there can be an attempt to understand these deaths with a view to developing police procedures and practices so that further deaths can be prevented or the risks can, at least, be minimised. [The confidential format, already used in other areas, would allow for presentation and discussion of controversial factors that might remain hidden in legal proceedings. Such a team might produce annual reports and recommendations

Recommendations

based upon their deliberations and experience, but would not comment upon individual cases. In similar panels used for other issues, individual cases are deliberately made anonymous.]

In order to help conclude the process that has flowed from the death of Mr Alder, I make the following specific recommendations for Humberside Police:

Specific recommendations to help conclude the process

- i. Apologise to the family of Mr Alder for the way in which he was treated on the night of his death, and specifically for the lack of care and compassion extended to him while in the custody of Humberside Police.
- ii. Conduct a debrief of all staff concerned in the detention and subsequent investigation, and specifically Matron Bridget Winkley. Counselling should be made available to any staff who so request.
- iii. Conduct a debrief of PC Beatrice Smith, the family liaison officer, to explain to her why she was removed from the case and to seek to address the ongoing distrust of her by the local black community arising from her role in this case.
- iv. Ensure that any remaining property belonging to Mr Alder and still in the possession of Humberside Police be returned to the Alder family.

I also make the following recommendations for Humberside Police that reflect the lessons that should be learnt by that specific force, following the death of Mr Alder:

Specific recommendations for Humberside Police

- i. Recruit an SIO to their Professional Standards Branch, who would take a lead in responding to deaths and critical incidents concerning the police.
- ii. Review its service policy for critical incident stress debriefing.
- iii. Obtain an external audit of its community race relations training and ensure that all officers and staff complete the course.
- iv. Liaise with its local hospital trusts to agree protocols for police officers attending hospitals and the role of police within hospitals.

Recommendations

- v. Ensure it has policy and training notes to cover issues of arresting for breach of the peace and ejecting persons from premises.

Review of previous recommendations

The Lord Macpherson report, following the racist murder of Stephen Lawrence, led to an extensive and detailed analysis of problems and failures in policing, with particular emphasis on the lack of recognition by some police of the need for racial awareness. Although Mr Lawrence died on 22 April 1993, nearly five years before the death of Mr Alder, the report of the Lord Macpherson Inquiry did not appear until 1999.

I acknowledge that the two cases are very different, and it would be invidious to make comparisons. Each, however, involves the death of a man, and in each case the handling of the aftermath of that death has added to the pain and anguish for the family of the deceased.

I bear in mind the following specific recommendations from that report:

26. That senior investigating officers and family liaison officers be made aware that good practice and their positive duty shall be the satisfactory management of family liaison, together with the provision to a victim's family of all possible information about the crime and its investigation.

47. That police services should annually review first aid training, and ensure that "public contact" officers are trained and tested to recognised and published standards;

and in particular the following:

49. That all police officers, including CID and civilian staff, should be trained in racism awareness and valuing cultural diversity.

50. That police training and practical experience in the field of racism awareness and valuing cultural diversity should regularly be conducted at local level. And that it should be recognised that local minority ethnic communities should be involved in such training and experience.

The recommendations of the Lord Macpherson Inquiry had not been published and would not have been known to Humberside Police at the time of Mr Alder's death. Since that time there has been ample opportunity to consider and to apply those recommendations. I take this opportunity to urge Humberside Police, and indeed all other forces in England and Wales, to review the progress they have made in applying the lessons learnt from the

Recommendations

case of Stephen Lawrence. The case of Mr Alder highlights all too clearly the continuing relevance of the report.

The discipline system has changed since the death of Mr Alder. Those changes have not gone far enough. At the request of the Home Secretary, Bill Taylor has recommended further substantial changes to the police discipline system. The IPCC has already welcomed his recommendations and participated in the committee that worked with him to develop them. These recommendations suggest how the police discipline system could be modernised and, as far as possible, brought into line with that in place for ordinary employment. I do not repeat his recommendations here but urge the Government to act on his recommendations as a matter of urgency.

CHAPTER 1: INTRODUCTION TO THE REVIEW

Establishment and terms of reference of the Review

1.1 On 20 April 2004, the Rt. Hon. David Blunkett MP, the then Home Secretary, wrote to the Independent Police Complaints Commission (IPCC) requiring it to undertake a Review of the events leading up to and following the death of Christopher Alder. Mr Alder died while in police custody at Queen’s Gardens police station in Hull during the early hours of Wednesday 1 April 1998. The Review was to be carried out under Section 79(1) of the Police Act 1996. This report sets out the findings and conclusions of the IPCC Review set up in response to that request.

1.2 The terms of reference of the Review were:

- to identify and take account of the concerns of the family of Christopher Alder in respect of his death;
- to consider the circumstances surrounding his death;
- to produce a report on the evidence surrounding his death that will include a view on whether or not the approaches taken at the criminal and disciplinary proceedings may, or may not, have been different had the investigation been conducted in a different way; and
- to make any recommendations for the benefit of policing that may arise from the Review.

1.3 The main events with which the Review is concerned were as follows:

1998	
1 April	Mr Alder is involved in a fight at the Waterfront Club in Hull. He is taken to hospital, discharged from hospital and then arrested by officers of Humberside Police.
- “ -	Mr Alder dies in police custody in Hull.
- “ -	Humberside Police starts an investigation into an assault upon, and possible murder of, Mr Alder.
- “ -	West Yorkshire Police is appointed to carry out an independent inquiry into the death in custody, under the supervision of the Police Complaints Authority (PCA).
- “ -	West Yorkshire Police officers and a PCA member attend Queen’s Gardens police station.
- “ -	Jason Paul attends Tower Grange police station and is arrested for suspected murder.
- “ -	A post mortem examination on Mr Alder proves inconclusive as to the cause of death but indicates the blow to the head

	was not a cause.
2 April	Mr Paul is de-arrested for murder and arrested for causing grievous bodily harm with intent. After interview he is charged with causing grievous bodily harm with intent to Mr Alder (the case is subsequently discontinued).
3 April	CCTV footage of the custody suite viewed for the first time by Supt Bates and Supt Holt.
8–9 April	A decision is made to serve Regulation 7 notices on the five Humberside police officers who were most closely involved with the arrest and detention of Mr Alder.
29 April	A pathologist confirms that Mr Alder did not die as a result of a blow struck by Mr Paul. The Humberside Police inquiry comes to an end.
30 April	Five officers are suspended from duty.
1 May	Jason Ramm is arrested and interviewed regarding possible violent disorder. No action is taken.
13–15 May	Five officers are interviewed by West Yorkshire Police.
4 June	An inquest is formally opened and adjourned.
30 June	West Yorkshire Police submits an initial report to the PCA.
7 August	West Yorkshire Police submits a supplementary report.
13 August	The PCA issues an 'interim statement'.
1999	
23 July	The Crown Prosecution Service (CPS) announces that the five officers will be charged, but only with misconduct in public office.
2 August	Summonses are issued for charges of misconduct in public office.
14 September	Following summonses, all five officers make their first appearance before Hull Magistrates' Court.
2000	
3 July	An inquest into the death of Mr Alder is held in Hull.
24 August	The inquest concludes with a verdict of unlawful killing.
2001	
9 April	A judicial review of the inquest verdict is rejected by the High Court.
25 April	Following review of new evidence, the CPS again declines to add manslaughter to the indictment.
29 June	The five officers are committed to stand trial.
24 October	Following additional medical evidence, the CPS agrees to add manslaughter to the indictment.
2002	
27 March	A voluntary bill of indictment adds counts of manslaughter against all five officers.
15 April	The trial of the five officers begins at Teesside Crown Court.
21 June	The case against all five officers on all counts is stopped by Mr Justice Roderick Evans following submissions of 'no case to answer'. Not guilty verdicts are entered on all the officers. The officers' suspension from duty is lifted.

30 September	Humberside Police declines to hold disciplinary hearings on the five officers.
17 December	The PCA directs Humberside Police to hold disciplinary hearings.
2003	
24 June	Following disciplinary hearings, the tribunal finds no case to answer against all five officers.
2004	
14 April	The BBC documentary <i>Death on Camera</i> is broadcast, dealing with the death of Mr Alder.
20 April	The Home Secretary directs the IPCC to undertake a Review.
2006	
27 January	Mr Paul wins his civil claim for wrongful arrest against Humberside Police

A chronology of the medical investigation appears at Appendix 5.

The concerns of the family

- 1.4 The terms of reference set by the Home Secretary enjoin the IPCC to take account of the concerns of the family of Mr Alder. In the main body of the report I deal in some detail with what I believe are the main concerns of the family. In Chapter 10, I list and respond to all the concerns I am aware of that Mr Alder’s family have raised since he died.
- 1.5 However, to provide context for the main body of the report, I have identified here what I understand to be the family’s main concerns:
- Why was Mr Alder arrested at the hospital?
 - Following his arrest, was he assaulted by police en route to the police station?
 - Why was he unconscious on arrival at the police station, and why was he incontinent, with his trousers coming down and his belt missing?
 - Was the investigation into his death adequate, and was there an attempt to cover up the cause of his death?
 - Were his treatment by the police and the investigation into his death influenced by Mr Alder’s race?
 - Why was nobody held accountable for his death, despite an inquest verdict of unlawful killing?

Methods adopted

- 1.6 To undertake the Review, the IPCC established a team of staff, and individuals from outside the organisation, to examine all of the available existing evidence and to identify which areas, if any, had been missed previously. The initial work on the Review was carried out under the direction of Claire Gilham, IPCC Deputy Chair for the North of England. Following Claire Gilham's departure from the IPCC, the Review continued under my personal direction, assisted by Judy Clements, the IPCC Regional Director for London and the South East.
- 1.7 The team comprised Roger Fitz-Patrick, a senior investigator of the IPCC, and the following individuals seconded from other organisations:
- Tracy Gupwell HM Revenue and Customs
 - Colin Dewar HM Revenue and Customs
 - Andrew McKie HM Revenue and Customs
 - David Williams Retired Police Superintendent
 - Ann Williamson Serious Fraud Office
 - Alex Milne Barrister of 18 Red Lion Court
- 1.8 The team also received assistance from Jennifer Henry and John Tate, both of the IPCC Legal Services Directorate, and from IPCC investigator Michelle Barden, as well as administrative support from Ivy Owusu-Baah. I established a strategy group of senior staff at the IPCC to provide guidance and advice during the preparation of this report. The strategy group met regularly during the course of the Review to consider the new material, and to provide assistance to the staff who were researching and helping to prepare the report. I am very grateful for the excellent support and back-up provided by my staff and those from other organisations who assisted us.
- 1.9 In the process of preparing this report, the IPCC has received assistance and documentation from the following organisations:
- Humberside Police
 - West Yorkshire Police
 - Hull Royal Infirmary
 - Mr Geoffrey Saul, the Coroner for Humberside
 - The Tees, East and North Yorkshire Ambulance Service NHS Trust

- The Crown Prosecution Service

- 1.10 I also wish to recognise and acknowledge the cooperation of many individuals who were interviewed by the IPCC and the Healthcare Commission (HCC) during 2005. A full list of those individuals appears at Appendix 2.
- 1.11 The view that I and my staff have taken is that the case is significant, not only as a personal tragedy for the Alder family, but also as an indicator of weaknesses in the system of police performance, training and discipline. I believe that there are important lessons to be learnt from Mr Alder's death, both for the police and for the IPCC, and the case resonates with much of the other work carried out by the Commission. I have been acutely aware, at the same time, of the personal and human loss and pain behind this case.
- 1.12 The process employed by the IPCC in conducting the Review was to obtain all available documentation from the West Yorkshire and Humberside police services, together with copies of the video footage of the events taken from CCTV of the custody suite where Mr Alder died. It was established that the CPS had submitted the videos for testing, and had already ascertained that the originals had not been tampered with or altered. Documentation used by the inquest and the trial was also made available, and full transcripts of both the inquest and trial were obtained.
- 1.13 All of the documents were broken down into separate files, consecutively numbered. All of these were then scanned onto disk and accessed using the Alphascan system provided by RWM Data Management Limited. Over 15,000 pages of material were scanned in this fashion, from the many hundreds of documents gathered and created in the course of the Review (and such documents are referenced in footnotes with eight-digit numbers). In addition, the Review had to consider over 2,500 pages of inquest transcript and over 1,700 pages of trial transcript. The analysis of material and preparation of this report took over 700 working days by the staff employed full time upon it, and many more working days on the part of those IPCC staff who also assisted.
- 1.14 Having categorised the documents, a long process of sifting and ordering was required; from this it became clear what was still required, and in what respects further enquiries might be possible. The initial sections of the report aim to provide a full and detailed history of the case, and much of this was derived from the existing documentation.
- 1.15 The approach taken in considering the documentation was to consider as many different sources of material as possible and to compare versions of events from different viewpoints. This led to new

perspectives being gained on the material: some issues that seemed potentially significant at the time of the original investigation proved to be, on reflection, of marginal importance. At the same time, other matters, which were overlooked or ignored at the time, took on new significance when seen in the context of a full Review.

- 1.16 In the final stages of the Review, judgement was given against Humberside Police for the wrongful arrest of Mr Paul. We have had access to trial bundles and the Recorder's summing up. Where appropriate the outcome of this case has been reflected in this report of my review.
- 1.17 It became apparent at an early stage that there was an overlap between the responsibilities of the police and those of healthcare professionals, both at the hospital where Mr Alder was taken and in the ambulance service. The IPCC has no jurisdiction to investigate or inquire into the administration of the health service, but we recognised the need to look at the full picture surrounding the death of Mr Alder. For this reason it was decided to undertake the Review in conjunction with the Commission for Healthcare Audit and Inspection (generally referred to as the Healthcare Commission or HCC).
- 1.18 The HCC exists to promote improvement in the quality of NHS and independent healthcare across England and Wales. It is a new organisation, which started work on 1 April 2004 (coincidentally the same day as the IPCC). It was created under the Health and Social Care (Community Health and Standards) Act 2003. Both the HCC and the IPCC are keenly aware of the need for clear and effective communication between the police and healthcare professionals when dealing with vulnerable individuals. It was felt from the outset that the interaction between the two organisations in this case might well be an important issue to be considered.
- 1.19 The HCC concentrated on the issues surrounding the clinical care provided to Mr Alder both by the ambulance service and the Hull Royal Infirmary where he was taken for treatment. Its report also considered at some length the process involved in the decision to release Mr Alder from hospital prior to full diagnosis, and without treatment. This raised a number of important questions regarding the transfer of detainees, or potential detainees, from the care of hospital into the custody of the police.
- 1.20 In order to maximise the effectiveness of our joint inquiries, HCC and IPCC staff worked together in interviewing healthcare professionals who had been in contact with Mr Alder. These were principally the doctors and nursing staff from the Hull Royal Infirmary, together with the ambulance crew who assisted Mr Alder on the night of his death. The HCC will be submitting its full report to the Department of Health and will disseminate it to healthcare professionals. I have attached the Executive Summary of the HCC's report as Appendix 8 to this Report

and a summary of their recommendations at the end of Chapter 5, and I endorse their views as to the improvements that are required in the system.

- 1.21 I would like to extend my personal thanks to the HCC and their staff for their hard work and commitment to the Review. The experience of working together has been a valuable and positive one; I hope that the relationship between the two organisations will develop further in the years to come. Although much was achieved through the voluntary cooperation between the two organisations, both the IPCC and the HCC are of the view that there should be statutory links between the two bodies to permit exchange of information and the undertaking of joint investigations.
- 1.22 One area that required careful consideration was that of the physical evidence. Much of that comprised CCTV records, which had been seized at the time and preserved. They fell into two parts: firstly, there was film from outside the Waterfront Club, where the events of the evening began; and secondly, there was the CCTV film from the custody suite of Queen's Gardens police station. This had been relied upon at the inquest and formed a central part of the case against the five officers at their trial.
- 1.23 Both sets of CCTV film were analysed and transferred to digital format, with a view to enhancing the pictures and audio soundtrack, where applicable, to the highest standard available. The passage of time between the events in 1998 and the Review in 2004–5 meant that techniques and facilities were available to the Review that could not have been used by the original investigating officers.
- 1.24 The Review has obtained the CCTV record on videotape of events in the custody suite covering the entire period from the start of the shift for the relevant officers, which was at 22.00 on 31 March, until 12.00 noon on the following day. That record was derived from nine separate cameras, recorded on a 'multiplex' tape. There was only one audio soundtrack, as the system records from two microphones, both of which are combined onto one track. These microphones are both in the custody desk area.
- 1.25 The video track was split onto nine separate tapes, each covering the full period from 22.00 until 12.00. The audiotape for the same period was enhanced and transcribed. This work was undertaken for the IPCC by Control Risks Group. The product of this exercise was video recordings amounting to 126 hours (9 x 14) of videotape. All of this material has been viewed by the members of the Review team.
- 1.26 The tapes of the audio record from the custody suite (again 14 hours) were also submitted to Control Risks Group for enhancement. The process involved passing the sound through the Speech Extraction System 4 (SES4) and copying them digitally. This resulted in the

suppression of the background noise, hum and buzz without interfering with the speech elements of the tape. The result was a clearer record of the actual words and noises from the officers. This was reduced to transcript form, which has been checked carefully against the enhanced tape to get the clearest and most accurate record available of the words used.

- 1.27 A computer-generated reconstruction of the interior of the detainee-holding area inside the van, during its journey from Hull Royal Infirmary to Queen's Gardens police station, was also produced by Control Risks Group at the request of the IPCC.
- 1.28 Having obtained the available information, the Review then sought to supplement this material by means of interviews with a number of the witnesses and the persons involved in the investigation and its supervision. A full list of those who were interviewed is attached at Appendix 2. Some interviews were taped, with the consent of the interviewee, and transcripts of the tapes prepared. In other cases, when taping was not desirable or appropriate, a full note was taken of the interview. Whichever method was adopted, the interviewee was always given the option of reviewing the written record to amend or add to what had been said. These interviews took place seven years after the events with which they were concerned. Inevitably memories sometimes failed after this passage of time. I believe all those we spoke to attempted to give us an honest account of what happened to the best of their recollection.
- 1.29 The IPCC sought from an early stage to meet with and interview the five police officers who were most closely concerned with Mr Alder on the night of his death. The pattern of events had been that each officer had given an initial statement following the death in custody, and then each was interviewed by officers from West Yorkshire Police in May 1998. A number of unresolved issues and discrepancies remained following these initial interviews, but no subsequent interviews were held. The officers declined to answer almost all questions put to them at the inquest and were not called upon to give evidence at the trial or disciplinary hearings. Accordingly, a number of issues and unanswered questions clearly needed to be addressed by the Review.
- 1.30 During the course of the Review, a dispute arose between the IPCC and the Humberside Police Federation, which represented the five officers who were investigated and prosecuted over the death of Mr Alder. Four of the five had applied for early retirement from Humberside Police, on the grounds of ill health, and those applications were being considered by the Humberside Police Authority (HPA) in late 2004. The HPA asked for my views on this. I considered that the IPCC had no remit to express a formal opinion upon the applications made by the officers.

- 1.31 I considered, however, that, consistent with the IPCC policy of openness and the family's previously expressed concern that they had not been kept properly informed, it would be appropriate that the family of Mr Alder be informed that the issue was to be considered by the HPA. The Humberside Police Federation and the HPA refused to do so. As a result, having told both bodies that I intended to pass on this information, on 25 November 2004 my staff informed the family of the proposed hearing. The original hearing date for the application was 30 November; this was adjourned until mid-December 2004, on which occasion four or the five officers were granted early retirement on health grounds. One of the five remained on the force.
- 1.32 Humberside Police Federation lodged a complaint against the IPCC on 13 December 2004. This complaint was against my decision to inform the Alder family of the date when the HPA would consider the officers' applications for retirement. In accordance with the IPCC complaints procedure, this was passed to the Home Office, as a complaint against me, on 20 January 2005. The Home Office response, dismissing the complaint, was issued in early August 2005. In the intervening period, the officers refused to discuss the case with the IPCC.
- 1.33 Following the resolution of the complaint, further approaches were made to the officers through their intermediary, the Police Federation. Eventually, by a letter dated 17 October 2005, I received a response from the Federation informing me that all five officers were unwilling to speak with me or my staff. I found this refusal to cooperate, on their part, deeply disappointing.
- 1.34 An essential and central aspect of the Review, reflected in the terms of reference set by the Home Secretary, has been to identify and take account of the concerns of the family of Mr Alder, in respect of his death. These issues emerge to some extent from the correspondence and meetings held between family members and the authorities, particularly the PCA, the CPS and the police services. Much of the family correspondence has come from Ms Janet Alder, who is the sister of Mr Alder, and her legal representatives. Solicitors for other family members have also written, not only to the Home Office, but also directly to the IPCC raising queries and concerns.
- 1.35 The Review team sought meetings with family members in order to clarify and prioritise the concerns raised. Claire Gilham and John Wadham, the IPCC Deputy Chairs, met with Ms Alder at her home on 29 April 2004 to discuss her objections. Ms Alder made clear from the outset that she had very strong concerns about the referral of the matter to the IPCC. During the course of the Review, I met personally with Jane Deighton, solicitor for the two sons of Mr Alder, to discuss their concerns. I and my team continued to speak regularly to Ms Alder on the telephone.

- 1.36 Identified issues, raised by the family, have been considered carefully by the Review. The full extent of these concerns is set out within the body of the report and they are itemised at Chapter 10, but several matters were clear to all concerned. The outcome of the inquest, which found that Mr Alder was unlawfully killed, was self-evidently at odds with the findings of the Crown Court and the disciplinary tribunal which appeared to exonerate the officers of blame. Ms Alder has stated publicly on a number of occasions that she believes that Mr Alder was assaulted by police officers and that this caused his death.
- 1.37 In addition, it became clear that the family of Mr Alder had concerns that arose not only from his treatment and death, but also from the handling of the investigation into his death. These included the way that they were treated by Humberside Police, and the quality of information provided in the early stages of the investigations; the delay in suspending the officers who were ultimately charged with the death of Mr Alder; the quality of forensic examination, and the failure to test many samples; and the return, untested, of the police officers' clothing, contrasted with the failure to return the clothing of Mr Alder to his family.
- 1.38 The family were deeply unhappy that the officers were not initially charged with the manslaughter of Mr Alder and were critical of the handling and outcome of the trial, which ended with the acquittal of the officers. The disciplinary hearing which Humberside Police held was also a source of anguish for them, as they were denied the opportunity to be present and learnt later that the charges had all been dismissed. Accordingly, there were issues from almost every element of the case that had given rise to controversy and dissatisfaction on the part of the family of Mr Alder.
- 1.39 The evidence received from the original investigations included material touching upon the previous physical and mental health of Mr Alder, and to some extent of his family. Because this material was clearly obtained and considered during the original investigations, we have also given it our consideration. Some statements, described as being on behalf of relatives of Mr Alder, suggested that these elements in the original inquiry amounted to attempts to damage the reputation of the deceased man. I have sought, in considering these matters, to establish whether these inquiries produced material that was relevant, and whether the making of such inquiries in the first place was appropriate and proportionate to the inquiries being run. I have only referred to this personal information in this report where strictly necessary.
- 1.40 I recognise that the terms of reference, while being relatively wide, also prevent me from considering certain aspects of the process that followed the death of Mr Alder. Examples of areas that lie outside the remit of this Review include the conduct of the inquest by the coroner and the conduct of the trial of the officers by Mr Justice Evans. The

decisions that were taken in those hearings are not the subject of this Review, since that would be a task for higher tribunals (and indeed both sets of proceedings were appealed).

- 1.41 I have not sought to usurp the role of the CPS Inspectorate by attempting to review the quality of the work undertaken by the CPS officials concerned with the case, although I do set out explanations that they have provided to some of the queries raised by Ms Alder. The close involvement of the CPS in the investigation meant that a proper consideration of that investigation would also take into account their actions. Consistent with the terms of reference, I have concentrated on considering whether the investigation, if handled differently, might have changed the approach taken in presenting the case.
- 1.42 The shape of this report is to some extent determined by the history of events. As was probably inevitable, a number of common misconceptions have beset the case from the very outset. I have sought to trace the history of those events as carefully as possible and to establish the truth as shown by the evidence. As a result, there are large sections of the report that deal with Mr Alder's personal history; the events of the night that he died; the pattern followed by the investigations; the medical evidence, and the hearings, both public and private, that followed. Towards the end of the report, I have assessed the actions and contributions of the different parties and I have sought to list and address all the concerns of the family of Mr Alder.
- 1.43 I also consider the issue as to whether racism may have played a part in the death of Mr Alder and set out my recommendations for policing, as required by the terms of reference.
- 1.44 I took the view from the outset of the Review that, since I was required to provide a report to the Home Secretary, I was not in a position to disclose drafts of the report to other parties, even if they were closely involved in the case. I did, however, regard it as appropriate that any individual who would be criticised in the report should be notified in advance and be given an opportunity to respond to those criticisms. This approach is in line with that of the 'Salmon principles' applied to tribunals of inquiry. Those responses received to such notifications have been considered and, where appropriate, referred to in the report.
- 1.45 I recognise that a Review, carried out several years after the crucial events, is unlikely to identify dramatic new facts or to cast a wholly fresh light upon previously identified facts. It can, however, serve to identify strategic errors or misconceptions, and to point up failures in the system. By doing so, a Review can highlight areas where improvements might reasonably avoid the need for others to undergo the suffering and anguish that fell upon Mr Alder and his family.
- 1.46 I also recognise that this Review cannot meet every hope or expectation of the family of Mr Alder. A Review of this nature will not

result in fresh charges against individuals; it will not categorise any person or group as being personally responsible for the death of Mr Alder. Nonetheless, I believe that it will help to identify the real issues and real failings, to allay suspicions and to dispel at least some of the misunderstandings that beset the investigation from the outset.

Brief summary of events of 1 April 1998

- 1.47 The following is a brief summary of the main events of the night, as related to the inquest and the subsequent trial. The issue as to whether this version of events was accurate or complete was central to the Review.
- 1.48 Mr Alder, a man of 37, spent the last night of his life at a nightclub named the Waterfront Club in the centre of Hull, near where he lived. At around 01.30, Mr Alder became involved in a dispute, and then a fight, with a man named Jason Ramm. As a result, the club's security officials ejected Mr Ramm from the club, but allowed Mr Alder to remain. Mr Alder left the club shortly after 02.00. There was a confrontation between Mr Alder and Mr Ramm, during which Mr Alder removed his sweater.
- 1.49 Other persons became involved. One of those was a man named Jason Paul who struck Mr Alder once, knocking him to the ground. The blow was forceful, as Mr Alder fell immediately, and doctors later observed that one of his teeth was knocked out, and another knocked backwards, out of line. Mr Alder struck the rear of his head on the ground and it is possible that he lost consciousness for a short time. He remained on the ground for approximately 11 minutes. The door staff from the club intervened, and placed Mr Alder in the recovery position and covered him with a blanket. An ambulance and the police were called. Mr Paul had left the scene, but in due course handed himself in to the police after hearing of Mr Alder's subsequent death.
- 1.50 The ambulance crew arrived at 02.29, and the police arrived very shortly afterwards. On arrival, the ambulance crew found Mr Alder to be conscious but confused. His behaviour over the following hour was characterised by swings in mood, between being quiet and cooperative, and being hostile and resistant to the attempts made to assist him. He was persuaded to walk, assisted to the ambulance, and was driven to hospital. The police officers spoke to the managers of the club, and briefly viewed a section of the club's CCTV footage, before following to the hospital.
- 1.51 At 02.44, Mr Alder arrived at Hull Royal Infirmary. He was found to be in an angry and uncooperative mood: he swore at the nurses and staff, and spat blood onto the floor, ignoring requests to use a receptacle provided. Attempts by nursing staff to calm him down were largely ineffectual, although he did cooperate to a greater extent with a hospital security guard who spoke to him, named Mr Rodgers. The duty doctor who dealt with Mr Alder was a senior house officer named Dr

Aamer Khan. The injuries recorded by Dr Khan were the loss of a tooth, the displacement of a second tooth, and a cut to the inside of the upper lip. He also observed a bleeding cut to the back of the head, seemingly from when Mr Alder had struck the ground. Dr Khan wished to have an X-ray taken of Mr Alder's skull to check for any unseen or internal injuries. By this time the two police officers from outside the club, Police Constables (PCs) Dawson and Blakey, had arrived at the hospital. The officers concluded that Mr Alder was not in a fit state to make any formal complaint of assault.

- 1.52 Mr Alder was wheeled to the X-ray department on a hospital trolley, but refused to cooperate with the radiographer in having his X-ray taken. He climbed off the trolley, but collapsed and had to be helped up. He demanded to go the lavatory and was taken along the corridor by the two officers, who supported his weight. Mr Alder was still swearing and arguing with them as he was being assisted. This led to one of the officers threatening to use CS spray to subdue Mr Alder. Once at the lavatory, Mr Alder urinated on the floor of the cubicle.
- 1.53 By the time he emerged from the lavatory, the medical staff had decided that it was not practical to X-ray or to treat him, and they told Mr Alder that he should return to the hospital when he was ready to cooperate and that then they would treat him. PC Dawson asked Dr Khan whether Mr Alder was fit to be detained and Dr Khan commented to PC Dawson that the injury to the back of Mr Alder's head was a "simple haematoma".
- 1.54 The officers then either escorted or dragged Mr Alder from the hospital premises. Once outside the Accident and Emergency Department, he stood arguing with the police for a number of minutes. Eventually he was told that he was being arrested on the basis that to do so avoided a potential breach of the peace. Mr Alder was handcuffed; a police van was called, and he was assisted into the van, apparently walking steadily by this stage. The van was driven by Acting Police Sergeant (A/PS) Ellerington. PCs Dawson and Blakey followed the van in their own car.
- 1.55 On arrival at Queen's Gardens police station, the van and car were seen to arrive, and the van was reversed to the back doors of the station. The security attendant at the gate saw, on CCTV, two officers carry a person from the back of the van, as did the custody sergeant. The two constables and A/PS Ellerington all described having opened the van, to find that Mr Alder was sitting in the same position that he had been in on departure, but seemingly asleep or unconscious, making a noise they described as "snoring". The two constables say that they lifted him out of the van and that he did not respond, being a "dead weight".
- 1.56 Video recordings of the corridor and custody suite show Mr Alder being carried down the corridor from the entry door, and turning into the

custody suite. This was recorded as being at 03.46. He was carried by the officers, one to each side, still handcuffed, and laid, face down, on the floor of the custody suite. His trousers and boxer shorts had come down his legs, and were halfway down his thighs. He was doubly incontinent.

- 1.57 A conversation ensued whereby the custody sergeant, Police Sergeant (PS) Dunn, initially told the two constables to take Mr Alder to hospital. They pointed out that he had just come from hospital and said that the hospital did not want him. They gave their opinion that his apparent unconsciousness was an act and that he had been difficult and uncooperative at the hospital; they appeared to interpret his lack of responsiveness as a deliberate ploy on his part. PS Dunn accepted their views. He made no separate checks on Mr Alder and did not attempt to rouse him.
- 1.58 At the request of PC Barr, the two arresting officers removed the handcuffs from Mr Alder; during this time it can be seen on the video that he made no spontaneous movements at all. It is common ground that once the handcuffs were removed he did not move his hands from the position in which they were left. Throughout this time Mr Alder could be heard making loud, irregular breathing sounds. These were later described by the officers as “snoring”. Following the removal of the handcuffs, Mr Alder was left face down on the floor of the custody suite. The police officers went behind the counter in the custody suite, and the audio recording indicates that a discussion took place as to whether he should be charged with an offence.
- 1.59 Mr Alder, who had not been covered up, continued to make the loud, irregular breathing noises for a few minutes until about 03.57, when he stopped breathing. After a few moments, PC Barr commented that Mr Alder had stopped making the noises, and the group went back round the counter to check on him. They established that he had stopped breathing, and they were unable to find any pulse. Attempts at resuscitation then began, while an ambulance was summoned.
- 1.60 By coincidence, the ambulance and crew that attended the police station were the same as those that had collected Mr Alder from the area of the Waterfront Club earlier that morning. Upon arrival, the crew took over the process of attempted resuscitation and continued for a period of approximately 30 minutes, before finally giving up. Mr Alder was formally declared dead at 07.20 by a doctor.
- 1.61 Issues were later to arise as to noises or comments made by police officers in the area of the custody suite over the ensuing hours which were thought to be potentially racist. Some of those comments were caught on the video soundtrack. Mr Alder’s body was removed from the custody suite and taken to Sheffield for a post mortem examination which took place later in the afternoon of the same day. The post

mortem, and others that followed, were inconclusive as to the cause of death, which was eventually described as “multi-factorial”.

The police officers

- 1.62 The records of the five officers who dealt with Mr Alder, and who were subsequently charged, were described in the following terms by the West Yorkshire Police report:

PS 1028 John Andrew Dunn
Born 23 April 1961
Joined Humberside Police 7 September 1987
Promoted to Sergeant 17 February 1997

PC 974 Matthew Wayne Barr
Born 27 April 1963
Joined Humberside Police 31 May 1988

PC 1229 Nigel Thomas Dawson
Born 31 October 1961
Joined Humberside Police 2 February 1981

PC 1443 Neil Blakey
Born 18 July 1959
Joined Humberside Police 30 July 1979

A/PS 324 Mark Ellerington
Born 25 July 1965
Joined Humberside Police 14 April 1986

- 1.63 PS Dunn, PC Dawson and A/PS Ellerington had no previously substantiated complaints against them. PS Dunn had one commendation. PC Barr had been fined for five counts of neglect of duty in 1996, and on a different date in the same year PC Blakey had also been fined for two counts of neglect of duty.

CHAPTER 2: CHRISTOPHER ALDER

Introduction

- 2.1 I have seen a great deal of material relating to the personal history and background of Mr Alder. The larger part of that material is irrelevant to the Review, and I do not deal with it in the report. I am therefore limiting myself in this chapter to a very brief summary of the personal history of Mr Alder.

Personal history of Christopher Alder

- 2.2 Christopher Ibikunle Alder was born on 25 June 1960, in Hull. His parents were Nigerian and he had three brothers and two sisters. He left school at the age of 16 and joined the Parachute Regiment, in which he served for six years, leaving in 1981. During his time in the army, Mr Alder had served in Northern Ireland and lived for a period in Germany. Mr Alder's mother had by then returned to Nigeria and his father died in 1981. From that time on, and throughout the 1980s, Mr Alder appears to have lived either in the Andover area or in Hull. Around 1990 he returned to live permanently in Hull and was a resident of the city until his death in 1998.
- 2.3 In the early 1980s Mr Alder had formed a relationship with a young woman named Nicola Wilson, with whom he had two sons, named Leon and Kelvin. The relationship with Ms Wilson ended in the mid-1980s and the two boys continued to live with their mother. Mr Alder formed another relationship with a young woman named Jennifer Hobson in late 1990, and moved with her to Hull. The relationship did not last, but both of them remained in Hull, living separately.
- 2.4 Mr Alder's brothers and sisters were living in different parts of the country. His elder brother, Richard Alder, was living in Hull, and the two were in contact with one another. Christopher Alder worked intermittently in the years following his discharge from the army, and at the time of his death he had undertaken a college course in computing skills, based in Hull.

Medical history of Christopher Alder

- 2.5 The medical history of Mr Alder was viewed as being potentially important during the course of the inquiries into his death. This was in part due to the uncertainty as to the cause of his death and the belief that it might have been due to some underlying medical condition. It was also relevant in seeking to explain his behaviour at the hospital, an unusually hostile reaction to those who were clearly trying to assist

Chapter 2: Christopher Alder

him. For this reason I deal in greater detail with Mr Alder's medical records in Chapter 5 below.

CHAPTER 3: EVENTS OF 1 APRIL 1998

Introduction

- 3.1 The events that gave rise to the death of Mr Alder all took place within the space of a few hours. I have attempted to trace the story of the evening, and what happened to Mr Alder, both inside and outside the Waterfront Club, where he spent his last evening. I have also sought to establish, as clearly as is possible, the actual events at the hospital, during his journey to the police station, and in the custody suite at the police station both before and after Mr Alder's death. Certain parts of the evening, specifically outside the club and in the custody suite, are caught on film. For other parts, I have been reliant upon the witness statements of those who were present.

The Waterfront Club

- 3.2 Mr Alder had spent the day of Tuesday 31 March at his college course, and mentioned to a friend, John Holdsworth, that he would be going out that evening.¹ Another friend, named Benjamin Walkup, described seeing him during the early evening when both he and Mr Alder met at the flat of a mutual friend named Neal Cross, who lived in an adjoining flat to Mr Alder in Lisle Court.²
- 3.3 Mr Walkup told the police that Mr Alder arrived at the flat at about 19.00, and that they, together with Mr Cross, went to three local bars before eating at a McDonalds restaurant in the town centre. He recalled that they had gone on to the Waterfront Club, at Mr Alder's suggestion, but that Walkup and Cross decided against entering the club. Benjamin Walkup gave Mr Alder £5, as he had little or no money. Mr Alder went into the club at about 22.30, and the two others went back to Mr Cross' flat in Lisle Court. Marc Atkinson, a friend of Mr Alder, also saw him arriving at the club with two white youths after 22.30.³
- 3.4 Another friend of Mr Alder, named Clare Robinson,⁴ gave conflicting evidence to that of Mr Walkup, in that she said that she and Mr Alder had been in conversation by telephone between 19.30 and 20.00 on the evening of 31 March. Ms Robinson and he had first met the previous week, and had arranged to meet the following evening. She

¹ John Holdsworth statement (29 April 1998) CA0095 pp.208–9 [00950209–10]

² Benjamin Walkup statement (8 May 1998) CA0095 pp.316–8 [00950317–19]

³ Marc Atkinson statement (27 April 1998) CA0019 pp.131–7 [00190133–9]

⁴ Clare Louise Robinson statement (4 April 1998) CA0095 pp.117–9 [00950118–20]

recalled that he sounded happy during the conversation, and that he commented that he would like to go out that night, but had only £3.00 available to him. Ms Robinson did not see him again, and learnt of his death the following day at about 13.00.

- 3.5 The conflict in evidence between the recollections of Mr Walkup and Ms Robinson does not appear to be of significance in the context of the later events of the evening.
- 3.6 Mr Walkup said that Mr Alder drank two pints of lager and two bottles of Beck's beer in the early part of the evening, and seemed sober at 22.30 when they parted company.
- 3.7 The Waterfront Club is a five-storey building in the Old Town area of Hull. It faces onto Prince's Dock Street, a cobbled street, and is opposite the former Prince's Dock. The building is on the corner of another street named Posterngate, into which there was a further exit from the club. The entry is on the ground-floor level, with cloakrooms on the ground floor, and a reception on the floor above. The second floor has a dance floor, and there is a bar on the third floor. The top floor is known as the Soul Suite, which is a separate area with dancing and a bar. This is the area in which Mr Alder spent most of the rest of the evening. A photograph of the external aspect of the club is attached at Appendix 10, and a map of the immediate area is at Appendix 11.
- 3.8 On Tuesday 31 March the club opened at about 21.30, and was due to remain open until 02.00. Tuesday evening was designated as 'Student Night', and the staff assessed the clientele as being about 700 people that evening. The total possible capacity of the club was 1076 people.⁵ The senior assistant manager on duty that night was Paul Myatt, and he was to describe the evening as being relatively quiet.⁶
- 3.9 At the club, Mr Alder was recognised by a number of the customers and staff, as he was known to be a regular attendee. Robert Stevenson, a doorman, said that Mr Alder had been attending the club regularly over the previous five-year period, and attended up to four times a week.⁷ Although a number of the customers recalled chatting with him, he was seen by others to be standing on his own, and he does not appear to have spent the evening with any one person or group of people.
- 3.10 The staff who recognised Mr Alder had mostly found him to be polite and cooperative on previous occasions. Mr Stevenson⁸ thought him:

⁵ Kevin Smith statement (4 April 1998) CA0095 p.280 [00950281]

⁶ Paul Myatt statement (1 April 1998) CA0019 p.21 [00190022]

⁷ Robert Stevenson (8 April 1998) CA0019 p.43 [00190045]

⁸ Robert Stevenson (1 April 1998) CA0020 p.29 [00200031]

“a very pleasant lad, who always had time to speak and was the same on this night”.

3.11 Jason Cooney,⁹ a door supervisor, said he was:

“an easy going guy”,

and Neil Goforth,¹⁰ the assistant head doorman, said of Mr Alder that:

“we had never had any trouble from him”.

3.12 In contradiction of this evidence the assistant manager, Adrian Broadhead,¹¹ described Mr Alder as a familiar face, but that he was:

“usually quite glum and I thought he had strange staring eyes”.

3.13 Another staff member, named Patrick Njie,¹² who knew Mr Alder rather better, said that:

“he seemed nervous and paranoid he just didn’t seem his normal self, his mannerisms were completely different he seemed to be miles away and didn’t appear to be taking in what people were saying to him”,

although he agreed that he had never seen Mr Alder being aggressive.

3.14 Sarah Williams,¹³ who was serving on the bar in the Soul Suite, said that she had sold two or three pints of lager to a man who was clearly Mr Alder. She described him as:

“both aloof and very serious...he looked unhappy”.

3.15 Those who mixed with him that evening were from various backgrounds. He spent several minutes talking to two young women, each of whom was 17 years old. In the view of those witnesses, Nicola Hudson and Lisa Taylor, he was ‘chatting up’ Lisa. They told him that he was too old for them, and laughed about it. Mr Alder took this in good humour. He also met and spoke to a doctor, who was based at the Hull Royal Infirmary. That man, Augustine Ayodele Ojo,¹⁴ recalled Mr Alder as being:

“pleasant and good natured”.

⁹ Jason Cooney statement (24 April 1998) CA0020 p.42 [00200044]

¹⁰ Neil Goforth statement (4 April 1998) CA0020 p.66 [00200068]

¹¹ Adrian Broadhead statement (14 April 1998) CA0019 p.30 [00190032]

¹² Patrick Njie statement (15 April 1998) CA0020 p.63 [00200065]

¹³ Sarah Williams statement (9 April 1998) CA0095 p.338 [00950339]

¹⁴ Augustine Ojo statement (28 April 1998) CA0095 p.247 [00950248]

The fight in the club

3.16 The dispute that broke out between Mr Alder and Jason Ramm is well documented in the evidence collected by Humberside Police Force, but the initial reasons for it remain unclear. Mr Ramm was questioned at the inquest about his relations with Mr Alder¹⁵:

Q. ...Christopher and yourself, you had seen him on previous occasions, yes?

A. Yes.

Q. But you had never had any cause to have an argument with him previously?

A. No, no, never.

Q. He was never abusive to you?

A. Not to me, no.

Q. And there was no cause so far as you could see as to why this man would suddenly spit beer at you for no reason?

A. No, no cause whatsoever.

3.17 Mr Cooney,¹⁶ who was involved as a staff member in breaking up the disturbance, said that after the event:

“Chris stated there had been a dispute between them for some time but he did not elaborate on this.”

3.18 No other explanatory evidence has come to light.

3.19 Descriptions of the scuffle that ensued all seem to indicate that it took place at around 01.30 in the Soul Suite. Mr Ramm gave a statement to the police on 3 April,¹⁷ explaining that he had stopped to talk to a male acquaintance standing near Mr Alder:

“I never said anything to Chris but suddenly he turned to face me and spit a mouthful of beer over me...I was taken aback by this and was shocked.”

3.20 He then related how Mr Alder did this again, before he, Mr Ramm, was gently pulled away by an older man. However, he went back to Mr Alder to demand to know why he had behaved that way and was spat on for a third time. At this point the struggle broke out.

¹⁵ Inquest Day 2, p.29

¹⁶ Jason Cooney statement (24 April 1998) CA0020 p.44 [00200046]

¹⁷ Jason Ramm statement (3 April 1998) CA0019 p.50 [00190052]

3.21 Aimun Friegoun saw Mr Alder spit beer into the face of Mr Ramm three times¹⁸; Mr Friegoun tried to intervene, and recalls having offered his sleeve to Mr Ramm to dry his face, but could not prevent Mr Ramm from striking out at Mr Alder. Mr Friegoun appears to have been the man that Mr Ramm describes as gently restraining him.

3.22 Jurgen Jarvis saw Mr Ramm asking Mr Alder:

“Sorry, what’s the problem, have I done something wrong?”

and Mr Alder spitting beer twice, and telling Mr Ramm to “Fuck off”, whereupon Mr Ramm pushed Mr Alder backwards onto the ground.¹⁹ Davinder Saggu also saw the spitting of beer and the struggle.²⁰ These three witnesses, Mr Friegoun, Mr Jarvis and Mr Saggu, do not appear, on the evidence, to be connected to one another, and each gives a broadly similar version of events. Even Mr Stevenson, who decided that Mr Ramm should be ejected from the club, recalled that Mr Ramm had beer on his jacket.

3.23 In the course of the inquest, Mr Jarvis speculated that Mr Ramm may have in some way knocked into Mr Alder, giving rise to the dispute²¹:

Q. What did you notice happen between this Jason and Christopher?

A. Well, I didn’t exactly see it altogether all at once. It was, you know, a bit of everything all the time, but Jason accidentally, I think he must have bumped into Jason at the time – that’s the way it looked – and he must have spilt some drink on him, and...

Q. I am sorry, who must have bumped into whom?

A. Jason bumped into Chris at the time.

Q. Did you think that that was a deliberate...?

A. But, you know, as in...I mean it wouldn’t be just a normal bump. It’s like, you know, more of a knock, you know, like to knock his drink.

Q. Then what did Christopher do?

A. Well, he reacted to it and I saw him actually drink the bottle and he actually spat some beer into Jason’s face at the time, and then a scuffle, you know, a scuffle came out and they started fighting. This was for about – I don’t know – 30 seconds or something like that.

¹⁸ Aimun Friegoun statement (2 April 1998) CA0019 p.72 [00190074]

¹⁹ Jurgen Jarvis statement (1 April 1998) CA0019 p.115 [00190117]

²⁰ Davinder Saggu statement (1 May 1998) CA0095 p.261 [00950262]

²¹ Inquest Day 1, pp 43–4, Jurgen Jarvis

3.24 Mr Jarvis had not mentioned this “knock” in his statement, and did not explain how this supposed collision would have spilt beer from a bottle in Mr Alder’s hand. No other witness refers to this supposed collision, or to seeing Mr Alder’s beer being spilt. In any event, this does not serve to explain why, if his beer were spilt, Mr Alder should have reacted in the way that he did. Mr Jarvis also reinterpreted his evidence²² before the inquest, and said that Mr Ramm had also done what Mr Alder did:

A. ...Well, he did it to him and he did it back. That’s what I think I meant by that. They did it to each other. One did it to one and then the other one did it, returned the compliment, as you might say, and then...

Q. That is quite a bit different from what you said at the time. I know that it is a long time ago.

A. Yeah.

Q. Are you speaking now from a recollection?

A. Of a recollection, yes.

Q. What are you telling us? Others may ask you some more questions about this, but what are you telling us, from the moment that there was this jostling?

A. Well, I mean, come to recollect now, I mean the statement says this, but to recollect now, they did it to each other once, you know. If somebody does it, you do it back to them. Well, that’s what happened in there.

3.25 Again, this evidence is at odds not only with the evidence originally given by Mr Jarvis but with that of the other witnesses, as nobody else saw Mr Ramm spitting. Mr Ramm has never suggested that he spat at Mr Alder.

3.26 Contradictory evidence emerges as to the extent that Mr Alder was under the influence of drink. A number of the witnesses recall Mr Alder being drunk by this stage in the evening. The staff members Andrew Edwards,²³ and Adrian Broadhead,²⁴ both described him as drunk at the time of the fight, or shortly afterwards; Stephen Todd,²⁵ the disc jockey, said:

“his speech was slurred and incoherent consistent with being drunk as was his demeanour”.

²² Inquest Day 1, p 44.

²³ Andrew Edwards statement (4 April 1998) CA0019 p.210 [00190212]

²⁴ Adrian Broadhead statement (14 April 1998) CA0019 p.32 [00190034]

²⁵ Stephen Todd statement (20 April 1998) CA0095 p.299 [00950300]

3.27 Mr Jarvis²⁶ said of him that he was:

“more noticeably drunk”,

and Shehzad Arshad,²⁷ another customer, said that Mr Alder seemed:

“very drunk”.

3.28 The staff members who gave statements do not mention seeing this behaviour by Mr Alder, and this may partly explain why it was Mr Ramm rather than Mr Alder who was subsequently ejected from the club. Later in the evening, when hospital staff administered a breath test, Mr Alder registered as being intoxicated to roughly twice the drink-drive maximum level. This evidence did not suggest that he was ‘very drunk’.

3.29 Mr Ramm reacted angrily to being spat upon by Mr Alder, and began to struggle with him. A number of the customer witnesses recall the event taking place, but most are vague as to the nature of the disturbance and those involved in it. Patrick Njie’s recollection was that there were two disturbances in the bar, each involving different parties, but both within a short time of one another. Accordingly, those people who were asked to recall a confrontation, in circumstances where they did not know either of those involved, could be forgiven for having described the wrong incident.

3.30 Mr Ramm’s recall of the fight was that:

“I went close to Chris and grabbed him with my arms around the chest area and he [sic] started grappling with each other...for a few seconds before we fell to the floor. No punches were thrown by either of us. As we fell to the wooden floor Chris was on the bottom and I was on top of him. Chris fell onto his back and I fell on top of him. I do not know if he banged himself as he fell. We were only on the floor for a few seconds before I was pulled off him by a bouncer.”

3.31 Mark Feasey,²⁸ a customer, recalled that:

“as the verbal exchange became more heated the confrontation developed...to a wrestling type of situation as they grappled with each other on the floor...I did not see any punches or blows struck by either male”.

3.32 Another customer, named Phillipe Mataix, was standing drinking a pint of beer, when a person answering the description of Mr Alder collided

²⁶ Jurgen Jarvis statement (1 April 1998) CA0019 p.115 [00190117]

²⁷ Shehzad Arshad statement (23 April 1998) CA0019 p.86 [00190088]

²⁸ Mark Feasey statement (24 April 1998) CA0095 p.174 [00950175]

with him from behind, causing him to drop his drink.²⁹ The glass broke. Mr Mataix turned and saw Mr Alder lying on the floor. Mr Mataix moved away to avoid trouble.

- 3.33 David Okwesia³⁰ was also a customer in the Soul Suite. He described what he saw as follows:

“Jason was saying in a raised angry voice something to a man...I have since learned...is called Chris Alder. I cannot recall exactly what was said...Jason then walked over to Chris angrily, apparently to sort him out. Jason grabbed Chris by his jumper around about his chest...There was a tussle between the two men which caused Chris to slip and fall to the floor.”

- 3.34 Jurgen Jarvis, who saw the original spitting of beer, described what followed:³¹

“Chris moved towards Jason and then Jason moved towards Chris and then pushed Chris in the chest but not too hard. Chris fell to the floor but not backwards, he just crumbled downwards to the floor with his knees bent with his head upright but as he got to the floor he leaned backwards, slowly and laid down on his back, and although his head probably touched the floor, it did not impact with it. He had his knees bent upwards and did not stay down very long but soon got to his feet. At this point Chris was not injured. Chris got to his feet and went for Jason again and began to swing punches at Jason, like a ‘windmill’ style, with the direction being all over. I couldn’t see whether or not he connected with Jason. I then got in between the two of them to stop the trouble, at which point the staff arrived...”

- 3.35 Milton Pokawa was also a customer;³² although he did not see the fight begin, he recalled crossing the dance floor:

“I noticed the man I know as Chris Alder lying on the dance floor...Another man was stood astride him and he appeared to be pushing Chris Alder back down to the floor whilst Chris Alder had grabbed hold of the man’s shirt. I did not see any punches being thrown...I pushed the man standing astride Chris with my left hand. I pushed him quite hard in an attempt to separate them...”

- 3.36 The staff members who intervened were Jason Cooney and Neil Goforth; Mr Goforth took hold of Mr Alder, and Mr Cooney held Mr Ramm. Mr Njie³³ intervened, and said later that Mr Ramm:

²⁹ Phillippe Mataix statement (28 April 1998) CA0019 p.94 [00190096]

³⁰ David Okwesia statement (9 April 1998) CA0019 p.57 [00190059]

³¹ Jurgen Jarvis statement (1 April 1998) CA0019 pp.115–16 [00190117–18]

³² Milton Pokawa statement (21 April 1998) CA0020 p.86 [00200088]

“was shouting threats towards Chris to the words similar [sic] to ‘I’ll fucking kill you and you fucking niggers are all the same’”.

3.37 Mr Njie is the only witness to mention this use of language by Mr Ramm. If he is correct about this recollection, this may also have served to exacerbate the tension between Mr Alder and Mr Ramm. However, no other witness refers to these words being used, and the matter was not put to Mr Ramm when he gave evidence at the inquest.

3.38 Mr Goforth³⁴ said that:

“I grabbed hold of Chris and pulled him away from Jason. At the same time Jason Cooney took hold of the other male (Jason) and pulled him away. I saw Jason Cooney escort the other Jason from the Soul Suite followed by other doormen. I remained in the Soul Suite with Chris trying to calm him down.”

3.39 Mr Cooney³⁵ saw that on his arrival the two men had already been separated:

“Chris was quite calm but Jason was clearly still agitated...[and] was restrained in an arm lock loosely behind his back.”

3.40 Robert Stevenson also went to the incident, and saw the two men “in a wrestling type fight on the floor”, before being separated by his colleagues. Mr Stevenson got between them to assist in the separation.³⁶

3.41 Mr Broadhead, the assistant manager, took the view that Jason Ramm was the party to be expelled.³⁷ This was partly because he seemed to be the more aggressive when the staff arrived; they had not seen the spitting, and Mr Ramm had been warned for his behaviour on earlier occasions and had a poor reputation among the Waterfront Club staff because of previous problems that they attributed to him.

3.42 Mr Cooney recalled that Mr Ramm:

“continued being objectionable but not aggressive towards us”,
and that,

“he felt aggrieved at being ejected”.

³³ Patrick Njie statement (15 April 1998) CA0020 pp.62–3 [00200064–5]

³⁴ Neil Goforth statement (4 April 1998) CA0019 p.189 [00190191]

³⁵ Jason Cooney statement (24 April 1998) CA0020 p.43 [00200045]

³⁶ Robert Stevenson statement (1 April 1998) CA0020 p.30 [00200032]

³⁷ Adrian Broadhead statement (14 April 1998) CA0019 p.30–1 [00190032–3]

3.43 He also recalled that, having escorted Mr Ramm to the exit:

“I saw Chris had come down and was standing on the top of the stairs near to the cloakroom, he appeared quite calm...I approached him and then led him up the stairs to the Soul Suite.”

3.44 Mr Stevenson³⁸ recalled that, having led Mr Ramm away,

“as we got to the base of the stairs Chris was there and he began to apologise to us about what had happened...Chris wanted to go out and speak to this male but I persuaded him to return to the club.”

3.45 Mr Stevenson watched to make sure Mr Ramm departed and then, he said:

“When I returned to the club I had a brief conversation with Chris who was calm and explaining it was not his fault. I told him it was all finished and he went back into the club.”

3.46 Karen Mills, a member of staff, had gone to the Soul Suite on hearing of the warning of trouble.³⁹ When she arrived, Mr Ramm was already being taken away, but she noticed that Mr Alder was still there, and he looked angry to her. Another man was shouting at Mr Alder to “Leave it, just leave it”.

3.47 Ms Mills took the view that this was only making matters worse, and took the second man aside to advise him to stop. The man involved may well have been Jurgen Jarvis, as Ms Mills mentions the man saying that he had lost his keys, which Mr Jarvis had complained of at about that time.

3.48 Mr Jarvis also recalled talking to Mr Alder,⁴⁰ and said that:

“I asked Chris why he had done what he did to Jason to which he mumbled something but was incoherent. Chris was on his feet but slow and lethargic.”

3.49 Mr Goforth also recalled the lost keys, and that when Mr Alder was calmer he (Mr Alder) helped to search for them.⁴¹

3.50 The club was due to close at 02.00. Mr Alder, who had returned to the Soul Suite, was seen in the bar shortly after 02.00, where he was the

³⁸ Robert Stevenson statement (1 April 1998) CA0020 p.31 [00200033]

³⁹ Karen Mills statement (5 April 1998) CA0019 p.194 [00190196]

⁴⁰ Jurgen Jarvis statement (1 April 1998) CA0019 at p.116 [00190118]

⁴¹ Neil Goforth statement (4 April 1998) CA0019 p.189 [00190191]

last remaining customer, and was chatting with Stephen Todd, the disc jockey. Mr Todd recalls Mr Alder's parting comment as being:

"Don't worry we'll all be friends tomorrow",
and patting him on the back.⁴²

3.51 At Mr Broadhead's request,⁴³ Mr Alder started walking downstairs:

"He was talking about being depressed that he was trying to make his friends have a good time and it was not happening...but he didn't seem angry about the incident. He was saying he was not a violent man he was saying he was an old man and I got the impression he didn't want to be bothered with it."

3.52 Mr Broadhead also recalled from this that:

"When I left him there it was clear to me that he had no injuries to his face, head, arms or hands."

3.53 Mr Goforth also said:

"I didn't see any injuries to him at this time."

Outside the club

3.54 When the club was closing, and customers began to step out into the street, Mr Ramm was still in the vicinity. Julius Adediran⁴⁴ described a man in a blue jacket:

"who appeared to be waiting for trouble".

3.55 Olliwaseyi Jolapamo,⁴⁵ who knew Mr Ramm, recalled speaking to him, who said:

"I'm waiting for that kid that I had the trouble with inside".

He saw David Okwesia trying to calm Mr Ramm down, but said that:

"Ram [sic] refused to leave and seemed adamant and intent to cause trouble, despite David's pleas. Jason Ramm seemed very irate and generally agitated."

⁴² Stephen Todd statement (20 April 1998) CA0095 p.300 [00950301]

⁴³ Adrian Broadhead statement (14 April 1998) CA0019 p.32 [00190034]

⁴⁴ Julius Adediran statement (3 April 1998) CA0095 p.129 [00950130]

⁴⁵ Olliwaseyi Jolapamo statement (14 April 1998) CA0019 p.126 [00190128-9]

- 3.56 Leon Layas⁴⁶ described Mr Ramm being “very upset...and he was crying” about the spitting incident.
- 3.57 Mr Okwesia also recalled his encounter with Mr Ramm, who was:
“very upset and sobbing, saying that he did not understand why ‘that man’ Chris had sprayed drink on him three times”.
- 3.58 Mr Okwesia had tried to calm him down and to persuade him that fighting would serve no purpose. Mr Ramm remained very upset.
- 3.59 Mr Okwesia saw Mr Alder leave the club and walk away.⁴⁷ At about the same time he noticed Mr Ramm begin to follow Mr Alder, and he intervened. He offered to speak to Mr Alder to avoid any problems, and Mr Ramm agreed to stay back and not approach while this was done. Although he didn’t describe the conversation, Mr Ramm agrees that his understanding was the same and that he was allowing Mr Okwesia to speak to Mr Alder.⁴⁸
- 3.60 Mr Alder left the club at around 02.15 and walked away from the building, south along Prince’s Dock Street in the direction of his flat. He was alone. This much is clear from the CCTV footage provided to the police by the management of the Waterfront Club. The time indicator on the video indicates a markedly different time to the time of the incidents described by the witnesses; Mr Myatt, the assistant manager, explained that this was because the video recorder’s timer had not been adjusted to British Summer Time on Sunday 29 March when BST began.⁴⁹ Accordingly the clock showed a time one hour earlier than the correct time. In addition to that, it is possible that the clock was not entirely accurate, even without the one-hour discrepancy.
- 3.61 The camera that recorded the incident is on the wall of the Waterfront Club, and looks down at the entrance door on Prince’s Dock Street. It views the street beyond the doorway, and points almost due south. The people who exit the club in Posterngate and turn left, southwards down Prince’s Dock Street, emerge from the bottom of the camera picture.
- 3.62 Mr Alder can be identified as the sole figure walking along the street, with no other persons in view. A second figure appears from the north end of the road, near to the club, and follows Mr Alder down. The evidence of Mr Okwesia suggests that he is the second man.⁵⁰ He describes approaching Mr Alder, and engaging in conversation with him. At this point Mr Alder had walked some distance along the street, and was in fact a matter of a few yards from his home address.

⁴⁶ Leon Layas statement (15 April 1998) CA0019 p.66 [00190068]

⁴⁷ David Okwesia statement (9 April 1998) CA0019 p.58 [00190060]

⁴⁸ Jason Ramm statement (3 April 1998) CA0019 pp.51–2 [00190053–4]

⁴⁹ Paul Myatt statement (2 April 1998) CA0019 p.26–7 [00190028–9]

⁵⁰ David Okwesia statement (9 April 1998) CA0019 p.59 [00190061]

- 3.63 Mr Okwesia's recollection was that they had shaken hands, and that he had made clear that he was not intending to cause trouble but to find out what had happened. He told Mr Alder of Mr Ramm's allegation concerning the spitting of beer. Mr Alder denied that he had done this. Mr Okwesia had said to him:

"Look can't we sort it out...It's no good blacks fighting blacks especially in this city where there is so few of us."

He said that Mr Alder's response was: "Oh bullshit".

The fight outside the club

- 3.64 At this point Mr Okwesia said that Mr Ramm approached and a fight broke out. Mr Ramm agreed that Mr Okwesia had gone to speak to Mr Alder⁵¹ Mr Ramm said that while the two were speaking:

"I believe I saw Chris throw some punches at Dave. I saw Chris get past Dave Okewsai [sic] and move to the Prince's Quay side of the road and I saw him pull his top off and started coming back towards me..."

- 3.65 Mr Okwesia does not describe being struck or even threatened at this stage, and does not describe Mr Alder walking towards Mr Ramm.

- 3.66 Another person who misinterpreted what had happened was Leon Layas,⁵² who saw Mr Okwesia approach Mr Alder:

"Dave then approached Chris and at this point it appeared they were just talking. I think he was trying to sort out what had happened with Jason. It was then I saw Chris turn and punch Dave..."

- 3.67 Aimun Friegoun, who did not know Mr Okwesia by name, nonetheless saw him approach Mr Alder. He said that:

"From where I was stood, which was about 15 metres away, could see this guy talking to Chris...I saw that no fighting took place, but arms were being waved about and Chris was leaning on this guy. Jason...walked over to where Chris was. Chris then punched Jason."

- 3.68 Mr Ramm justified his approach by saying that, as Mr Alder was coming towards him:

⁵¹ Jason Ramm statement (3 April 1998) CA0019 p.52 [00190054]

⁵² Leon Layas statement (15 April 1998) CA0019 p.67 [00190069]

“I then left the group I was with and walked towards Chris as it was obvious that he wanted to get to me and I felt that it was no good walking away. I had to confront him.”

3.69 Mr Ramm’s recall of events is not supported by the evidence of the videotape, which clearly shows that it was he who approached the other two men. Mr Alder does not appear to be approaching Mr Ramm at that point. Although indistinct at a distance, it is clear that there is a fight when Mr Ramm reached the other two men.

3.70 Mr Okwesia recalled that:

“Jason then seemed to appear from nowhere and started fighting with Chris. They were certainly tussling with each other and I saw punches being thrown but not connecting. I decided to break them apart so I put my arms between them in order to separate them. This I managed to do.”

3.71 Around this time Mr Okwesia recalled a taller, light-skinned black man of about 20–26 years standing nearby. This description would probably fit Ian Lynch (22 years old, 6 feet 4 inches tall and of mixed race) who was standing outside the club awaiting his girlfriend. Mr Lynch recognised a number of the persons involved, and had seen Mr Ramm approaching Mr Alder.⁵³ He had looked away briefly, and looked back to see the two men wrestling on the ground:

“I saw David Okwasi [sic] go towards Chris and Jason Ram [sic] so I followed him. David got hold of Chris and I got hold of Jason Ram. They were both still wrestling on the floor when I got to them.”

3.72 Mr Lynch describes pulling Mr Ramm away and telling him to calm down. As this was going on, he was aware that Mr Okwesia was still trying to calm Mr Alder. The videotape of the scene illustrates the fact that the fight was stopped and restarted at least once. Mr Okwesia describes a crowd gathering, and others becoming involved in the attempts to separate the two men. He describes Mr Alder taking off his sweater and throwing it to the ground. Mr Okwesia recalls saying to him:

“Chris that’s enough right”.

3.73 Mr Alder, however, was:

“very angry, fired up and wanted to continue to fight”.

⁵³ Ian Lynch statement (23 April 1998) CA0019 p.80 [00190082]

- 3.74 Shehzad Arshad, who had just left the club, emerged to see the fight in progress.⁵⁴ He described having seen the man remove his sweater. This person was then:

“swinging punches at male 2”.

- 3.75 He took the view that Mr Alder was getting the better of his opponent, even though his blows were misdirected and not really connecting. He described a third man intervening. This person was:

“6’ plus tall, with a skinhead, shaven head and a goatee beard”.

- 3.76 This man, he saw, took hold of Mr Alder and pulled him to the ground to stop the fight. Mr Arshad was clear this caused no injury, but made Mr Alder angrier, whereupon he got to his feet and pursued Mr Ramm further.

- 3.77 Mr Ramm at this stage was walking away, and Mr Alder was walking after him. Zuber Pandor recalled that the retreating Mr Ramm was making it clear that he did not want to fight, but that Mr Alder:

“was determined to continue being aggressive and fight”,

despite attempts by the crowd to stop it.⁵⁵ He saw Mr Alder seize Mr Ramm in a headlock, and the two fell to the ground together. Mr Pandor saw one other man step in to stop the fight and receive a punch, before Mr Paul attempted to do the same (the first man who attempted to intervene was probably Aimun Friegoun, who described this happening to him⁵⁶).

- 3.78 The evidence concerning the involvement of Mr Paul suggests that it was at this point that he intervened. The witnesses, Shehzad Arshad and Faizal Ravat,⁵⁷ describe him as intervening to stop the fight, and saying words to the effect of:

“Just relax, calm down.”

It is also clear from the evidence that this had little effect upon Mr Alder, who lashed out and struck Mr Paul about the head at least twice.

- 3.79 Mr Pandor also saw the man whom he knew as Jason try to stop the fight and heard him attempt to placate Mr Alder; the attempts were unsuccessful, and Mr Alder punched Mr Paul several times.

⁵⁴ Shehzad Arshad statement (23 April 1998) CA0019 p.87 [00190089]

⁵⁵ Zuber Pandor statement (28 April 1998) CA0019 p.100 [00190100]

⁵⁶ Aimun Friegoun statement (2 April 1998) CA0019 p.74 [00190076]

⁵⁷ Faizal Ravat statement (1 May 1998) CA0019 p.186 [00190188]

- 3.80 Mr Friegoun, similarly, saw Mr Paul struck in the face by Mr Alder, as did Olliwaseyi Jolapamo,⁵⁸ Jurgen Jarvis,⁵⁹ David Okwesia,⁶⁰ Leon Layas,⁶¹ Mohammed Malik⁶² and Jonathan Bird.⁶³
- 3.81 All of the witnesses listed above who recalled Mr Paul intervening and receiving a blow or blows to the head went on to describe Mr Paul striking Mr Alder with one blow to the mouth area. The evidence is also wholly consistent that this blow knocked Mr Alder back over, resulting in his falling heavily to the ground and not moving. Mr Paul accepted as much in his interview and agreed at the inquest that he had been hit three times before striking back.⁶⁴ A number of the witnesses recall that Mr Alder struck his head audibly upon the ground.
- 3.82 One witness whose evidence was treated as being of potential significance at the inquest was Richard Hillyard, who had been outside the club, and was near a burger stall. Mr Hillyard's account differed in a number of important respects from other witnesses. His evidence suggested that Mr Paul initially prompted Mr Ramm to physically confront Mr Alder. After the fight with Jason Ramm had ended, Mr Hillyard suggested Mr Paul himself confronted Mr Alder and then Mr Paul:

“unleashing one almighty blow”

to the jaw of Mr Alder. The inquest jury were obviously concerned to assess whether the blow struck by Mr Paul was excessive in its force. Mr Hillyard was the only witness who placed the emphasis upon the blow that he did. The video evidence does not support Mr Hillyard's suggestion that Mr Paul was seeking a confrontation with Mr Alder. The tenor of the other evidence was that Mr Paul acted proportionately to the assault upon him by Mr Alder, although it is also evident that as a result of the blow Mr Alder lost one tooth and had another displaced.

- 3.83 Joanne Knapp,⁶⁵ who had left the club and was standing outside, saw a man of about 6 feet in height wearing a distinctive “American football type jacket” which had “yellow motifs”. This description fits the person and jacket of Jason Paul, as can be seen in the video. He was shouting:

“Get off me”,

⁵⁸ Olliwaseyi Jolapamo statement (14 April 1998) CA0019 p.128 [00190130]

⁵⁹ Jurgen Jarvis statement (1 April 1998) CA0019 p.120 [00190122]

⁶⁰ David Okwesia statement (9 April 1998) CA0019 p.60 [00190062]

⁶¹ Leon Layas statement (15 April 1998) CA0019 p.68 [00190070]

⁶² Mohammed Malik statement (23 April 1998) CA0019 p.144 [00190146]

⁶³ Jonathan Bird statement (22 April 1998) CA0019 p.177 [00190179]

⁶⁴ Inquest Day 3, p.7

⁶⁵ Joanne Knapp statement (3 April 1998) CA0020 p.124 [00200126]

and was struggling. This would appear to reflect the view from the video recording of Mr Paul being held back from the supine Mr Alder by about three other men (video timer at 01:19:07); a still picture of this point is attached at Appendix 13. Mr Friegoun⁶⁶ recalled that he:

“grabbed hold of Jason Paul from behind and put both of my arms around his chest and dragged him away”.

3.84 Mr Ravat also said that:

“The male who had struck the bald male was taken away by someone”,

and Abbas Ali Shah⁶⁷ saw:

“Aamon [sic] and a few other black people bundle Paul away from Chris”.

3.85 The video recording that covers the point immediately after the blow was struck to Mr Alder shows Mr Paul standing over him, and another man, possibly Jurgen Jarvis, appearing to be fending him off. A still of this scene is attached at Appendix 12, and shows the video timer at 01:18:58. Mr Jarvis did say in his statement⁶⁸ that the man who had struck Mr Alder:

“moved forward to Chris who was prone on his back [sic]. Male 1 went to go down on Chris, looking in a rage, I thought he was going to hit Chris again, he had his hands in front of him.”

3.86 The video then shows Mr Paul clearly being restrained. The still picture of this is attached at Appendix 13. When asked at the inquest whether he had to be restrained from pursuing an assault against Mr Alder, once the latter was on the floor, Mr Paul said:⁶⁹

“it’s a load of rubbish”.

3.87 Ms Knapp moved away to avoid trouble, and at that stage noticed the man who was lying out on the ground. Having seen this person being put into the recovery position by a man who was shouting for an ambulance, Ms Knapp then ran into the club reception and asked for one to be called. Mr Myatt, the assistant manager, recalled a young woman coming into the reception to notify them of the trouble outside.⁷⁰

⁶⁶ Aimun Friegoun statement (2 April 1998) CA0019 pp.74–5 [00190076–7]

⁶⁷ Abbas Ali Shah statement (23 April 1998) CA0019 p.108 [00190110]

⁶⁸ Jurgen Jarvis statement (1 April 1998) CA0019 p.120 [00190122]

⁶⁹ Inquest Day 3, p. 7

⁷⁰ Paul Myatt statement (1 April 1998) CA007 p.6 [00070007]

3.88 Ms Knapp also described Mr Ramm standing nearby when a large doorman was accusing him of causing the trouble. Mr Ramm was denying this. Andrew Edwards, who worked at the club, also described a man arguing with a staff member,⁷¹ and Mr Jarvis described “Jason” nearby arguing with door staff.⁷²

3.89 The evidence available suggests that there was a point when Mr Alder left the club at which he was walking away in the direction of his home address. As Mr Saul, the coroner,⁷³ expressed it, in summing up:

“Life is full of ‘but ifs’, but if he had continued on his way, the tragic scene of events which led to his death only a couple of hours later, which we have tried so hard for so long to unravel, would never have taken place.”

3.90 His behaviour from the point when he came into contact again with Mr Ramm outside the club, his sudden outburst of temper and his determination to attack Mr Ramm in an aggressive fashion is difficult to account for. The reason for his initial confrontation with Mr Ramm and his angry response and aggressive pursuit of Mr Ramm outside the club remain unexplained. The drink that he had consumed may have played some part in his actions. He was described by friends as having been in fights while in the army. Nonetheless, his motivation on the night remains obscure, and is likely always to be so.

3.91 A considerable number of observers who were independent of him, or who counted themselves his friends, described him as being out of control. The violence originally offered to Mr Ramm, and which led to him hitting Mr Friegoun and Mr Paul, supports this view.

3.92 The balance of the available evidence regarding Mr Paul suggests strongly that he was, at least initially, trying to calm Mr Alder down. The consensus among the witnesses appears to have been that he was simply struck because he was in the way. There was, in fact, some former friction between Mr Alder and Mr Paul. Evidence of this surfaced during the Humberside Police investigation. The problem arose because of an argument between Mr Paul and the 16-year-old daughter of Mr Richard Alder.⁷⁴ Mr Paul took the view that Ms Alder, who was a friend of Mr Paul’s girlfriend, was interfering in his relationship. On an evening in March, at the Waterfront Club, he had confronted Ms Alder and behaved in a threatening fashion towards her. At that point Christopher Alder, who was standing nearby, had intervened and pushed Mr Paul back, telling him to leave the girl alone. The matter went no further.

⁷¹ Andrew Edwards statement (4 April 1998) CA0019 p.211 [00190213]

⁷² Jurgen Jarvis statement (1 April 1998) CA0019 p.121 [00190123]

⁷³ Inquest Day 30, Summing up, p. 14

⁷⁴ Laura Alder statement (8 April 1998) CA0095 p.131 [00950132]

- 3.93 Although there is an element of coincidence in this, there is no evidence to suggest that there was any ongoing antipathy between the two men, and it was not suggested that Mr Paul was seeking revenge upon Mr Alder. In interview Mr Paul denied knowing any other members of the Alder family.⁷⁵

The effects of the blow to the head

- 3.94 The civilian witness who saw Mr Alder most clearly after the blow to his jaw was Jurgen Jarvis. Mr Jarvis had seen Mr Alder throughout the course of the evening. In a statement given to the police, he said that he had been active in trying to prevent Mr Alder from fighting. When Mr Alder was struck, Mr Jarvis said of him that:⁷⁶

“Chris fell over backwards immediately...’like a log’ and onto the ground with the back of his head striking the floor very hard. I heard a loud crack as it impacted...Chris was lying still on the ground on his back with his arms on the floor but above his head, blood was dribbling out of his mouth. I went to him and placed him in the recovery position, he was breathing, at this point blood poured out of his mouth. He then began to mumble something, he seemed [half] conscious to me.”

- 3.95 During the inquest, Mr Jarvis was asked about the state of Mr Alder,⁷⁷ of whom he said:

“When he hit the floor he was in a daze, very much in a daze...but he wasn’t moving...Because I was the closest person to him I could see that he was conscious at the time. I mean from somebody who was standing up would probably think he was unconscious because he was very still.”

- 3.96 He went on to say that he had argued with “the bouncers” from the club, who had disagreed with his method of placing Mr Alder in the recovery position. Mr Jarvis had then left the care of Mr Alder to them.⁷⁸ Mr Jarvis thought that he had waited about 20 minutes with Mr Alder for the ambulance to arrive.⁷⁹
- 3.97 The video footage obtained by the Waterfront Club’s external CCTV video camera, which viewed that area, clearly shows Mr Jarvis beside Mr Alder on the ground, with members of the staff standing around.

⁷⁵ Jason Paul interview (2 April 1998) CA0019 p.30 [00190342]

⁷⁶ Jurgen Jarvis statement (1 April 1998) CA0019 pp.120–1 [00190122–3]

⁷⁷ Inquest Day 1, p.53

⁷⁸ Inquest Day 2, p.13 at B

⁷⁹ Inquest Day 1, p.53 at F

- 3.98 When Paul Myatt went out to investigate what was happening in the street,⁸⁰ he recalled seeing:

“a male laid unconscious in the road. He was laid in the prone position on his right side facing the club...”

- 3.99 He described how a member of his staff brought a blanket to cover the man, while he went inside to call an ambulance. Mr Myatt said that he rang twice for the ambulance, which arrived a couple of minutes after his second call. He recalled that the ambulance crew:

“approached the unconscious male and began examining him. At this point the male began to move around...”

- 3.100 It was later confirmed that the police dispatcher who took the call from Mr Myatt at 02.20 was Sally Beckett, who contemporaneously created an incident on the Command and Control computer system⁸¹ under their reference “Log 72”. At 02.23 hours she asked her colleague June Wallace on another terminal to notify the ambulance control, which was done.⁸²

- 3.101 Possibly the first member of the club’s staff to reach Mr Alder on the ground was Jason Cooney, who was working as a door supervisor.⁸³ He was inside the club when someone called through the door for an ambulance to be summoned. Mr Cooney went outside and saw Mr Alder lying on the ground, with a man kneeling beside him. It was Mr Cooney, on his recollection, who called over Michael Coombs, a doorman, because of Mr Coombs’ first aid training. Mr Cooney described Mr Alder as semi-conscious, but still moving around on the floor, prior to the ambulance arriving. He stated that Mr Alder was in:

“a semi-recovery position”,

and a man was tending to him (presumably Mr Jarvis) who was:

“panicking a bit about getting an ambulance”.

- 3.102 At the inquest Mr Cooney clarified that he and Mr Coombs had jointly been responsible for placing Mr Alder in the recovery position, and that:

“he was down for a good while before I actually saw his eyes open...”

and that he had started to move before the ambulance arrived.⁸⁴

⁸⁰ Paul Myatt statement (1 April 1998) CA007 pp.6–7 [00070007–8]

⁸¹ Sally Beckett statement (6 May 1998) CA0095 pp.145 [00950146–7]

⁸² June Wallace statement (3 May 1998) CA0095 p.321 [00950322]

⁸³ Jason Cooney statement (24 April 1998) CA020 pp.44–5 [00200046–7]

⁸⁴ Inquest Day 2, pp. 94 and 99

- 3.103 Mr Coombs had approached Mr Alder on the ground and checked that he was breathing. Mr Coombs later commented that:

“The man when I initially looked at him appeared to be unconscious and his eyes were closed”.

- 3.104 Mr Coombs,⁸⁵ with the help of another man, placed Mr Alder into the recovery position. He said that:

“After a minute or so of waiting the injured man regained consciousness and he tried to get up”.

He recalled that Karen Mills, another door supervisor at the club, had placed a sweater over Mr Alder.

- 3.105 A club doorman, Robert Stevenson, had come out of the club after being told of a disturbance and saw Mr Alder, whom he knew as Chris, on the floor. As he approached he saw another doorman put Mr Alder into the recovery position. Mr Stevenson did not describe him as unconscious, but said that he seemed confused and had to be persuaded to remain on the ground.⁸⁶

- 3.106 The assistant manager, Adrian Broadhead, had also seen Mr Alder lying in the street but not the events immediately prior to this. He recalled that by the time he arrived Mr Alder was in the recovery position and that it was he, Mr Broadhead, who called for a blanket. He said of Mr Alder that:

“he appeared unconscious”,

but that he began to move and tried to sit up before the ambulance arrived.⁸⁷ Mr Broadhead gave evidence before the inquest and pointed out that his opinion was formed on the basis that he saw that Mr Alder was not speaking or moving, and therefore his conclusion was that he might be unconscious.⁸⁸

- 3.107 Ms Mills, who also emerged from the club when told of a problem, had found Mr Alder on the ground. She did not see him unconscious, and she spoke to him and reassured him while he was on the ground. He replied to her, saying:

“It’s me fucking teeth”.

⁸⁵ Michael Coombs statement (6 April 1998) CA0019 p.204 [00190206]

⁸⁶ Robert Stevenson (1 April 1998) CA0019 p.39 [00190041]

⁸⁷ Adrian Broadhead statement (14 April 1998) CA0019 p.33 [00190035]

⁸⁸ Inquest Day 2, p. 85

3.108 Ms Mills retrieved his sweater and later obtained a blanket from the club to place over him.⁸⁹ Mr Alder only became irate, in her presence, when another man approached him, who seemed to be the source of some upset to him. Ms Mills also commented that prior to the arrival of the ambulance he had altered his breathing pattern and began panting and breathing quickly, as if in a panic. She sought to calm him down, and said his breathing gradually returned to normal.

3.109 Another possible sign of panic on the part of Mr Alder emerged a few minutes later, after he had been put on board the ambulance, when the paramedic Stephen Krebs⁹⁰ commented that:

“at one point he grabbed hold of both of my hands with his hands, I believe this was for assurance and comfort”.

3.110 Another doorman, Andrew Edwards, also emerged after Mr Alder was knocked down, and saw Mr Coombs attending to him. By the time Mr Edwards approached, Mr Alder was already in the recovery position, and seemed to him to be conscious, albeit not moving.⁹¹ Similarly, the doorman Neil Goforth saw Mr Alder on the ground, but apparently conscious by this stage.⁹²

3.111 While still awaiting the ambulance, a number of the door staff from the club were keeping an eye upon Mr Alder, and can be seen on the CCTV tape surrounding him on the ground. Mr Coombs describes watching him to ensure that he was still breathing.⁹³ He saw Mr Alder open his eyes and kick out at the man standing nearby who had helped to put him in the recovery position. That man, who was most probably Jurgen Jarvis, was moved away by other staff to avoid any confrontation. Mr Jarvis himself recalled Mr Alder trying to kick him, while still on the floor,⁹⁴ and that the paramedic who approached shortly afterwards helped Mr Alder to his feet and to the ambulance.

3.112 Staff members Michael White⁹⁵ and Kevin Smith⁹⁶ also saw the kicking, and Mr Smith recalled the man on the ground saying:

“Fuck off, leave me alone”.

3.113 Adrian Broadhead described Mr Alder attempting to get up before the ambulance arrived.⁹⁷ He said that:

⁸⁹ Karen Mills statement (5 April 1998) CA0019 p.196 [00190196]

⁹⁰ Stephen Krebs statement (4 April 1998) CA007 p.15 [00070016]

⁹¹ Andrew Edwards statement (4 April 1998) CA0019 p.210 [00190212]

⁹² Neil Goforth statement (4 April 1998) CA0019 p.190 [00190192]

⁹³ Michael Coombs statement (6 April 1998) CA0019 p.204 [00190206]

⁹⁴ Jurgen Jarvis statement (1 April 1998) CA0019 p.121 [00190123]

⁹⁵ Michael White statement (6 April 1998) CA0095 p.328 [00950329]

⁹⁶ Kevin Smith statement (4 April 1998) CA0095 p.282 [00950283]

⁹⁷ Adrian Broadhead statement (14 April 1998) CA0019 p.33 [00190035]

“he tried to get up onto his elbows and was looking around in a dazed manner”.

3.114 Mr Broadhead said that despite advice to stay where he was, Mr Alder was:

“obstructive and aggressive”,

and he got to his feet before the ambulance arrived. In fact Mr Broadhead’s recollection is contradicted by the CCTV videotape of the scene, which shows that Mr Alder did not move from his position on the ground until the ambulance crew had attended to him.

3.115 The more accurate description of Mr Alder getting to his feet after the arrival of the ambulance crew is borne out by the police officers who arrived after the ambulance, but who observed Mr Alder still lying down, and by the evidence of other door staff. Mr Goforth⁹⁸ says that after the crew spoke to him, Mr Alder:

“suddenly sprung to his feet and started looking around him. It was obvious that he didn’t know what or where he was and he was becoming very aggressive.”

3.116 Mr Goforth said that it was his colleague Mr Cooney who talked him into getting into the ambulance. Robert Stevenson⁹⁹ also saw him receive assistance, whereupon:

“he suddenly jumped up and was moving around quickly and pushing people and bystanders away”.

A barman at the club named John Boothby¹⁰⁰ also saw him:

“suddenly...jump up and it was obvious he was very angry”.

3.117 Jason Cooney¹⁰¹ was another witness who described Mr Alder getting up quickly:

“All of a sudden Chris jumped up from the ground in an unusual movement and he was on his feet and he was kicking out and he kicked me on the leg as he did this.”

⁹⁸ Neil Goforth statement (4 April 1998) CA0019 p.191 [00190193]

⁹⁹ Robert Stevenson statement (1 April 1998) CA0019 p.40 [00190042]

¹⁰⁰ John Boothby statement (7 April 1998) CA0019 p.216 [00190218]

¹⁰¹ Jason Cooney statement (24 April 1998) CA0020 p.45 [00200047]

Arrival of the ambulance

- 3.118 Following the calls to the ambulance service made by the staff at the club (Mr Myatt recalled that two calls were made) an ambulance was directed to the club. The local ambulance authority was known then as the Humberside Ambulance Service NHS Trust (and is now the Tees, East and North Yorkshire Ambulance Trust). The vehicle despatched was staffed by technician Victoria Drennan and paramedic Stephen Krebs (Mr Krebs surname is frequently misspelled as 'Krebbs' in the documentation). Ms Drennan recorded the time of call-out as being 02.26,¹⁰² and the arrival time at the Waterfront Club as being three minutes later. The ambulance log confirms these timings.¹⁰³
- 3.119 The arrival of the ambulance can be seen clearly on the CCTV videotape as it approached the area outside the club from the south. The vehicle parked on Prince's Dock Street opposite the junction of Posterngate. As the ambulance arrived, Ms Drennan saw a man lying in the street, surrounded by staff from the club. Mr Krebs was the first to leave the ambulance and to approach the man on the ground.¹⁰⁴
- 3.120 The actual amount of time that Mr Alder had been on the ground prior to the arrival of the ambulance can be seen from the video. Bearing in mind the inaccuracy of the video timer clock, by one hour, the ambulance is seen to arrive at 01.30 (i.e. 02.30) by that timer, which is very close to the time recorded by Mr Krebs and Ms Drennan. The timer shows the period between Mr Alder being knocked to the ground and the arrival of the ambulance, which is 11 minutes. Mr Alder was still lying down, surrounded by concerned people, as Mr Krebs approached him. The somewhat jumpy nature of the film makes further assessment difficult, but Mr Alder has been helped up and moved out of shot towards the ambulance within two minutes of the arrival of the crew. Mr Jarvis's assessment of 20 minutes on the ground is therefore longer than was actually the case.
- 3.121 Mr Krebs described that when he approached Mr Alder he did not see him as being unconscious, and he was able to have a conversation with him. He saw immediately that Mr Alder had blood around and in his mouth, and that there was blood on the floor around his head. When asked what had happened, Mr Alder said:

"My teeth".

- 3.122 Ms Drennan, who followed from the ambulance, described Mr Alder as confused, and asking:

"Where's me teeth?"

¹⁰² Victoria Drennan statement (4 April 1998) CA007 p.25 [00070026]

¹⁰³ Ambulance log CA0067 at D41 [00670170-1]

¹⁰⁴ Stephen Krebs statement (4 April 1998) CA007 p.12 [00070013]

3.123 He appeared calm to Mr Krebs, who could see that he had an injury to the back of his head, which appeared as a large lump or swelling. Mr Krebs thought that the skin was broken, although he was not positive about this. Ms Drennan saw the same haematoma when Mr Alder stood up, and said of it that the surface appeared to be grazed. Mr Krebs asked him if he could stand, and Mr Alder said that he could.

3.124 The description given by Mr Krebs was that:

“we then escorted him to the rear of the ambulance. He walked slowly but normally to the vehicle.”

3.125 Ms Drennan¹⁰⁵ described Mr Alder as follows:

“The victim was conscious and speaking to Mr Krebs. He was not fully orientated and although he was understandable he seemed somewhat confused.”

She also recalled that on at least two occasions he tried to walk away into the crowd:

“in a bewildered disorientated state”.

3.126 A report by Dr G E Cook, a consultant in accident and emergency services, dated 11 March 1999, assessed the issue of his unconsciousness, and his treatment at the scene and later at hospital. Dr Cook concluded on his reading of the papers that Mr Alder was “unconscious” for 11 minutes, and commented that:

“Very little time was spent at the scene with Mr Alder (around 2 minutes) before him being led into the ambulance.”

3.127 He was of the view that a stretcher should have been used for Mr Alder. He went on to say that:

“When handing over Mr Alder to the staff at Hull Royal Infirmary, clear details obtained from the scene would have included definite history of being assaulted by being punched on the mouth and having hit the back of his head on the road and having lost consciousness for a considerable period of time.”

He is evidently critical of the failure to do this.

3.128 Contrasting with this is a report of Dr J E Porter, another consultant in accident and emergency, commissioned by the solicitors Messrs Hempsons of Harrogate, and dated 16 June 2000.¹⁰⁶ She commented

¹⁰⁵ Victoria Drennan statement (4 April 1998) CA007 p.27 [00070028]

¹⁰⁶ Dr Porter report (16 June 2000) CA0023 [00230119–42]

on the criticisms of the assessment and reporting by the ambulance crew in the report by Dr Cook as follows:

“It is important to recognise that consciousness is not an on/off phenomenon, it is a continuum. The depth of Mr Alder’s unconsciousness cannot be determined but by the time the ambulance crew arrived he was immediately rousable by the ambulance crew, was able to get to his feet, give his name and respond to questions, although he was confused...The duration of apparent unconsciousness – i.e. the time during which a patient is seen by observers to be on the ground is not a valid measure of head injury severity.”

- 3.129 Mr Krebs recalled that before entering the vehicle Mr Alder had turned and demanded to know what was going on, and that he became aggressive in tone and was:

“flaying his arms in a gesticulating manner”.

- 3.130 Ms Drennan recalled their attempts to persuade him firmly to get into the ambulance, despite a marked reluctance on his part to cooperate. She noted that:

“he was behaving erratically as his behaviour moods were swinging from being talkative and cooperative to resisting any help”.

- 3.131 Mr Krebs went on to describe Mr Alder having problems entering the vehicle, and his legs buckling as he went up the step, requiring support. He described an exchange between the patient and one of the club staff, and that while moving into the vehicle Mr Alder lifted an arm, causing Ms Drennan to move backwards. Mr Krebs did not view this as an attempt to assault his colleague. Mr Jarvis thought that Mr Alder had swung a punch at the paramedic, presumably meaning Ms Drennan, which:

“connected, but not directly”.

- 3.132 Ms Drennan described the sudden movement as being like:

“a tennis backhand”,

which caused her no injury, but did knock her back by a couple of paces. Once in the ambulance Mr Alder was persuaded to lie down on the trolley bed and receive assistance.

- 3.133 Jason Cooney, who had been one of the staff from the club calming Mr Alder, recalled that even when he had been persuaded into the

ambulance he was still sitting up and having to be persuaded to lie down again. Mr Cooney¹⁰⁷ said that:

“It was obvious he did not realise they were helping him. I said things to him that were a bit abrupt.”

3.134 Mr Krebs confirmed that one particular staff member had been talking to Mr Alder as he got into the ambulance, saying:

“Get in there Chris and get yourself sorted and we’ll see you later.”

Evidently this produced a heated response from Mr Alder, although the paramedic could not recall the exact words, and the staff member, who was presumably Mr Cooney,¹⁰⁸ said:

“Well that’s me and you finished, I thought we were mates.”

3.135 One of the door staff, Andrew Edwards, said that while the ambulance was still at the location:

“there was a blood soaked tissue on the floor. I picked up the tissue and saw a tooth in the pool of blood. It was a whole tooth including the root part, it looked large and I think it was a front tooth. The ambulance crew told me they ‘did not need’ the tooth and told me to dispose of it.”

He then wrapped the tooth up and placed it in a dustbin behind the club.¹⁰⁹

3.136 Neil Goforth¹¹⁰ witnessed this, and the response from the:

“female member of the ambulance crew”,

saying that they did not need the tooth.

3.137 Robert Stevenson¹¹¹ also described this incident:

“I noticed a tooth, including the root in the pool of blood. I asked the ambulance staff if they wanted the tooth. They said no. I believe another doorman picked it up and threw it away.”

3.138 Both Mr Krebs and Ms Drennan were interviewed by the Healthcare Commission (HCC) in the course of this Review. A representative of

¹⁰⁷ Jason Cooney statement (24 April 1998) CA0020 p.45 [00200047]

¹⁰⁸ Stephen Krebs statement (4 April 1998) CA007 p.14 [00070015]

¹⁰⁹ Andrew Edwards statement (4 April 1998) CA0019 p.212 [00190214]

¹¹⁰ Neil Goforth statement (4 April 1998) CA0019 p.191 [00190193]

¹¹¹ Robert Stevenson statement (1 April 1998) CA0019 p.40 [00190042]

the IPCC was also present. Mr Krebs was asked about the suggestion that the crew had refused the tooth. His response¹¹² was:

“No, because we would take that as evidence of an injury. You don’t just willy-nilly throw a tooth away and I know, sometimes they put these things back. It would...if I had been told that then we would have said because it’s Chris’s tooth and you know, whether he was vain about his teeth or not don’t come into it but you know, ‘There you are Chris, there’s your tooth’...So if that had been offered to us we would have taken that, there’s no two ways about that.”

3.139 He also denied that he had seen a doorman discussing it with Ms Drennan. Ms Drennan also denied that she was offered the tooth, or ever saw it at the scene.¹¹³ When the statement of the doorman was read to her she made it clear that she had no recall of the tooth being offered to her.¹¹⁴

3.140 The recollections of the two ambulance crew members differed on a number of points as to the behaviour of Mr Alder. Mr Krebs, who travelled in the back of the ambulance with the patient, said that he did not smell alcohol on Mr Alder, whereas Ms Drennan said that she did. Mr Krebs said that he was able to administer oxygen to Mr Alder, with his consent while en route; Ms Drennan stated that Mr Alder refused oxygen. The patient report form¹¹⁵ says:

“O₂ therapy attempted but refused”.

3.141 Mr Krebs stated that:

“at no point whilst in my company at the scene was the patient abusive, uncooperative or violent towards anyone”.

3.142 Ms Drennan, by contrast, said that while driving to the infirmary:

“I maintained a view in the rear mirror due to Chris’ violent nature.”

3.143 Both of the crew agreed that Mr Krebs developed a rapport with Mr Alder as the journey progressed, as both were of a similar age and had served in the armed forces.

3.144 The evidence of Nurse Helen Townend,¹¹⁶ who dealt with Mr Alder at Hull Royal Infirmary, was that:

¹¹² Stephen Krebs interview (10 March 2005) Tape 2, pp.21–2 [01200055–6]

¹¹³ Victoria Drennan interview (10 March 2005) Tape 1, p.11 [01190013]

¹¹⁴ Victoria Drennan interview (10 March 2005) Tape 2, p.3 [01190035]

¹¹⁵ Patient report form CA0041 [00410008]

¹¹⁶ Helen Townend statement (5 April 1998) CA007 p.58 [00070059]

“The male paramedic took me aside and told me to be careful as he said the patient had been abusive to him during transit and had tried to punch him.”

3.145 As the male paramedic could only have been Mr Krebs, this would appear to contradict what he later said about his impression of Mr Alder. Mr Krebs¹¹⁷ does accept that:

“when he began to raise his voice I advised the staff that perhaps another nurse should also attend in case he became aggressive”.

3.146 At the inquest¹¹⁸ he described this as follows:

A. He seemed to be fine. I do recollect mentioning to the nursing staff at the time just to be a little bit aware that Chris was having mood swings, you know, and to just be a little bit extra careful.

Q. Careful about what?

A. About their own safety and that of Christopher’s as well.

3.147 A full assessment of the activities of the ambulance crew is contained in the HCC report and was considered in the context of the subsequent inquest. The HCC report is critical of the decisions taken by the crew.

Arrival of the police at the scene

3.148 The police had been notified by the 999 calls, and the arrival of the ambulance at the scene outside the Waterfront Club was followed a few seconds later by the police. This much can be confirmed by reference to the video taken by the club, as the headlights of the police car can be seen approaching as the ambulance draws to a halt. The two officers were PC1229 Nigel Dawson and PC1443 Neil Blakey. The two uniformed officers were on a night shift covering the period from 22.00 on 31 March until 06.00 on 1 April, patrolling in a marked police car. The officers recorded their call to the scene as being 02.23 and arrival as being 02.30, one minute later than the ambulance.

3.149 The two officers both made statements on 1 April; both of those statements were timed as being made at 05.15, subsequent to Mr Alder’s death.¹¹⁹ The descriptions given by the two officers were that they saw a man on the ground being attended to by ambulance staff. Neither officer spoke to Mr Alder or attempted to speak to him at the

¹¹⁷ Stephen Krebs statement (23 April 1998) CA007 p.17 [00070018]

¹¹⁸ Inquest Day 5, p.82

¹¹⁹ PC Dawson and PC Blakey statements (1 April 1998) CA008 [00080151–70] & [00080171–88]

scene. In determining how much the officers saw of Mr Alder at this stage, it may be relevant to note that PC Dawson¹²⁰ saw:

“an Afro Carribean [sic] male lying on the road covered with a blanket”,

but described no injury; PC Blakey¹²¹ described:

“a coloured male lying in the road...had a head injury and there was blood next to his head on the road surface”.

3.150 PC Dawson recognised Mr Myatt, the manager of the club, and went to speak to him. He stated that Mr Myatt gave him a brief version of events, and suggested that the events might be caught on video. PC Blakey related how he shouted to the people standing around to ask whether anyone had seen what had happened. PC Blakey stated that one man volunteered information, but did not wish to speak in front of the club staff. The person in question was recorded by the officer as being Mr Jarvis, and PC Blakey said of him that he:

“seemed quite drunk and stated he did not want to give a statement to get anyone into trouble as there was no assault. This male did not give any rational account, other than people were swinging at each other and fell.”

3.151 Mr Jarvis told the inquest that he tried to explain the sequence of events to PC Blakey, and to tell the officer that the blow struck had been in self-defence,¹²² but that he felt that PC Blakey did not wish to listen to this, so he gave up trying to explain:

Q. And you gave your details to the police.

A. Yeah, they asking me if it was, they said “Who assaulted who?”, I said “Nobody assaulted anybody,” I said “It was self-defence”. He kept on trying to insist that was an assault. I just shut up after that and left it.

3.152 PC Dawson and PC Blakey both saw Mr Alder once he got to his feet. PC Blakey described him as

“shouting”, and, “quite vocal”.

3.153 PC Blakey saw Mr Alder shrugging off those who tried to help him, but appearing to collapse when he was left unaided, before being persuaded into the ambulance and driven off. At around this time the door staff at the nightclub arranged for one of the staff members to wash away the blood on the road surface with two buckets of water. It

¹²⁰ PC Dawson statement (1 April 1998) CA008 p.2 [00080152]

¹²¹ PC Blakey statement (1 April 1998) CA008 p.2 [00080172]

¹²² Inquest Day 1, pp.52–3

appears from the video not only that the police were present when this happened but that they were standing only a few feet away and did not seek to interfere with the process. The staff member in question was John Boothby,¹²³ who described using three buckets of water to wash away the blood. He said:

“The only people about at this time was Adrian [Broadhead], two police officers and Paul [Myatt].”

- 3.154 PC Blakey,¹²⁴ when interviewed on 14 May 1998, referred to the issue of the blood being removed in the following terms:

“the blood that had come from Mr Alder’s head was probably washed away by a member of the Waterfront staff outside the club which we thought we could have kept but he’d already washed it away, it was too late to actually keep a blood scene there”.

- 3.155 Both officers then relate being taken into the nightclub by Mr Myatt and being shown the video taken from the camera facing onto Prince’s Dock Street. From the descriptions given by both officers, it is clear that the section of the video shown to them covered only the early part of the incident, before the parties had returned close to the door of the Waterfront Club. Being unable to relate this incident to the scene that they had come across in the street, the officers did not seize the video, but asked Mr Myatt to retain it, which he agreed to do.

- 3.156 While the two constables were at the club viewing the video, Acting Police Sergeant (A/PS) 324 Mark Ellerington arrived at the club, having earlier heard the request for police to attend. A/PS Ellerington, who also made a statement on 1 April, related that upon his arrival, at about 02.50, he found the street by the club to be empty and quiet.¹²⁵ He was admitted to the club by a member of staff, and joined his two colleagues, who were still with Mr Myatt. Together they watched the video, which he described as being:

“not very distinct”.

- 3.157 All three officers described leaving the club after the viewing of the video, at which point the two constables pointed out where Mr Alder had been seen lying in the road. They then walked over the area where the initial blows had been struck between Mr Alder and Mr Ramm, as seen on the video. As no evidence was found, PCs Blakey and Dawson departed for the hospital, and A/PS Ellerington resumed his patrol.

¹²³ John Boothby statement (7 April 1998) CA0019 p.216 [00190218]

¹²⁴ PC Blakey interview (14 May 1998) CA0011 1/5 [00110008]

¹²⁵ A/PS Ellerington statement (1 April 1998) CA008 p.1 [00080196]

- 3.158 At the point when the ambulance was leaving the area by the Waterfront Club, a message, timed at 02.37, was passed from the two officers, PCs Blakey and Dawson, reporting their action.¹²⁶ The message read:

“We’ve got one male adult being taken to HRI with, well in drink, with a head injury caused by falling over having been hit in the face. We’re just going to see what evidence we’ve got inside the Club at The Waterfront. Then we’ll go to the HRI. Over.”

- 3.159 The expression “well in drink” does not appear in the statement of either officer made later in the morning, after the death of Mr Alder. However, A/PS Ellerington, in making his statement, said that he had been:

“appraised of the circumstances by the officers”

on his arrival, which was after the ambulance departed. He too had been told by them that Mr Alder was:

“in drink”.

- 3.160 The comment made by PC Dawson or PC Blakey in the message, and evidently repeated to A/PS Ellerington, indicates a conclusion on the part of the first two officers that Mr Alder was the worse for drink. They do not indicate in their statements what basis they had for this conclusion; Mr Myatt is the only staff member with whom they mention speaking, and he did not purport to have seen Mr Alder before observing him lying in the street or to know how much he had drunk. Unless the officers had spoken to other parties, whom they failed to mention at any point, it would appear that they reached a conclusion about his state of inebriation in the few moments that they saw him standing and being helped into the ambulance.

- 3.161 This judgement, based upon very little evidence, tends to suggest that the two officers were making assumptions about Mr Alder’s behaviour, and choosing to attribute it to alcohol taken rather than the injury sustained, from an early stage in their dealings with him.

Hull Royal Infirmary

- 3.162 Both members of the ambulance crew agreed that the departure of the ambulance from the Waterfront Club was timed at 02.37 and arrived at Hull Royal Infirmary (HRI) at 02.44.¹²⁷ Checks were later made with the ambulance authority. The ambulance dispatcher on duty at the time

¹²⁶ Humberside Communications Room transcript CA008 [00080041]

¹²⁷ Stephen Krebs statement (4 April 1998) CA007 p.16 [00070017], and Victoria Drennan statement (4 April 1998) CA007 p.29 [00070030]

was named Samantha Adams,¹²⁸ and the call taker was Patricia Wheatcroft.¹²⁹ Ms Adams and Ms Wheatcroft made statements based upon their computerised records, which confirmed that the initial call was received via the police at 02.23; the ambulance was mobilised at 02.26, after a momentary misdirection being entered and corrected. The confirmation of arrival at the scene was given as 02.29. The same system recorded the ambulance departing the Waterfront Club at 02.37 and arriving at HRI at 02.44. The accuracy of the clock on the computer system used by the ambulance service is checked daily against the British Telecom speaking clock. There is no reason to believe that it was inaccurate on that day.¹³⁰

3.163 HRI had no CCTV or video surveillance equipment that covered the Accident and Emergency (A&E) Department in April 1998, nor was any of the outside area of the hospital covered in the section where ambulances would have parked. Accordingly there is no filmed record of the events surrounding Mr Alder's arrival at the hospital, nor of his time spent there or his departure.¹³¹ There is a computer record for his arrival retained by the Patient Records and Management System (PRAMS), which was entered by an HRI staff member, Carole Walker. That shows his records being started at 02.45.¹³²

3.164 On arrival at the hospital, Mr Krebs described having taken Mr Alder, on a trolley, from the ambulance and into the reception area of the A&E Department.¹³³ With some persuasion Mr Alder agreed to being moved onto another trolley, and was taken into an examination room by a porter. He was saying:

“Where am I?” and, “What’s happened?”

to Mr Krebs as he did this, but seemed calm other than that. The porter was David Frankland,¹³⁴ who agreed that Mr Alder moved himself from one trolley to the other, but said of him that he:

“appeared confused and dazed. He was moaning about a mouth injury and being generally abusive saying things like, ‘Get my fucking lip sorted out’.”

3.165 From the point at which Mr Alder removed his sweater outside the nightclub, no witness described him putting it back on at the scene, nor do the ambulance crew describe him replacing it. Mr Frankland also recalled that Mr Alder was bare-chested upon arrival at the hospital,

¹²⁸ Samantha Adams statement (7 April 1998) CA0095 p.120 [00950121]

¹²⁹ Patricia Wheatcroft statement (7 April 1998) CA0095 p.323 [00950324]

¹³⁰ Victoria Barker statement (23 April 1998) CA0095 p.138 [00950139]

¹³¹ Michael Prince statement (6 January 2000) CA0089 p.946 [00890013]

¹³² PRAMS record at CA008 [00080027]

¹³³ Stephen Krebs statement (supra) at p.16 [00070017]

¹³⁴ David Frankland statement (8 April 1998) CA007 p.36 [00070037]

but there was a sweater with him that was on the trolley, and which fell off at some stage. This sweater was later retrieved by Nurse Helen Townend,¹³⁵ and handed to Mr Alder before he left the hospital. However, Nurse Jacqueline Smith,¹³⁶ who was the first medical person who dealt with him, said that:

“He was wearing a crew necked long sleeved woollen jumper...He was fully dressed upon admittance.”

3.166 She went on to say that the aim was to remove his clothes, but that he was uncooperative and that she only managed to remove his sweater as he sat up.

3.167 The clerical officer who was on duty as receptionist at the HRI was Carole Walker.¹³⁷ It was she who recorded his arrival at hospital (on the PRAMS) as being 02.45, which reflects almost exactly the ambulance service record. Because Mr Alder was admitted by the ambulance crew, he was taken directly to the examination area and his details were passed to Ms Walker by the crew. The details passed on amounted to nothing more than his name, and that he had been the victim of an assault outside the nightclub. Ms Walker had no direct dealings with Mr Alder, although she could overhear him shouting:

“Fuck off”,

from the cubicle where he was being examined. Nurse Smith had met the crew at the door of the department, and it was she who accompanied Mr Alder into cubicle number 8 in the medical bay. A map of the internal layout of the department, as it was then, is attached at Appendix 14.

3.168 Nurse Smith confirmed that Mr Alder was swearing:

“He was staring about as if confused. He was continually saying, ‘Fucking bastards, fucking bastards’ and generally cursing and swearing. He kept asking ‘Where am I, what am I doing’.”

3.169 Nurse Smith provided him with a bowl, as he was spitting blood and saliva onto the floor of the cubicle, but he proceeded to throw the bowl onto the floor, and spat and swore at her, saying:

“Fuck off you silly cow”.

3.170 The bowl was given back to him, but he threw it at Nurse Smith and continued to swear at her. Nurse Townend, her supervisor, intervened and Nurse Smith withdrew.

¹³⁵ Helen Townend statement (5 April 1998) CA007 p.64 [00070065]

¹³⁶ Jacqueline Smith statement (8 April 1998) CA007 p.43 [00070044]

¹³⁷ Carole Walker statement (4 April 1998) CA007 p.40 [00070041]

3.171 The senior registered nurse Helen Townend was the nurse in charge that night, being the most senior nurse on duty. She took over responsibility from Nurse Smith, and tried to explain to Mr Alder that he had been involved in an assault.¹³⁸ He continued to spit onto the floor of the cubicle, and to be abusive, despite her best efforts to assist him. She recalled that he referred to an earlier shoulder injury, as he pointed to his right shoulder and said:

“I can’t believe this shit has happened again, it happened five years ago, all this shit again”.

(The available records suggest that Mr Alder had last dislocated his right shoulder in 1991.)

3.172 Mr Alder was consistently resistant to attempts to help him and referred to his head hurting and being tired. Nurse Townend did, however, succeed in taking his blood pressure and in determining that his eyes were equally reacting to light. She completed a neurological assessment chart, and assessed his Glasgow Coma Score as being 14.

3.173 The Glasgow Coma Score (GCS) is scored between 3 and 15, 3 being the worst and 15 the best. It is composed of three parameters: Best Eye Response, Best Verbal Response and Best Motor Response. Each category is marked as follows:

Best Eye Response (maximum possible score 4):

1. No eye opening
2. Eye opening to pain
3. Eye opening to verbal command
4. Eyes open spontaneously

Best Verbal Response (maximum possible score 5):

1. No verbal response
2. Incomprehensible sounds
3. Inappropriate words
4. Confused
5. Orientated

Best Motor Response (maximum possible score 6):

1. No motor response
2. Extension to pain
3. Flexion to pain
4. Withdrawal from pain
5. Localising pain
6. Obeys commands

¹³⁸ Helen Townend statement (5 April 1998) CA007 p.57 [00070058]

- 3.174 Because it is made up of different parameters, a phrase such as “GCS of 11” is essentially meaningless, and it is important to break the figure down into its components, such as E3V3M5 = GCS 11. A score of 13 or 14 correlates with a mild brain injury, 9 to 12 is a moderate injury and 8 or less a severe brain injury.¹³⁹
- 3.175 In the case of Mr Alder, the only deficiency detected by Nurse Townend was that he was confused in his verbal responses, hence the score of 14 rather than 15.
- 3.176 Two police officers were present in the A&E Department at the time of Mr Alder’s arrival, involved in other duties and therefore unaware of the circumstances leading to his transfer to the department. These officers were PC Danielle Rogers and PC Ian Goode. Nurse Townend recalled that it was Ms Drennan who offered to call those officers over when Mr Alder was being difficult;¹⁴⁰ Ms Drennan did recall asking PC Rogers to assist,¹⁴¹ and PC Rogers confirmed that she was approached by Ms Drennan.¹⁴² The two officers later made statements, in which they described how they had spoken to Mr Alder when he was spitting on to the floor and requested that he cooperate with Nurse Townend.¹⁴³ He became calmer, and the two officers then withdrew as Nurse Townend was cleaning his mouth wound. They recalled him being confused and complaining of feeling tired.
- 3.177 A hospital security guard, Malcolm Rodgers, also intervened, at the request of Nurse Townend, and stood in the cubicle for a while. He attempted to engage Mr Alder in conversation and to build some rapport with him.¹⁴⁴ He recalled that Nurse Townend was being calm and professional, but that Mr Alder was being deliberately rude and insulting to her, using expressions like:
- “Fuck off, you silly old cow”,
- and continuing to spit on the floor of the cubicle.
- 3.178 At some stage, Dr Aamer Khan, the locum senior house officer, who was on duty that night, also entered the treatment area.¹⁴⁵ Mr Rodgers was also present when Dr Khan arrived and attempted to examine Mr Alder. The doctor was met with the same level of abuse and antagonism that Mr Alder had shown to the nursing staff, and his

¹³⁹ Information sourced from Teasdale G, Jennett B, *Lancet* (ii) 81–3, 1974

¹⁴⁰ Helen Townend statement (5 April 1998) p.58 [00070059]

¹⁴¹ Victoria Drennan statement (4 April 1998) CA007 p.30 [00070031]

¹⁴² Danielle Rogers statement (1 April 1998) p.84 [00070085]

¹⁴³ Danielle Rogers statement and Ian Goode statement (both 1 April 1998) CA007 pp.84 & 87 [00070085 & 00070088]

¹⁴⁴ Malcolm Rodgers statement (16 April 1998) CA007 p.91 [00070092]

¹⁴⁵ Aamer Khan statement (3 April 1998) CA007 p.72 [00070073]

patient continued to spit blood out, some of which struck the doctor's clothing.

Arrival of the police at the hospital

- 3.179 While Mr Rodgers was present the two officers from the Waterfront Club arrived to speak with Mr Alder. In their statements, PC Dawson¹⁴⁶ and PC Blakey¹⁴⁷ both recorded their arrival at the hospital as being at about 03.05, and therefore about 20 minutes later than Mr Alder. (PC Dawson also made a record of the time of arrival in his notebook.¹⁴⁸) Carole Walker commented that she thought the police arrived only ten minutes after Mr Alder, at 02.55, when she made a statement a few days later.¹⁴⁹
- 3.180 If A/PS Ellerington was correct as to his arrival time at the Waterfront Club (02.50), after which all three officers watched the tape and walked around the area checking for evidence, and then two of them drove to the hospital (which took the ambulance seven minutes), it is very unlikely that the two men would have reached the hospital before 03.05. On arrival at the A&E Department, they seem to have been admitted to the area where Mr Alder was due to receive treatment, in cubicle 8.
- 3.181 Given the nature of the events during the course of the evening, there is some confusion as to the precise order of events. Both Mr Rodgers¹⁵⁰ and Dr Khan¹⁵¹ recalled that the two officers arrived shortly before Dr Khan came in. Nurse Townend¹⁵² and Nurse Pam Merrills thought that Dr Khan had joined her before the police arrived, although Nurse Merrills¹⁵³ was not in the room at the time. It is, however, possible that confusion may have arisen as to which pair of officers was present, as PC Goode and PC Rogers were with Mr Alder and had left before PC Dawson and PC Blakey arrived.
- 3.182 Dr Khan does describe his examination of Mr Alder, which necessitated some persuasion on the doctor's part.¹⁵⁴ He then went to order an X-ray of Mr Alder; to do this he had to walk a few yards away and electronically enter the request. PRAMS records this request as being made at 03.06.¹⁵⁵ Given the seeming accuracy of his arrival time, as

¹⁴⁶ PC Dawson statement (1 April 1998) CA008 [00080155]

¹⁴⁷ PC Blakey statement (1 April 1998) CA008 [00080175]

¹⁴⁸ PC Dawson notebook CA008 [00080215]

¹⁴⁹ Carole Walker statement (4 April 1998) CA007 p.41 [00070042]

¹⁵⁰ Malcolm Rodgers statement (supra) at p.92 [00070093]

¹⁵¹ Aamer Khan statement (supra) at p.72 [00070073]

¹⁵² Helen Townend statement (5 April 1998) CA007 p.61 [00070062]

¹⁵³ Pam Merrills statement (9 April 1998) CA007 p.50 [00070051]

¹⁵⁴ Aamer Khan statement (supra) at p.73 et seq. [00070074]

¹⁵⁵ PRAMS document CA008 [00080027]

recorded on PRAMS, there seems no good basis to doubt the accuracy of the timing of the doctor's request, which is marked as being by "Locum". If so, and if the police officers are reasonably accurate as to their 03.05 arrival time at hospital, then Dr Khan was almost certainly dealing with Mr Alder prior to the arrival of PCs Dawson and Blakey.

3.183 PC Dawson, in his initial statement, described how he had spoken to the nurse treating Mr Alder, who told him that the patient was uncooperative and had taken a dislike to her.¹⁵⁶ PC Dawson also saw Mr Rodgers, who was trying to calm Mr Alder down. Mr Rodgers recalled that the officers attempted to engage him in conversation and he remembered that the slimmer of the two (PC Blakey was noticeably slimmer than PC Dawson at the time) asked Mr Alder whether he had a brother called Richard.¹⁵⁷ Mr Rodgers altered this evidence slightly at the inquest:¹⁵⁸

Q. The point is that you say one of the police officers asked Christopher Alder if he had a brother called Richard?

A. That's correct.

Q. And am I to...

A. No, he didn't ask him if he had a brother called Richard. He said, "Have you got a brother?", and it was Chris that said, "Yes, it's Richard".

3.184 He then clarified the matter in later questioning by Mr Thomas, the Alder family barrister:¹⁵⁹

Q. It is completely different, because on the one hand the officer, on the interpretation of your statement, knew Christopher and recognised Christopher as having a brother called Richard. That is how your statement reads. On the other hand, the second way you gave your evidence, it may be suggested the officer was just asking Christopher: "Do you have a brother?", not knowing that Christopher had a brother and Christopher has volunteered the information: "Yes, I've got a brother called Richard." I want to ask you for clarity which version is the correct one on your account?

A. This one that I've put down here. He said: "Have you a brother called Richard?" The patient's answered: "Yes, I have."

Q. So, Richard came from the officer?

A. Yes.

¹⁵⁶ PC Dawson statement (1 April 1998) CA0029 p.5 [00290007]

¹⁵⁷ Malcolm Rodgers statement (16 April 1998) CA007 p.92 [00070093]

¹⁵⁸ Inquest, Day 24, p.69.

¹⁵⁹ Inquest Day 24, p.77

- 3.185 The question, of itself, may have been no more than an attempt to form a rapport with Mr Alder and to win his cooperation. However, PC Blakey makes no comment about this question in his statement, and has never given any explanation as to how he knew this fact about Mr Alder. The fact that Mr Alder does have a brother named Richard makes it highly unlikely that Mr Rodgers imagined or misunderstood the question.
- 3.186 It would therefore appear that PC Blakey was aware of some details of Mr Alder's family; this may be because of some personal contact, or because the little information he already had was sufficient to enable him to carry out some form of check upon Mr Alder prior to his arrival at hospital. Given that Mr Alder was, and remained, the victim of a possible crime, the need for such a check, if it were done, would be questionable. This is an issue that calls for an explanation from PC Blakey.
- 3.187 In the absence of any such explanation from the officer, the most likely interpretation to be placed upon this comes from the discovery that PC Blakey attended the same school as Christopher and Richard Alder. This emerged in a letter from solicitors representing Richard Alder, sent in January 2000 to the Crown Prosecution Service (CPS).¹⁶⁰ It was the conclusion of those solicitors, a reasonable one in the circumstances, that PC Blakey knew the family and had done so for some considerable time. Richard Alder (born August 1959) and PC Blakey (born July 1959) may well have been in the same year at school. Christopher Alder, born the following year, is likely to have been in the year beneath.
- 3.188 PC Dawson's¹⁶¹ description was that the first question that he asked Mr Alder was in fact:

"Is there anything you can tell me about the assault?"

to which he received the reply:

"I can't remember nothing".

- 3.189 PC Blakey, who would have made his statement in conjunction with his colleague, described precisely the same exchange.¹⁶² Mr Rodgers recalled that both the nursing staff and the police were seeking details from Mr Alder, asking for his address and date of birth. He was not forthcoming with those details.

¹⁶⁰ Stamp Jackson Procter letter (6 January 2000) CA0098 [00980035]

¹⁶¹ PC Dawson statement (1 April 1998) CA008 p.7 [00080157]

¹⁶² PC Blakey statement (1 April 1998) CA008 p.6 [00080176]

- 3.190 A concerted attempt to properly examine Mr Alder was made by the doctor and nurse, with Mr Rodgers¹⁶³ holding Mr Alder's arms:

"in a gentle restraint in front of him".

This enabled Nurse Townend to take the patient's blood pressure and test his level of alcohol, by means of an alcohol test machine, into which he blew. Mr Rodgers¹⁶⁴ observed that his:

"behaviour was very strange and swang from one extreme to another within seconds. He would momentarily speak normally and appear to calm down then suddenly within seconds his mood would change and he was once again being extremely abusive and aggressive."

The closest Mr Alder came to providing his own details was saying that he lived near the Waterfront Club.

- 3.191 The police officers were almost certainly present at the time when the Alcometer test for alcohol consumed by Mr Alder was performed, as PC Dawson describes the test taking place. The officer recalled that he saw a reading of 82; the officer asked whether the test was the same as that employed by the police, and the nurse confirmed that it was. PC Dawson observed, correctly, that this reading was the equivalent of approximately twice the legal driving limit. He expressed surprise at the reading, which he had expected to be higher.¹⁶⁵

- 3.192 There was some confusion over this test, in that Nurse Townend¹⁶⁶ said:

"Chris Alder initially just breathed into the device so I reset the machine and explained that a good breath with one blow was required. Chris inhaled and gave one decent blow sufficient to provide a reading. In view of his mouth injury it was the best that could be expelled in the circumstances. The reading displayed is converted into a blood alcohol reading, which I recorded as one hundred and ninety. I believe the Alcotest machines are calibrated regularly. I think that one of the police officers witnessed the reading obtained".

- 3.193 When questioned about this by the coroner at the inquest,¹⁶⁷ Nurse Townend explained:

Q. You get a display on the machine, is that right?

¹⁶³ Malcolm Rodgers statement (16 April 1998) CA007 p.93 [00070094]

¹⁶⁴ Malcolm Rodgers statement (supra) p.93 [00070094]

¹⁶⁵ PC Dawson statement (1 April 1998) CA008 p.6 [00080156]

¹⁶⁶ Helen Townend statement (5 April 1998) CA007 p.61 [00070062]

¹⁶⁷ Inquest Day 7, pp.8-9

- A. That's right.
- Q. And that gave a blood alcohol reading of 190, is that right?
- A. It gives a breath alcohol reading of .83 to begin with and then we convert it over on a form that we have in the department.
- Q. It first gives the breath reading?
- A. The breath.
- Q. Is that in microgrammes?
- A. Yes.
- Q. That was what, I am sorry?
- A. That was 83.
- Q. And then that is converted to a blood reading of 190?
- A. That's correct.

3.194 This would explain why PC Dawson saw the reading as 82, and yet Nurse Townend recalls 190: the readout did give the breath figure of .83 (rather than "82") but she converted that figure to the equivalent blood alcohol figure of 190. Both figures represent the same level of intoxication, and are roughly double the legal limit for driving.

3.195 Nurse Townend described the injuries to Mr Alder's mouth¹⁶⁸ as follows:

"he had a laceration to his upper lip which required stitching. The cut had gone beyond his actual lip into the border of skin above the lips. One of his upper teeth was missing a further upper tooth adjacent to the missing one was pushed into the mouth cavity at an angle of 10 to 15 degrees. There was a lot of blood around the mouth and gums."

3.196 Nurse Smith¹⁶⁹ had briefly examined Mr Alder, despite his resistance, and had said that:

"it was obvious he had sustained a mouth injury, as there was a laceration [sic] to his upper lip, an upper tooth missing and an adjacent tooth slightly pushed into his mouth area".

3.197 Doctor Khan¹⁷⁰ said that:

"Examination of his mouth (oral cavity) was difficult due to his demeanour and as far as I could ascertain the front left canine

¹⁶⁸ Helen Townend statement (5 April 1998) CA007 p.58 [00070059]

¹⁶⁹ Jacqueline Smith statement (8 April 1998) CA007 p.44 [00070045]

¹⁷⁰ Amer Khan statement (3 April 1998) CA007 p.76 [00070077]

tooth was knocked out and the tooth adjacent to it upon the left upper side was pushed into the mouth some 10 degrees from normal. There was minimal bleeding from the tooth that was knocked out.”

3.198 Even PC Rogers,¹⁷¹ who dealt briefly with Mr Alder, said that when she saw him:

“he had a cut to his upper lip and was bleeding and also had a tooth missing”.

3.199 Accordingly, each of the three medical professionals who examined Mr Alder while he was in the A&E Department commented upon the loss of one tooth and the weakening of the second. The same injuries were seen by PC Rogers. None noticed a second cut on his inside lower lip, which was clearly present when his body was subsequently examined, despite the examination of his mouth at close quarters, particularly by Dr Khan and Nurse Townend.

3.200 The two officers state that they had decided that Mr Alder was not in a fit state to assist them, and PC Dawson wrote out a note for Mr Alder, providing a log number for the incident in which he had been the victim, in case Mr Alder wished to make a complaint at a later stage. This piece of paper, they both said, was handed to the guard, Mr Rodgers, to pass on to the patient.¹⁷² Nurse Townend also recalled that the two officers had wished to give a reference number to the patient.¹⁷³ However, Mr Rodgers did not mention this paper in his statement, and when asked about it in inquest¹⁷⁴ he said:

A. Definitely not. This is the first time I've ever seen that paper. Definitely I was not handed anything when he climbed into the van, nothing at all.

3.201 The actual note was recovered by Detective Constable Stephens on the morning of 1 April 1998. It had been stored with other hospital documentation in a file that was handed over by Alan Harper, the general manager of Trauma Services.¹⁷⁵ The documents were handed to him by his secretary, Victoria Frost,¹⁷⁶ who had received them from the senior charge nurse, Lesley Whittaker.¹⁷⁷ The fact that the note was in the file, and contained the correct police log number, suggests that it must have been left by the police while they were at the hospital and filed following the departure of Mr Alder.

¹⁷¹ PC Rogers statement (1 April 1998) CA007 p.84 [00070085]

¹⁷² Note at CA0039 [00390003]

¹⁷³ Helen Townend statement (5 April 1998) CA007 p.61 [00070062]

¹⁷⁴ Inquest Day 24, p.55

¹⁷⁵ Alan Harper statement (1 April 1998) [00800716-7]

¹⁷⁶ Victoria Frost statement (22 April 1998) [00800751]

¹⁷⁷ Lesley Whittaker statement (22 April 1998) [0080761-2]

3.202 At about 03.19 the Humberside Communications Room recorded a message from the two officers which was later transcribed as follows:

0319 Comms 18 go ahead. Over.

FRI 8 We're presently still at the HRI. Our complainant is being a wee bit troublesome. Probably the reason why he got smacked in the first place. Over.

Comms Roger.

It is not evident from this message which of the two officers was using the radio, although PC Dawson was later to use the same radio when calling for an ambulance to the police station.

3.203 Nurse Townend¹⁷⁸ remembered also that the patient had continued to spit on the floor after the police officers arrived, and that he said to the police:

“You wipe it up”,

to which one officer said:

“No mate, just behave yourself, just use the bowl”.

Mr Alder said again:

“You wipe it up, you're there”.

3.204 Dr Khan had booked an X-ray for Mr Alder at 03.06 and returned to the examination area. When he did so, he found Mr Alder sitting on the floor, having climbed off the trolley, and attempting to pull his sweater back on.¹⁷⁹ After some persuasion he got back on to the trolley, but was heard saying:

“I'm alright, I don't wanna stay, I fucking wanna go home”.

3.205 PC Dawson described the same event, saying that he had seen Mr Alder getting off the trolley, despite requests not to. He said that, once off the trolley, Mr Alder was unable to support himself and he collapsed in a heap on the floor.¹⁸⁰ PC Blakey described the same incident, and both officers agreed they had put on some rubber gloves before lifting Mr Alder back onto the trolley.¹⁸¹

¹⁷⁸ Helen Townend statement (supra) p.62 [00070063]

¹⁷⁹ Aamer Khan statement (supra) p.77 [00070078]

¹⁸⁰ PC Dawson statement (1 April 1998) CA008 p.8 [00080158]

¹⁸¹ PC Blakey statement (1 April 1998) CA008 p.7 [00080177]

Attempt to X-ray Mr Alder

3.206 Mr Rodgers described how Dr Khan and Nurse Townend wanted Mr Alder to be given an X-ray, and because the department was fairly quiet, and because of the uncooperative behaviour of Mr Alder, they pushed his trolley to the department themselves. The officers and Mr Rodgers followed the trolley to the department and waited nearby. Mr Rodgers recollection was that Mr Alder had taken himself off the trolley in the corridor,¹⁸² while en route to the X-ray department, rather than in the examination area, but the evidence of Dr Khan and the two police officers points to the incident occurring in the examination area.

3.207 PC Dawson made a note in his pocket notebook concerning the behaviour of Mr Alder. The note was made, according to his explanation in interview,¹⁸³ at the time that Mr Alder was being wheeled to the X-ray Department. He told Supt Holt that he made the note:

“At that time in front of PC Blakey and the Porter”.

The note stated that:

“Male is heavily in drink”,

and described his injuries.¹⁸⁴ The note goes on to record the handing of the log number to staff and to express the view that:

“Alder in my opinion is very up and down one second aggressive [sic] next quite [sic], typical of people I’ve seen in the past on amphetamine”.

3.208 This view is mentioned in PC Dawson’s statement¹⁸⁵ and is also referred to by PC Blakey in his statement.¹⁸⁶ Both expressed the view that:

“something other than alcohol”

had been taken. Mr Rodgers does not mention any conversation about drugs in his statement.

3.209 Upon arrival at the X-ray Department, Mr Alder was wheeled, on the trolley, into the department. The radiographer on duty at the time was named Beverley Tweed.¹⁸⁷ Ms Tweed recalled having been asked to assist with an X-ray of a patient by a doctor, whom she did not know by

¹⁸² Malcolm Rodgers statement (16 April 1998) CA007 pp.93–4 [00070094–5]

¹⁸³ PC Dawson interview (13 May 1998) CA0010 p.10 [00100013]

¹⁸⁴ PC Dawson note CA008 [00080215]

¹⁸⁵ PC Dawson statement (1 April 1998) CA008 p.9 [00080159]

¹⁸⁶ PC Blakey statement (1 April 1998) CA008 p.8 [00080178]

¹⁸⁷ Beverley Tweed statement (9 April 1998) CA007 p.101 [00070102]

name. The request came at about 03.15, and the doctor indicated that he thought she would need assistance with the patient, so he put on a protective apron.

- 3.210 Ms Tweed described how Mr Alder was lying on his side on the trolley that was wheeled in. Although asked repeatedly to cooperate, by lying still and in the correct position for the X-ray, Mr Alder refused to do so, and swore constantly at the staff. At one point, Mr Alder having moved onto his back, Ms Tweed thought she might be able to take an X-ray, whereupon the patient moved deliberately onto his front, thereby frustrating her efforts. Ms Tweed was left in no doubt that Mr Alder was purposely obstructing her efforts to perform the procedure.
- 3.211 Eventually Mr Alder raised himself up and squatted on the trolley, waving his arms around, and spat both on the trolley and at the doctor. Again, Ms Tweed was left in little doubt, from her observations, that these were deliberate actions on the part of Mr Alder. Ms Tweed said in her statement that she felt threatened by the behaviour of Mr Alder, although in her interview with the HCC she denied that this was the case.¹⁸⁸ In any event she concluded that the exercise that she was attempting was pointless.
- 3.212 She described a short conversation with the doctor, in which she suggested that the patient should come back later. She recalled that Dr Khan had said to her that Mr Alder was being too aggressive to be put into the short stay ward, and that he would probably leave with the police.
- 3.213 Ms Tweed said that at this stage Mr Alder announced that he wanted to use the toilet;¹⁸⁹ when told he would be taken back to the A&E Department he got off the trolley, and refused requests to get back on the trolley:

“Mr ALDER just sat down on the floor and began to undo his trouser zip. (The patient was bare chested)”.

- 3.214 Ms Tweed did not mention anything else about his trousers, or whether he was wearing a belt. She did not see whether he later refastened them. Dr Clark in the post mortem commented upon Mr Alder’s trousers having buttons, implying that they did not have a zip.¹⁹⁰
- 3.215 Nurse Townend went to fetch a urine bottle.¹⁹¹ At this stage Ms Tweed recalled the two police officers entering the X-ray area.¹⁹² Mr Alder was

¹⁸⁸ Beverley Tweed interview (9 March 2005) p.2

¹⁸⁹ Beverley Tweed statement (9 April 1998) CA007 p.106 [00070107]

¹⁹⁰ Dr Clark report (27 May 1998) CA007 pp.139 [00070140]

¹⁹¹ Helen Townend statement (5 April 1998) CA007 p.63 [00070064]

¹⁹² Beverley Tweed statement (supra) p.107 [00070108]

on his feet by this stage, and she related how the doctor told the police that Mr Alder would have to go back to A&E.

3.216 Ms Tweed said that one of the policemen said they were concerned that they might have to take him away without knowing whether or not he had a fractured skull.¹⁹³ In response to this Dr Khan had said that he did not think Mr Alder did have a fracture of the skull, although he obviously did have a haematoma to the back of the head.

3.217 PC Dawson¹⁹⁴ described the conversation as being a comment by Dr Khan:

“There’s nothing we can do for him now, he’s going to have to go with you”,

to which the officer replied:

“Is he really in a condition suitable to be kept in police custody?”

3.218 PC Dawson said the doctor told him:

“Well it looks like it’s a simple haematoma.”

PC Dawson says that he commented:

“The custody sergeant isn’t going to be happy with his condition”,

and the doctor then said:

“It’s a simple haematoma, if we can’t X-ray him there is nothing further we can do.”

3.219 Dr Khan had not referred to this conversation in his initial statement, but when seen again by Inspector Keith Tolan of West Yorkshire Police he said:¹⁹⁵

“I recall one of the Police Officers asking me if Mr Alder was fit to be detained in police custody and also some reference to a ‘Sergeant’. I cannot recall specifically what was said to me or how I replied. There was a brief discussion during which I intimated that Mr Alder was fit to be with the police. I gave Mr Alder verbal advice that he should return if he felt unwell.”

3.220 Nurse Townend¹⁹⁶ was also seen by West Yorkshire Police, and added the comment that at some stage the police asked herself and Dr Khan:

¹⁹³ Beverley Tweed statement (supra) p.107 [00070108]

¹⁹⁴ PC Dawson statement (1 April 1998) CA008 p.10 [00080160]

¹⁹⁵ Amer Khan statement (6 April 1998) CA007 p.83 [00070084]

“Are you happy for us to take him to the cells?”

3.221 Mr Alder then walked out of the department with the officers, and Ms Tweed did not see him again, although she did hear some shouting.

3.222 After he exited the X-ray Department, the officers described having followed him. PC Dawson saw him lying on the floor in the corridor; the two policemen later said that they picked him up as he was complaining that he wanted to go to the lavatory. They told him that they would take him to the toilet. They described Mr Alder as being a:

“dead weight, having no support”,

as they carried him by his arms. However, PC Dawson¹⁹⁷ said that within a few moments:

“Alder stood upright fully supporting himself and shrugged me away from his support and then pointed at me and said ‘I can have you, you I can have any time.’”

3.223 PC Dawson’s response to this was to say:

“If you’re going to threaten me and be aggressive, I warn you that I will use CS gas to restrain you.”

3.224 Mr Alder responded:

“Wait till the papers hear what you’ve just said.”

He then started to collapse again, and had to be held by the officers.

3.225 Mr Alder was seen by Nurse Townend, who returned with a plastic urine bottle. She saw him in the corridor with the two officers, and then saw him sitting down on the ground. Nurse Townend heard them say that they would take Mr Alder to the lavatory, and she led the way. She described¹⁹⁸ Mr Alder being:

“totally uncooperative with the police, constantly swearing and struggling with them physically to such a point where I heard one of the officers say something like, ‘Calm down, one more time and we’ll gas you’”.

3.226 The policy for use of CS spray by officers in Humberside Police is quoted in the training manual used by the force:¹⁹⁹

¹⁹⁶ Helen Townend statement (30 April 1998) CA007 p.67 [00070068]

¹⁹⁷ PC Dawson statement (1 April 1998) CA008 p.11 [00080161]

¹⁹⁸ Helen Townend statement (5 April 1998) CA007 pp.63–4 [00070064–5]

¹⁹⁹ Aerosol Incapacitants Instructors’ Manual [01260032]

“Aerosol Incapacitants may be used as a response option when an officer finds it necessary to defend him/herself or others or effect arrest or prevent the commission of an offence when lower levels of force have been ineffective or the officer considers lower levels of force would be ineffective or inappropriate in the circumstances.”

3.227 The training manual makes no reference to the use of spray in air-conditioned buildings, or the likelihood of widespread dispersal of the incapacitant as a result of that. Nurse Townend was adamant, in discussion with the HCC, that if the officers had attempted to use CS spray, she would have intervened to stop them.

3.228 The officers then took Mr Alder through to a toilet pointed out to them by Nurse Townend. PC Dawson²⁰⁰ described how he had held the door open, whereupon Mr Alder walked into the toilet area, turned and said:

“You can’t gas me”,

to which the officer said:

“Look, just use the toilet, that’s what you wanted.”

3.229 PC Dawson also recalled that he had waited for Mr Alder in the doorway of the toilet area, when he heard the sound of splashing, and realised that Mr Alder was urinating on the floor. The officer saw Mr Alder open the door of the cubicle, saying:

“I’m the one who’s been assaulted.”

As he said this he was still urinating on the floor. PC Dawson said to him:

“You’re pissing all over the floor, stop it.”

Mr Alder replied:

“So fucking what”,

and the officer said:

“Fine”,

and pulled the door to, in order to avoid being urinated on. He could still hear the splashing for several seconds inside the toilet area.

²⁰⁰ PC Dawson statement (1 April 1998) CA008 p.12 [00080162]

3.230 When he emerged from the toilet, PC Dawson related how Mr Alder was saying:

“I want to see them”,

which the officer took to mean the medical staff.²⁰¹ PC Dawson told him:

“They do not want to treat you whilst you’re behaving this way.”

Mr Alder responded:

“It’s not up to you, I want to speak to them.”

3.231 PC Dawson spoke to Nurse Townend, who was nearby, and said:

“Would you like to tell him what’s happening?”

She said, as he recalled:

“We cannot do any more for you whilst you are behaving as you are. When you’ve settled down you can come back and we’ll have a look at your mouth and tooth.”

Mr Alder insisted:

“I want to see the other bloke.”

3.232 PC Dawson said to him:

“That’s it mate, you’ve blown all your chances, you’ve got to leave they can’t do any more for you”,

and despite Mr Alder saying:

“I’m staying”,

he was taken out of the hospital by the two policemen. PC Blakey, in his statement made at the same time as PC Dawson, describes the exchange in exactly the same terms as his colleague.²⁰²

3.233 Dr Khan’s recollection was different,²⁰³ in that he said that he had gone to the door of the toilet and saw Mr Alder urinating on the floor and heard him threatening the officers, saying he would:

“take them on”.

²⁰¹ PC Dawson statement (1 April 1998) CA008 p.13 [00080163]

²⁰² PC Blakey statement (1 April 1998) CA008 p.12 [00080182]

²⁰³ Amer Khan statement (3 April 1998) CA007 p.79 [00070080]

3.234 He thought that it was at this stage that the officers threatened use of CS spray. Dr Khan made a final plea for Mr Alder to cooperate, but said that the response he received was Mr Alder approaching him in an aggressive fashion, saying:

“words similar to, ‘Fuck off you, I don’t need your help’”,

while pointing his finger in the doctor’s face. Dr Khan said that Mr Alder was restrained by the police and it was at that point the doctor told him:²⁰⁴

“We are willing to help you, but you’re not co-operating, so you’re going to be taken away by the police, but when you’re in a better state come back and we will willingly treat your injuries.”

3.235 Nurse Townend recalled that Mr Alder was saying to the officers:²⁰⁵

“Come on mate, let’s have a go at you.”

3.236 She said of the situation that:

“the police said they were taking the patient to police cells”,

and that Mr Alder was on the floor:

“struggling to be restrained by the police”.

3.237 She did not describe the conversation set out by the two officers, nor did she recall saying to Mr Alder that they would not treat him, although she thought that Dr Khan had said that.

3.238 Paradoxically, the officers’ description of the conversation suggests that once he emerged from the toilet, Mr Alder wanted to speak to the doctor and was saying that the police could not stop him; this evidence also suggests that Dr Khan was not present at that moment, as Mr Alder was saying that he wanted to speak to him. The medical staff, both Nurse Townend and Dr Khan, say that Dr Khan **was** present, and asking to treat Mr Alder, who was being abusive and continuing to resist.

3.239 The issue of the handover from the medical staff to the police and the misunderstandings on the part of the doctors and nurses is covered in the report prepared by the HCC, and is explained in the Executive Summary of that report at Appendix 8.

²⁰⁴ Aamer Khan statement (3 April 1998) CA007 p.80 [00070081]

²⁰⁵ Helen Townend statement (5 April 1998) CA007 p.64 [00070065]

Removal of Mr Alder from hospital

3.240 Nurse Townend also recalled that when Mr Alder realised he was being taken away, he had said that he wanted his sweater, and that she went to get it. When she gave it to him, he put it on. Dr Khan also remembered her retrieving the sweater, and that Mr Alder was struggling with the police. Mr Rodgers thought that he had not been given back his sweater until after he was removed from the building, and Carole Walker thought that he was still bare-chested when he was escorted from the building.²⁰⁶

3.241 There is a clear divergence between the police and the hospital staff as to the method of removal of Mr Alder from the hospital. Dr Khan²⁰⁷ said that:

“He would not allow the officers to walk him normally, by resisting and slumping, the police had to drag him backwards bodily out of the building.”

3.242 Nurse Townend²⁰⁸ saw him:

“dragged backwards by his arms with his legs trailing and his buttocks close to the floor”.

3.243 Mr Rodgers²⁰⁹ recalled him:

“resisting the officers’ attempts to restrain him. He was eventually dragged out of the doors backwards with his buttocks close to the floor surface.”

3.244 Even Nurse Smith,²¹⁰ who had handed over to Nurse Townend, happened to see him leaving:

“being dragged backwards by two male uniformed police officers. It looked like Alder was resisting by trying to sit on the floor.”

3.245 Ms Walker²¹¹ described his ejection:

“He was being bodily dragged backwards from the building with his arms above his head as he was not cooperating by attempting to sit on the floor.”

²⁰⁶ Carole Walker statement (4 April 1998) CA007 p.41 [00070042]

²⁰⁷ Amer Khan statement (supra) p.80 [00070081]

²⁰⁸ Helen Townend statement (5 April 1998) CA007 p.65 [00070066]

²⁰⁹ Malcolm Rodgers statement (16 April 1998) CA007 p.95 [00070096]

²¹⁰ Jacqueline Smith statement (8 April 1998) CA007 p.46 [00070047]

²¹¹ Carole Walker statement (supra) at p.41 [00070042]

3.246 The officers described the exit in entirely different terms. PC Dawson²¹² said:

“I took Alder’s left arm, PC Blakey took his right arm and we escorted him outside...and immediately let go of him.”

3.247 PC Blakey’s words²¹³ were almost identical:

“I then took Alder’s right arm and PC Dawson took his left arm and we escorted him outside.”

3.248 PC Dawson,²¹⁴ when interviewed by West Yorkshire Police, said that:

“without incident myself and PC Blakey escort him out...There was no force as such to escort him. It was basically with a view to him not falling and collapsing again.”

3.249 PC Dawson²¹⁵ also went on to say that:

A. “My best recollection as we escorted him down with a hand under each arm...I think PC Blakey took one arm and I took the other one and he walked with us out of the hospital.

Q. So was he facing the same direction as you were?

A. Yes.

Q. Or did you have an arm each locked and...?

A. Oh no, no, no, we weren’t dragging him, no. He went with us...He came out with us although we were, if you like dictating the direction which he left.

Q. Right.

A. No struggle or no...

3.250 PC Blakey’s interview²¹⁶ dealt with the same thing:

A. We escorted him out of the hospital. He walked out but we had a gentle hold on both arms I can remember and he just walked out of the hospital.

Q. Were you all facing the same direction as you left the hospital. I mean did you drag him out backwards, did you walk out...?

²¹² PC Dawson statement (1 April 1998) CA008 p.13 [00080163]

²¹³ PC Blakey statement (1 April 1998) CA008 p.12 [00080182]

²¹⁴ PC Dawson interview (13 May 1998) CA0010 at 1/18 [00100021]

²¹⁵ PC Dawson interview (13 May 1998) at 2/5 [00100038]

²¹⁶ PC Blakey interview (14 May 1998) CA0011 at 1/21–22 [00110024–5]

- A. The three of us yes. Myself PC Dawson either side of him, him in the middle walking in the same direction yes.
- Q. Other than – but you did have hold of him?
- A. I think we had hold of him 'cos I was a bit more concerned again that he would fall to the floor and hurt himself. It was a guiding hand as opposed to gripping somebody when they're under arrest.

3.251 Mr Rodgers was asked to clarify matters in response to questions from the Coroner when giving evidence before the inquest.²¹⁷ He said the following in response to questions:

- Q. Can you remember what chain of events happened from then to him leaving the hospital?
- A. Yes. We got him back to the trolley and he seems reasonable, and this is when Dr Khan says to him, "Are you going to let us give you some treatment? Take you for an X-ray and we'll see to you?" and he said "No you're not". So he said "The only thing I can suggest to you is you go home, come back tomorrow when you're in a better mind and not so aggressive and we'll see to you". And at this time Christopher was stood up talking as clear as I'm talking to you now. And he had a jumper with him, it was underneath the trolley and he started to walk out of the A&E Department and I was with him and as he goes back for his jumper he got funny with the two police officers. So all they did, they didn't push him or manhandle him again in any way, they just got hold of his arms and he dropped his legs on the floor so his bum was nearly on the floor and they only dragged him about 10, maybe 5 or 10 yards and then he stood up. I was still alongside of him, I said to him "Come on Chris, it's no good" so he said "Aye" and he's put his jumper on and walks out the first set of sliding doors in the A&E Department...

The belt

3.252 One issue raised by the family of Mr Alder at a later stage was whether he had been wearing a belt that evening. By the time he arrived at the police station he did not have a belt, but the question as to whether he had been in possession of one earlier in the evening remained unclear. This issue would not have been evident at the time when the initial statements were taken from the hospital witnesses, and no mention of a belt features in their statements, although there is some description of his clothing.

²¹⁷ Inquest Day 24, p.32

3.253 Dr Khan²¹⁸ described Mr Alder as:

“wearing dark coloured, loose fitting jeans. He had dark socks underneath black dress shoes with a silver coloured buckle. He was also in possession of a smart looking light blue long sleeved crew necked woollen thin sweater.”

3.254 Mr Krebs and Ms Drennan only recalled that he had “dark coloured trousers”.²¹⁹ Nurse Smith²²⁰ also remembered the dark trousers or jeans, and a:

“crew necked long sleeved woollen sweater”.

3.255 When the issue of a belt was raised at the inquest, Mr Rodgers and Dr Khan both commented upon it. Dr Khan was questioned by the Coroner and said the following:²²¹

Q. And what was he wearing?

A. No shirt on top, no vest or anything. As far as I could ascertain, black jeans, shoes – quite smart shoes – and a belt.

3.256 However, the matter was later taken up by counsel, Mr Ferm, acting on behalf of PC Dawson, and the following exchange took place:²²²

Q. In none of your statements, is this right, you refer to anything other than his jumper and his trousers?

A. Yes, that’s true.

Q. Do you have any recollection of a belt at all?

A. It’s going back two years, but – I can’t recollect for sure, but I thought he did have a belt on, but I wouldn’t like to say for sure that he did have a belt on, because I can’t remember the fact.

Q. Is this right: that at the time you did not direct your mind specifically to his clothing at all?

A. That would be right.

Q. Do you agree there is no reference to a belt in any of the three statements that you made in April and early May 1998?

²¹⁸ Aamer Khan statement (3 April 1998) CA007 p.73 [00070074]

²¹⁹ Stephen Krebs statement (4 April 1998) CA007 p.12 [00070013], and Victoria Drennan statement (4 April 1998) CA007 p.29 [00070030]

²²⁰ Jacqueline Smith statement (8 April 1998) CA007 p.43 [00070044]

²²¹ Inquest Day 8, p.7

²²² Inquest Day 8, p.65

- A. Yes. If they're not on the statements they're not there, yes.

3.257 Mr Rodgers said the following in response to questions from Mr Ferm.²²³

- Q. And you go on to describe his clothing do you not? And you say – and just look at your statement so that you can follow please and confirm what I say – “He was wearing dark coloured trousers and black shoes. He was being attended to by Nurse Helen Townend.”

A. That's correct.

- Q. And you never mention a belt anywhere in your statement?

A. No.

- Q. That's right isn't it? Thank you...

3.258 When Mr Rodgers came to give evidence before the Crown Court in the trial of 2002 his memory of a belt was rather stronger, as he volunteered that Mr Alder was wearing a belt.²²⁴ He does not appear to have been challenged on this evidence at the time. In interview with the IPCC in 2005 Mr Rodgers was “80%” sure that Mr Alder was wearing a belt.²²⁵

3.259 The only other evidence that I have been able to identify that touches upon the issue of the belt is to be found in a still photograph extracted from the Waterfront Club video, after Mr Alder was knocked to the ground. This photograph was enlarged and enhanced to achieve the clearest possible image. It is attached as Appendix 13. This shows him lying face up on the ground. Although a line can be seen along the top of his trousers, no belt buckle is apparent. It has not proven possible to enhance this picture any further, and it is the only photograph of Mr Alder that evening, prior to his arrival at the police station, that might have demonstrated whether or not he was in fact wearing a belt. The evidence remains equivocal on this point.

The arrest of Mr Alder

3.260 PC Dawson²²⁶ related how, once they were outside, Mr Alder said:

“I want to be in there,”

²²³ Inquest Day 24, p.62

²²⁴ Trial transcript, 18 April, p.49 line 3 & p.57 line 13

²²⁵ Malcolm Rodgers interview (16 May 2005)

²²⁶ PC Dawson statement (1 April 1998) CA008 p.14 [00080164]

and

“I want to see the doc.”

3.261 PC Dawson said that PC Blakey told Mr Alder that:

“They are not going to treat you, you are free to go home.”

3.262 PC Blakey describes the situation in almost precisely the same terms.²²⁷ Both agree that they were saying to Mr Alder that he had to leave the hospital grounds, while he was insisting that he wanted to re-enter the hospital.

3.263 Mr Rodgers had followed Mr Alder and the police officers out of the building, and went on to describe what he saw happen.²²⁸ He recalled a conversation between the police officer with the larger build (PC Dawson) and Mr Alder:

“[PC Dawson saying to Mr Alder] something like ‘Look you’ve refused treatment Chris and they can’t treat you whilst your like that, why do you come back [sic] later on in the day, when you’ve calmed down’. The patient Chris was stood with his back to the wall between the two sets of doors and said to me, ‘Mally, I don’t want to speak to these dick heads, I just wanna go.’”

3.264 Mr Rodgers recalled urging him simply to leave, and to return later, but that Mr Alder continued to be argumentative with the officers. When seen by West Yorkshire Police officers, Mr Rodgers further contradicted the account of the police officers, by saying that:

“I do not recall him saying that he would go back in the hospital”.

3.265 At the inquest Mr Rodgers was asked further about this aspect by the coroner, and he appeared to amend slightly what he was saying:²²⁹

Q. ...do you have any recollection of him saying that he wanted to go, that he would go back in hospital, or wanted to go back in hospital then?

A. Oh he said he would go back but he said “If I go back in them dickheads are not touching me” so I said “What are you going to gain?”

Q. What did you understand him to be saying he wanted to do?

A. Well he wanted to go back in in one breath and then the next – and I was saying “Well go back in”, he was saying

²²⁷ PC Blakey statement (1 April 1998) CA008 p.13 [00080183]

²²⁸ Malcolm Rodgers statement (16 April 1998) CA007 p.95 [00070096]

²²⁹ Inquest Day 24, p.33

“No I’m not”. He was like, he was altering from minute to minute, you know, his temperament.

3.266 The issue arose again in questions from Mr Thomas, counsel for the family, to Mr Rodgers:²³⁰

Q. You see, there came a point, did there not, Mr Rogers, that Christopher said to the police that he wanted to go back inside to the hospital or words to that effect?

A. No. I asked him to go back in. It was me that asked him. I said: “Why don’t you go back in and get seen to Chris?”

Q. At any stage did you hear Christopher use the words, and this is a summary, it might not be these exact words, saying to the police: “I want to go back inside to see the doctor”?

A. No.

Q. Or words to that effect?

A. No.

Q. You say that did not happen?

A. Well, I never heard it, I’ll put it that way. I asked him to go back in.

3.267 PC Dawson said that it was the refusal of Mr Alder to leave which caused the officers to tell him that they would call the van, and if he had not left by the time it arrived, he would be arrested for breach of the peace.²³¹ Both officers’ statements describe how Mr Alder took up an aggressive stance, and said:

“You’re in a lot of trouble, I’m the guy who can take you one to one any time.”

3.268 PC Dawson at that stage was said to have formally arrested Mr Alder, whereupon Mr Alder poked him on his left shoulder three times, saying:

“I can take you any time.”

3.269 The officers say that PC Dawson drew his CS spray at that stage and threatened to use it unless Mr Alder complied with his instructions.²³² PC Dawson then handed the spray canister to PC Blakey before handcuffing Mr Alder’s hands behind his back.

²³⁰ Inquest Day 24, p.52

²³¹ PC Dawson statement (1 April 1998) CA008 p.14 [00080164]

²³² PC Dawson statement (supra) at p.15 and [00080165],and PC Blakey statement (1 April 1998) CA008 p.14 [00080184]

3.270 Mr Rodgers, however, makes no reference in his statement to the threat of using CS spray. He was asked about this by the coroner:²³³

Q. Did you see the officers take their batons out at any time?

A. No.

Q. Or the gas cylinders out?

A. No. In my own opinion I don't think, as regards the batons and the gas, I don't think he was in that much of an aggressive mood where it had to be used or even thought of being used. When he was in one of these moods for these minutes you could talk to him and then he was answering you quite, you know, reasonable like.

3.271 When questioned further by Mr Thomas,²³⁴ he went on to say:

A. As regards the gas, I never saw it, put it that way then, and I was stood outside all the time with him. I never saw no attempts to spray him with gas or use anything like that, and I was stood with him.

3.272 Mr Rodgers was also asked by Mr Thomas about the alleged 'poking in the shoulder' that the officers describe:²³⁵

Q. Can I just put this to you: if it were suggested that Christopher started making personal threats towards the officers and at one point started poking PC Dawson in the chest with his finger, pushing him back, saying: "Have you any time", you didn't see any of that?

A. No.

Q. Then Dawson saying: "Look. Go. If you don't you'll be arrested"?

A. He did say that, but it wasn't Richard – Christopher.

Q. There is no physical contact with Christopher poking Dawson?

A. Definitely not.

Q. And just so we know where the source of that comes from, that comes from Mr Blakey?

A. Definitely not. He didn't touch no police officers at all didn't Christopher.

3.273 PC Dawson claimed that he called the van before he arrested Mr Alder. He stated that, having encouraged Mr Alder to leave, he then made the

²³³ Inquest Day 24, p.34

²³⁴ Inquest Day 24, p.50

²³⁵ Inquest Day 24, p.78

arrest and immediately informed control of it. The message recorded by the communications centre²³⁶ was timed at 03.34. That message suggests that the request for the van came **after** the arrest, as the centre agreed to send a van and at the same time queried the reason for the arrest. The centre received an immediate answer: "Prevent a breach of the peace". Both police officers said that the arrest only occurred after the van had been called and about one minute before the van arrived.

3.274 The printed command log times the message at 03.35, but only records the comment regarding the arrest for breach of the peace as being at 03.43. By that time, however, both vehicles might be assumed to have been en route to the police station,²³⁷ because Mr Alder was carried into the custody suite only 3–4 minutes later.

3.275 Subsequent tests (described below) to establish the likely travel time between the hospital and police station suggest that it was approximately a five minute journey, in each direction. As the van was called from the station, collected Mr Alder and returned to the station by 03.47, the callout time of 03.34 or 03.35 would be consistent with this. I assume for this purpose that a minute or so was required for putting Mr Alder into the van, and the same again for carrying him out of it.

3.276 The fact that PC Dawson is recorded as stating the reason for the arrest when he called the van, at around 03.34, points to his having arrested Mr Alder already. This means that the claim that he called the van as a threat, and arrested Mr Alder later, just before the van arrived, cannot be correct.

3.277 In his interview with West Yorkshire Police, PC Blakey²³⁸ insisted that they had not wished to arrest Mr Alder, and had called for the van first, before actually arresting him:

"we wanted him to go on his way so PC Dawson called for a van to come. It was explained to Mr Alder that we'd called for a van to come to the hospital and that he had the time basically it took for the van to get here to make up his mind and go away. If not he'd have to be arrested..."

3.278 Similarly, PC Dawson in his interview with West Yorkshire Police said that the van was called prior to the arrest, and that Mr Alder was told of this.²³⁹

²³⁶ Transcript of radio messages, CA008 [00080041]

²³⁷ Command log CA0067 at D10 [00670031]

²³⁸ PC Blakey interview (14 May 1998) CA0011 at 1/9 [00110012]

²³⁹ PC Dawson interview (13 May 1998) CA0010 at 2/8 [00100041]

3.279 The officers accept in their statements that Mr Alder was compliant, but:

“continued with his argumentative banter”.

Arrival of the police van

3.280 A/PS Ellerington, who had previously attended at the Waterfront Club, was the van driver sent to the scene. In his statement he indicated that he received the request and drove to HRI directly from Queen’s Gardens police station.²⁴⁰ A/PS Ellerington thought this request was made at about 03.40, but this timing is inconsistent with the communications record and would not have allowed sufficient time for the return to Queen’s Gardens, which was almost certainly by 03.46, just six minutes later. Mr Rodgers²⁴¹ thought that, after the handcuffs were placed on Mr Alder, the van took “five or six minutes” to arrive.

3.281 This is broadly consistent with the period of time that the ambulance took to travel from the Waterfront Club to the HRI, and later the period claimed for the trip by the police van to Queen’s Gardens police station (the club and Queen’s Gardens being very close to one another).

3.282 Mr Rodgers said that it was PC Blakey, the shorter of the two officers, who said that Mr Alder had ten minutes to leave the area, but that Mr Alder was saying that they could not arrest him.²⁴² After a few minutes the larger officer did caution and arrest Mr Alder, and Mr Rodgers saw him placed into handcuffs. Mr Rodgers said that it was at this stage that a van was requested, and that Mr Alder calmed down.²⁴³ He said that Mr Alder behaved quite reasonably at this point, and that when the van arrived, Mr Alder had said:

“See you tomorrow Mally”,

before climbing into the rear of the van and being driven away. The police officers, however, said that Mr Alder was saying:

“I want your name”,

to the security guard standing with them.²⁴⁴

²⁴⁰ A/PS Ellerington statement (1 April 1998) CA008 p.2 [00080197]

²⁴¹ Inquest Day 24, p.53

²⁴² Malcolm Rodgers statement (16 April 1998) CA007 p.96 [00070097]

²⁴³ Malcolm Rodgers statement (16 April 1998) CA007 p.97 [00070098]

²⁴⁴ PC Dawson statement (1 April 1998) CA008 p.16 [00080166], and PC Blakey statement (1 April 1998) CA008 p.15 [00080185]

- 3.283 Mr Rodgers recalled that one officer arrived in the van, and the two who were already present left the scene in the same car in which they had arrived.²⁴⁵ Mr Rodgers placed that departure at about 03.45.
- 3.284 Once Mr Alder had been taken outside the hospital, the only hospital staff member who saw what went on was Mr Rodgers. Dr Khan did not see him again, after he was taken out. Similarly Nurse Smith, Nurse Merrills and Ms Walker did not observe this stage of the events. Nurse Townend²⁴⁶ said that:
- “I was stood near the open doors when I heard the stocky policeman request a police van. The other policeman was stood with the patient who was now on his feet stood near the doors. I then returned to the department.”
- 3.285 The evidence of the conversations and events that took place both inside and immediately outside the hospital appears, at first glance, to be broadly consistent. However, there are potentially important differences between the explanations given by the police officers, on the one hand, and the hospital staff on the other.
- 3.286 The two officers’ recollection is that from the point at which Mr Alder emerged from the toilet, he was saying that he wanted to see the doctor (Dr Khan); that Dr Khan, by implication, was not present at that moment; that Mr Alder wanted to be treated, and was saying that the police could not prevent it; that Nurse Townend told him to come back later when he had calmed down; that Mr Alder was “walked” out of the hospital in such a manner as to ensure he did not fall over; that he was insisting, once outside, that he would go back into the hospital; that he was threatened with CS spray; that once he was told of his arrest he poked PC Dawson in the shoulder with his hand; that the van was called before he was arrested; and that he asked for the guard’s name before getting into the van.
- 3.287 The hospital staff recalled that even when he came out of the toilet, Mr Alder was still aggressive and refusing treatment; that Dr Khan was present, and urging him to cooperate, which he refused to do; that Mr Alder was dragged backwards out of the hospital; that once outside the hospital he made no move to return, nor did he indicate a wish to do so; that he was actually saying that he wanted to go home, but was arguing with the police; that CS spray was not drawn or threatened; that Mr Alder did not touch or poke either officer; that the van was not called until he had been arrested; and that he clearly knew the guard’s name and said goodbye to him.

²⁴⁵ Malcolm Rodgers statement (16 April 1998) CA007 p.97 [00070098]

²⁴⁶ Helen Townend statement (5 April 1998) CA007 p.65 [00070066]

The van journey

3.288 A/PS Ellerington, in his duty statement, had described being called to the hospital at approximately 03.40 by PC Dawson. He said that he had left Queen’s Gardens to travel to the hospital.²⁴⁷ In interview with West Yorkshire Police he confirmed²⁴⁸ that he had been at Queen’s Gardens at the point when the call came through:

“I was in the office again and we received a call from the hospital from PCs Blakey and Dawson requesting a van attend at Hull Royal Infirmary.”

3.289 The two constables did not specify the time that they called for the van, but the Humberside Police Communications Room log²⁴⁹ indicates that the request was made at 03.34. The log also indicates that at 03.43 the call sign used by PC Dawson and PC Blakey, ‘FR18’, called in to say that the man arrested for the possible breach of the peace and the victim of the earlier assault were the same man.²⁵⁰

3.290 Although it is not possible to confirm the accuracy of the timing recorded by the Communications Room, it is possible to confirm that the later call for assistance was made by PC Dawson using his personal radio, and is timed at 03.59. The timing on the custody suite video is also at 03.59 at that point. This is evidence that the timings used by the Communications Room and the custody suite video are the same.

3.291 It is therefore possible to say that the van was called from Queen’s Gardens at 03.34 and was back at Queen’s Gardens, having collected Mr Alder, at 03.46, which is the time on the custody suite video when he was brought into the suite. That is a period of 12 minutes, which would include the time taken to place Mr Alder in the back of the van and take him out again at Queen’s Gardens police station.

3.292 All three officers described the police car having followed the van, and Kenneth Crichton, the gate-keeper at Queen’s Gardens police station, was in due course to describe them arriving together.²⁵¹ The only disagreement with that appears to have been by Mr Rodgers, who gave evidence at the trial²⁵² to the effect that the “panda car” had left after the van had departed:

“it would have been a period of maybe six, seven or eight minutes afterwards”.

²⁴⁷ A/PS Ellerington statement (1 April 1998) CA08 p.2 [00080197]

²⁴⁸ A/PS Ellerington interview (15 May 1998) CA026 p.5 [00260007]

²⁴⁹ Humberside communication log (1 April 1998) CA008 [00080041]

²⁵⁰ Humberside communication log (1 April 1998) CA008 [00080042]

²⁵¹ Kenneth Crichton statement (5 June 1998) CA007 pp.110–11 [00070111–12]

²⁵² Malcolm Rodgers trial evidence (18 April 2002) p.60

3.293 When asked what they were doing during that period he said that the officers:

“had the notepads out and writing whatever, I mean I don’t know what they was putting down, they were writing times down, I assume, of what’s happened.”

3.294 The police van in which Mr Alder was placed was a Mercedes Benz ‘Sprinter’, registration number R507 GAG. The van is hard-sided, without windows in the rear half of the vehicle. The double rear doors open outwards; immediately inside the doors is found a caged area for transportation of detainees. There is a small bench on either side of the interior of the cage, allowing detainees to sit with their backs to the wall. A photograph of the van is attached at Appendix 16.

3.295 The description by both officers, and by Mr Rodgers, was that Mr Alder was handcuffed with his hands behind his back, and that he stepped into the van and sat down with his back to the right-hand wall, that being the ‘offside’.

3.296 The evidence of the three officers involved in the arrest, PCs Dawson and Blakey and A/PS Ellerington, was that the two vehicles drove without stopping to Queen’s Gardens police station. As A/PS Ellerington²⁵³ described it:

“The prisoner compartment was closed and I drove the van straight to Queen’s Gardens Police Station. The traffic lights were in my favour. I am an advanced driver qualified at first class level. I drove smoothly, in silence to the police station.”

3.297 A/PS Ellerington also stated in interview with West Yorkshire Police that he did not stop en route from the hospital to the police station, and that he thought the return journey took:²⁵⁴

“three to four minutes probably nearer to three than four”.

3.298 He told the interviewing officers that he could see the following police car with PCs Dawson and Blakey behind him when he looked in his mirror, but that there was no internal mirror, and therefore he could not see Mr Alder during the journey. He also stated that he did not hear him make any noise. PC Dawson²⁵⁵ and PC Blakey²⁵⁶ also confirmed that the journey from hospital to station was uninterrupted, and took under five minutes.

²⁵³ A/PS Ellerington statement (1 April 1998) CA08 p.4 [00080199]

²⁵⁴ A/PS Ellerington interview (15 May 1998) CA026 pp.16–17 [00260018–19]

²⁵⁵ PC Dawson interview (13 May 1998) CA0010 Tape 2, p.19 [00100052]

²⁵⁶ PC Blakey interview (14 May 1998) CA0011 Tape 2, p.4 [00110039]

- 3.299 The journey from Hull Royal Infirmary to Queen's Gardens police station traces much of the same route, in reverse, that was taken from the Waterfront Club to the hospital. The journey from the Waterfront Club to the hospital by ambulance was said to have taken seven minutes (02.37 to 02.44). A round trip of 12 minutes for the police vehicle would therefore have to have been carried out at a faster pace, or with fewer delays en route for traffic lights etc.
- 3.300 A map of the route has been provided by Humberside Police and can be seen at Appendix 15. This shows that there are seven sets of traffic lights between the Waterfront Club and the HRI. There is no evidence as to how many of these might have delayed the ambulance. The same seven traffic lights, plus one other, would be passed on the journey from the HRI to the police station, although the evidence of A/PS Ellerington was that none of them were against him when during his return to the station. That route is 1.16 miles.
- 3.301 Insp. Tolan of West Yorkshire Police arranged for a series of tests to be performed with the same vehicle between Hull Royal Infirmary and Queen's Gardens police station. A West Yorkshire Police constable, named PC Kane, was handcuffed in the same fashion as Mr Alder had been and conveyed in the same seat that Mr Alder had been in.²⁵⁷ Mr Kane was approximately the same height and build as Mr Alder. The purpose of the experiment, carried out on 24 March 1999, was in part to see how difficult it would have been for a man restrained in that fashion to remain on the seat. It also allowed for a test of the time required for the journey.
- 3.302 In the test the van was driven by PC Bates of West Yorkshire Police, who performed seven journeys between 03.30 and 05.00 (the day of the experiment was also a Wednesday).²⁵⁸ The first five journeys were made at a normal speed, with speed limits and all traffic signals obeyed. The sixth journey was made as fast as traffic conditions allowed, treating all red signals as 'give way' signs. The final journey was made to video the route.
- 3.303 Each journey was timed by Inspector Derek Whitehouse of West Yorkshire Police and was from HRI to Queen's Gardens.²⁵⁹ In each case Insp. Whitehouse started the timer when he walked from the rear of the van to the passenger door, entered the cab and was driven off. Upon arrival at the police station, the van was reversed into the position in which it had been placed by A/PS Ellerington, and Insp. Whitehouse went to the back of the van, at which point the timer was stopped. The times of the five journeys at normal speed were:

4 mins 37 secs

²⁵⁷ PC Kane statement (24 March 1999) CA0080 pp.486-7 [00800410-11]

²⁵⁸ PC Bates statement (24 March 1999) CA0080 pp.482-3 [00800406-7]

²⁵⁹ Insp. Whitehouse statement (24 March 1999) CA0080 pp.484-5 [00800408-9]

5 mins 08 secs
5 mins 37 secs
5 mins 32 secs
4 mins 49 secs

3.304 The average time was therefore 5 minutes and 9 seconds for each journey. The sixth trip, the fastest, was made in 3 minutes and 11 seconds.

3.305 PC Kane in his statement²⁶⁰ commented on the effect of being transported in this fashion:

“During these journeys the travel motion that I experienced was, in the main, side to side and not to any great extent to the front or back. Very little effort was used to remain on the bench seat nor was there very much discomfort experienced during the journeys.

A sixth journey was made at a faster speed. The Journey was uncomfortable and more effort was used to remain seated. During the sixth journey I was unable to relax.”

3.306 Insp. Tolan did comment during the course of the trial²⁶¹ that having seen the journey made in the van:

“a person so inclined could have fallen asleep during the short journey”.

3.307 The IPCC arranged for a computer simulation to be created of the position of Mr Alder once in the van, using the correct dimensions, as recorded for the confines of the vehicle and for him. The reconstruction was undertaken by Control Risks Group, who were provided with full details of the dimensions of the van and of Mr Alder. The aim of the exercise was to consider any potential scenarios for the journey that might not have been considered during the initial investigation.

3.308 Still prints of this simulation are attached at Appendix 18. The prints indicate, firstly, that while there would have been room for a person to have sat opposite Mr Alder in the van, on the bench facing him, there would not have been room for anyone to sit next to him.

3.309 When the van was examined by a scene of crime officer (SOCO), marks were found that had the appearance of blood, and these were recorded, photographed and swabbed. These were on the bench in the detainee area and on the wall of that area. Two photographs showing these marks are attached at Appendix 17. The swabs taken were never examined to confirm that they were blood or to establish whose blood it

²⁶⁰ PC Kane statement (24 March 1999) CA0080 pp.486–7 [00800410–11]

²⁶¹ Trial transcript 27 May 2002, p.9 line 26 to p.10 line 14

was. The assumption was made at the time that they were blood marks from Mr Alder, but the swabs were in due course destroyed, and later checks have therefore been impossible.

- 3.310 The simulation demonstrates that the blood, if that is what it was, found on the wall and on the bench where Mr Alder had apparently been sitting could have come from him. Finally, the simulation shows the way that he might have fallen forward had he been pitched from his seat by the movement of the van. It is important to remember that there is no independent evidence to suggest that he did fall forward in this fashion, and the exercise was, to that extent, speculative. If he had fallen from his seat, he is unlikely to have been returned to that seat by the motion of the van, and therefore would almost certainly have been on the floor of the van when the doors were opened by the officers. Assuming their evidence on the point to be correct, he was in a sitting or slumped position on the seat upon arrival at the station.
- 3.311 The computer reconstruction makes a useful counterpoint to the actual reconstruction, using the same van, carried out by West Yorkshire Police. The evidence from the filmed van journey of PC Kane bears out his explanation that he did not have a difficult time in remaining seated as long as the van was travelling at a steady pace. Once the van moves at a faster rate, he clearly does have difficulty in remaining still. Had Mr Alder been unconscious during the whole or most of the journey, it seems likely, given that the van had to turn corners en route, that he would not have been able to remain in his seat.
- 3.312 As was to be seen later, there was no scientific evidence, based upon blood splashes found, to suggest that Mr Alder fell forward or came out of his seat during the van journey.
- 3.313 Assuming that the three officers are accurate in their descriptions of his having been in the same position upon arrival as on departure, this would tend to suggest that he had lost consciousness at a very late stage in the journey.
- 3.314 The police van arrived at Queen's Gardens police station, followed by the car used by the two officers. This much is known. Within a few moments of his arrival, Mr Alder was carried by PC Dawson and PC Blakey into the custody suite of the police station and placed on the ground. From the moment that he was brought into the building, Mr Alder and the officers were caught on CCTV, and the video recording of the events in the police station details many, although not all, of the activities in the custody suite area.
- 3.315 Regrettably, the arrival of the van, the opening of that vehicle and the removal of Mr Alder are not recorded, as the video cameras covering the area did not record the scene.

3.316 Subsequently the van was examined by a SOCO and by a forensic scientist. Their evidence is considered in Chapter 4.

Queen's Gardens police station prior to the arrival of Mr Alder

3.317 Queen's Gardens police station is a large police station situated in the centre of the city. The station is a long rectangular building facing out onto, and running alongside, the area of Queen's Gardens, with a public entrance on that side of the building. A map of the building is attached at Appendix 19. This map shows that the secure entrance, which is guarded, is at the bottom, south-west end of the building. This gives access to a yard where police vehicles are parked, and from there into the custody suite entrance. A photograph of the external part of the custody area is attached at Appendix 20.

3.318 On duty as custody sergeant that night was Police Sergeant (PS) John Dunn, assisted by PC Matthew Barr, who acted as the warder to the cells. A civilian 'matron' named Bridget Winkley was also on duty. Matron Winkley was not a qualified nurse, as that is not a requirement for the post. Her duties included assisting in the care of female detainees and juveniles. On the evening of 31 March/1 April the station had, or received, a total of 15 other detainees, of whom six were women and two were 12 year old boys. Several of those in custody were drunk or recorded as having mental health issues. A summary of the persons held in custody is attached at Appendix 26. Names of those in custody have been redacted.

3.319 No complaint has ever been recorded concerning the treatment of the other detainees that evening, and nothing about their custody records gives rise to any comment. The relevant sections of all custody records, save for one, were retained as part of the original investigation and were made available to the IPCC. Thirteen of the 15 detainees were later spoken to by West Yorkshire Police as part of their inquiries. All apart from one detainee recalled nothing out of the ordinary in the period before they were removed from their cells and transferred to different police stations. Only one claimed to have heard a disturbance, but that person did not sign the statement that she made. She was described on her custody record as a "traveller", and it has proven impossible to contact her.

3.320 The CCTV reveals only a routine evening in a city centre police station, and reflects the sort of scene one might expect in dozens of other police stations across the country. However, two incidents occurred during the course of the evening, both of them being well before the arrival of Mr Alder and not directly related to his case. Both incidents do, however, give cause for disquiet at the attitude of the police officers. One of these concerns the behaviour of PC Barr; the other concerns PS Dunn.

- 3.321 Analysis of the tapes taken from the custody suite covering the period prior to the arrival of Mr Alder has revealed that at around 01.34 PC Barr made one, and possibly two, telephone calls which appear from the context to be to other police stations in Hull.²⁶² In those telephone calls, he claimed to be from the *Hull Daily Mail*, which is the local newspaper, and to be enquiring about a death in custody. This is evidently intended to be an April Fool's Day joke. Understandably, given the events of that night, suspicions arose that this tape had been mislabelled, and the joke was being made subsequent to Mr Alder's death, and at his expense.
- 3.322 Examination of the transcript and the videotape of the custody suite for the evening shows that it is quite clear this was not the case. PC Barr's conversation can be overheard in the background as the video shows work continuing as normal in the custody area. While PC Barr was on the telephone, PS Dunn, who played no part in the joke, can be seen to be completing a written record for a man who was sitting on the bench in the custody area. The camera clock shows the time to be around 01.34. As the audio track is an integral part of the videotape, it would not be possible to transpose the audio recording onto another part of the videotape without the use of sophisticated equipment. It could not be done by accident.
- 3.323 The timing of this joke is unfortunate to say the least. PC Barr was not to know at that time how the events of the rest of the evening would progress. Nonetheless, it is completely unacceptable that a serving police officer, particularly one who is acting as a warder, should regard deaths in custody as a matter for practical jokes while on duty.
- 3.324 The incident involving PS Dunn occurred earlier in the evening, shortly before midnight. It involved the mocking abuse of a drunken woman prisoner. The significance of this abuse was that it appeared to involve him impersonating a monkey. This behaviour is dealt with below, because it is of possible relevance to other behaviour observed two hours after the death of Mr Alder.

Arrival of Mr Alder at the police station

- 3.325 Upon arrival at the police station the two vehicles were admitted to the yard by Mr Crichton, who was a civilian employee of Humberside Police working as the gatekeeper. Mr Crichton was not asked to give a statement to the police until 5 June 1998. At that stage, he told West Yorkshire Police.²⁶³

“During the early hours of 1 April 1998, I was on my duties when a prisoner was transported into the rear yard by a police van

²⁶² Custody suite tape 04 (1 April: 01.00–02.00) pp.18–20

²⁶³ Kenneth Crichton statement (5 June 1998) CA007 pp.110–11 [00070111–12]

driven by one Police Officer who was on his own. This vehicle was followed in by another police car which parked beside my office. I'm not sure how many were in this vehicle – obviously there was at least one and I believe it was an officer I know only as 'Tudor'. He walked out of my sight to the Custody Suite entrance.

I then observed from my TV monitor two Police Officers emerging from the back of the police van assisting a prisoner in. I saw them take him up the ramp and through the door into the Custody Suite and out of my sight on the TV monitor. The image is not recorded and there is no sound with it.

They were in my TV monitor sight for about 30 seconds during which time they took him directly to the custody door. At no time did they stop. There was one officer on either side and they were each holding an arm and the prisoner appeared to be slumped.”

3.326 Mr Crichton gave evidence at the inquest and was able to recall that the van had reversed in so that its rear doors were near the entrance door to the custody suite. He recalled seeing one officer in the van, and recalled one officer in the car ('Tudor' being a nickname for PC Dawson). Mr Crichton also recalled two officers assisting Mr Alder into the custody suite but did not see a third officer.

3.327 When asked about his recollection,²⁶⁴ he said:

“I think there was two in the car. I can only remember one...But there may have been two. I'm not actually sure.”

He recalled seeing only one officer in the van.

3.328 Mr Crichton also gave evidence at the trial.²⁶⁵ He described the van and car arriving, and the van being parked in the custody yard. He only recognised PC Dawson, who came from the car, and walked into the custody yard. Mr Crichton's recall at that time was that there were only two officers taking the detainee from the back of the van into the custody suite.

3.329 It is also worth noting that Mr Crichton was asked about the legs of the arrested man. He said:

“They were trying to walk but I don't think he was making much success out of it”,

and that the man's body was “upright”:

²⁶⁴ Inquest Day 8, p.94

²⁶⁵ Trial evidence (19 April 2002) p.41

“He was being helped in...He wasn't being pulled in or anything like that, he was just being helped in.”

3.330 In interview with the IPCC Mr Crichton gave further details, and the following note was made of his comments:²⁶⁶

“The police car then parked outside Mr Crichton's office approximately 5 to 6 feet away with the bonnet facing away from the office towards the exit gate of the yard. Mr Crichton remembers seeing Tudor Dawson walking across the yard towards the caged area, a distance he estimates to be around 15 feet. Mr Crichton does not recall seeing another officer in the police car at all. He stated that 'any passenger would have had to get out of the car and walk directly in my line of vision in order to get to the caged area'. He stated, 'If there were two, I would have seen them, to the best of my recollection there was only one'. Mr Crichton was actually watching the car when it pulled up.

Mr Crichton said that he vaguely knew PC Blakey and would recognise him but did not know him as well as Tudor Dawson. He also knew Mark Ellerington by sight.”

3.331 My team has had the opportunity to examine the yard where vehicles would be parked; it is a long, relatively narrow area, and vehicles are parked parallel to the wall on the right hand side. This is illustrated by the photograph of the police van, later parked in this fashion, and examined in situ by the SOCO and forensic scientist (at Appendix 16). Given that the passenger's door would be close to the wall, to avoid blocking the yard, it is possible that PC Blakey got out of the car before PC Dawson parked it. This might explain why Mr Crichton only saw PC Dawson walking back from the vehicle. There is no reason why this incident would have attracted his attention, as it would have been a routine arrival of van and car.

3.332 The doors to the van were opened after the van had parked next to the entrance to the custody suite area. This area, without the van in place, can be seen in a photograph at Appendix 20. The statements of all three officers confirmed that they had arrived at the police station in the same vehicles as described at the hospital: A/PS Ellerington driving the van and PCs Dawson and Blakey in the car. All three stated that the van reversed towards the custody suite, and that the two constables parked the car, and then walked to the rear of the van where they met the acting sergeant.

3.333 Each officer was to give a description of opening the van doors. PC Dawson²⁶⁷ said:

²⁶⁶ Kenneth Crichton interview (12 March 2005) pp.2–3

“I parked our vehicle opposite the garage office mans hut and with PC BLAKEY went to the rear of the Mercedes van, which had been reversed into the CCO yard. PC BLAKEY opened the rear doors to the Mercedes vehicle and I saw ALDER sat in the same position as he was placed originally.

PC BLAKEY said ‘Come on mate, out you come, we’re here’.

ALDER did not respond but was snoring loudly.”

3.334 PC Blakey’s statement²⁶⁸ was couched in almost identical terms:

“I opened the rear doors of the van and I saw ALDER sat in the same position as he was in originally and I said ‘Come on mate, out you come, we’re here’.

ALDER did not respond but was snoring loudly...”

3.335 By the time of his interview with West Yorkshire Police,²⁶⁹ PC Blakey was less sure, and said that:

“All three of us were present when the van doors were open. Quite who opened it I really can’t remember.”

3.336 A/PS Ellerington recalled matters slightly differently.²⁷⁰ He said:

“On arrival at the police station I was joined by PC DAWSON and PC BLAKEY. I opened the back doors of the van and the prisoner compartment door. ALDER was seated as he had been when I left the hospital. He was what sounded like snoring and appeared to be asleep.

He did not respond to a request from PC DAWSON to get out of the van. PC DAWSON and PC BLAKEY lifted ALDER from the back of the van and, keeping his head and torso off the ground, dragged him into the Charge Room.”

3.337 A/PS Ellerington was therefore saying that it was he, not PC Blakey, who opened the doors of the van, and PC Dawson rather than PC Blakey who spoke to Mr Alder.

3.338 The CCTV video recording of the custody suite area shows clearly that PC Dawson and PC Blakey entered with Mr Alder, and A/PS Ellerington followed down the corridor within a matter of moments. The

²⁶⁷ PC Dawson statement (1 April 1998) CA008 p.17 [00080167]

²⁶⁸ PC Blakey statement (1 April 1998) CA008 p.17 [00080186]

²⁶⁹ PC Blakey interview (14 May 1998) CA0011 Tape 2 p.5 [00110040]

²⁷⁰ A/PS Ellerington statement (1 April 1998) CA008 p.4 [00080199]

video recording showing the entrance indicates that Mr Alder was brought into the suite at 03:46:45 on the video counter. The two officers were either side of him. The camera that shows the entrance is camera 3 on the sketch map of the custody suite area, attached as Appendix 21. The two officers, PCs Dawson and Blakey, manoeuvred the evidently unresponsive body of Mr Alder through the doorway from the yard outside the door, and although the area outside the doorway was dark, it is clear that Mr Alder's body was, at times, allowed to lie almost completely on the ground. His hands were handcuffed behind his back and he was held by the two officers, who grasped his upper arms and dragged him along the corridor, with his face downwards, and his face and upper body lifted approximately two feet from the ground. His feet and the lower part of his legs appear to have dragged along the floor.

3.339 It was later noted that Mr Alder's trousers had come down his legs as far as his knees. It is not possible to see this process occurring on the videotape of him entering the custody suite. It was, however, commented upon by some of those present.

3.340 A/PS Ellerington, in his statement of 1 April,²⁷¹ observed that:

“Moving along the floor the friction pulled ALDER's trousers and underpants partially down.”

3.341 PC Barr's statement of the same date²⁷² stated that:

“His feet were trailing along the floor behind him, his trousers were half way down due to them dragging along the floor.”

3.342 PC Dawson also referred to this during the course of his interview with West Yorkshire Police²⁷³ when he said:

“I remember one of his shoes coming off and I can recollect him losing his trousers which seemed strange at the time because there was no reason why he should be losing his trousers.”

3.343 There have been numerous references to the fact that Mr Alder's trousers came down, but no clear explanation as to why it happened; on the face of the comments from the officers they are in no better position to explain it than any other commentators. No specific allegation has ever been made regarding this event; there is no evidence to suggest that it was engineered deliberately by any of the officers. Mr Alder had undone his trousers at the hospital in order to urinate. They had button fastenings. He was confused and disorientated at that point. It is possible that he may not have refastened them properly when he came out of the hospital toilet and

²⁷¹ A/PS Ellerington statement (1 April 1998) CA008 [00080199]

²⁷² PC Barr statement (1 April 1998) CA008 p.2 [00080190]

²⁷³ PC Dawson interview (13 May 1998) CA0010 Tape 2 p.24 [00100057]

they were later dragged off as he was manoeuvred from the police van to the custody suite. I have not been able to find any other explanation.

3.344 In an address to the National Civil Rights Movement, Janet Alder, the sister of Mr Alder, commented that:

“The police dragged him out and in the process his trousers and his boxer-shorts ended up down his legs. They dragged him into the police station, put him on the floor.”

(Quoted on the NCRM website as “Christopher Alder’s sister, Janet’s testimony given at the NCRM launch meeting, March 1999”.²⁷⁴)

3.345 I agree with this assessment. The issue in relation to the trousers is, in my view, not why did they come down but rather why did the fact they came down not alert the police to a possible problem, and why did the police do nothing about it?

Events in the custody suite

3.346 Once he was placed on the ground, a pool of blood gradually formed around the mouth of Mr Alder, and his subsequent laboured breathing was through that blood. It was commented upon by the officers, although no action was taken to examine his mouth or to determine why he was bleeding. This blood was more copious than the apparent blood seen in the van, suggesting that bleeding had worsened since Mr Alder’s removal from the van.

3.347 Once he was inside the custody suite the principal actions and activities, together with the conversation, are recorded on videotape. The main events of the following minutes were as follows:

- PCs Dawson and Blakey laid Mr Alder face down on the floor of the custody suite with his head facing slightly to one side and his left cheek to the ground.
- From the moment he was laid on the ground, Mr Alder made no unaided movement at all. He could be heard making irregular noises, which sounded like heavily laboured breathing.
- PS Dunn, the custody sergeant, immediately indicated that Mr Alder should be taken to hospital.
- The two arresting officers told the custody sergeant that he had just come from the hospital and that the medical staff did not want Mr Alder there, and they expressed the opinion that the apparent unconsciousness was an act.

²⁷⁴ <http://www.ncrm.org.uk/campaigns/alder.html>

- PC Blakey, with some difficulty, removed the handcuffs from Mr Alder. It was noticeable that once they were removed, Mr Alder did not move his hands, which remained in the same position behind his back. It is evident from the video that PC Blakey was wearing latex gloves. It is possible he had worn them since the time he was at the hospital.
- At no time, while Mr Alder remained on the floor, was any attempt made by any of the officers present to talk to Mr Alder or to rouse him.
- A/PS Ellerington, who had driven the van, remained at the door of the custody suite for a few minutes. He said nothing that is audible on the tape, and eventually left.
- After some discussion PS Dunn appeared to accept the explanation given to him by the two constables. A conversation then ensued, behind the counter of the custody area, regarding possible charges that could be laid against Mr Alder.
- PC Barr looked over the counter from time to time.
- The noises being made by Mr Alder became more infrequent.
- The noises eventually stopped altogether.
- PC Barr pointed out that he had stopped making noises. He gave his opinion that Mr Alder had stopped breathing.
- PS Dunn went to Mr Alder to examine him. He began attempts at resuscitation, assisted by PC Barr.
- PC Dawson called the Communications Room to ask for an ambulance.

3.348 A 'timeline' of events in the custody suite from the arrival of Mr Alder onwards has been prepared and attached at Appendix 22. A full transcript of the full period of the shift has been prepared. An extract of that transcript, reflecting the time from when Mr Alder was brought into the custody suite through to the arrival of the ambulance crew, is attached at Appendix 23.

3.349 As is clear from the timeline, the realisation that Mr Alder was in a serious condition did not seem to dawn upon the officers present until after PC Barr pointed out that he was no longer making any noise. At that point, for the first time, PS Dunn and PC Barr touched Mr Alder, and moved him into a position to commence resuscitation. The process

of resuscitation that was started by the officers continued until the arrival of the ambulance crew.

- 3.350 The efforts made by the police, specifically PS Dunn, PC Barr and Matron Winkley, although vigorous and determined, were subsequently criticised as being disorganised and potentially ineffective. PS Dunn was given a protective plastic mouthpiece for the purposes of mouth to mouth resuscitation. It is evident from comments made by PS Dunn that he did not know which way to insert the plastic device into the mouth of Mr Alder. There is no evidence that the officers appreciated the need to ensure a fully clear airway first.
- 3.351 The ambulance crew who arrived to assist were the same crew who had attended Mr Alder at the Waterfront Club and taken him to hospital. The evidence of Mr Krebs²⁷⁵ and Ms Drennan²⁷⁶ was that the call-out on this occasion was at 04.02 and that they reached the police station two minutes later.
- 3.352 Ms Drennan entered the custody suite first [at video counter 04:04:59] and said, "It's Chris", having recognised Mr Alder. Mr Krebs later explained that having entered the station he returned to the ambulance for some more equipment and returned almost one minute later [video counter 04:05:55]. The ambulance crew then took over the attempts to revive Mr Alder. Several questions were asked of the police officers concerning the treatment that Mr Alder had received at the hospital, and it is evident from the questions that the crew had not been aware of his release from the hospital.
- 3.353 One question that was asked by Mr Krebs [at 04:07:00] was:
- "How long has he been down?"
- to which PC Barr replied:
- "Not more than three or four minutes".
- 3.354 This answer was seriously wrong, although the pressures upon PC Barr at that time were clearly great, and a miscalculation of time was understandable. In fact, by the time that Mr Krebs asked the question it was fully 20 minutes since Mr Alder had been brought into the custody suite. There is nothing to suggest that he was conscious at any point in the 20 minutes, and very probably he had been unconscious from an earlier time still. He had not made any noises to suggest breathing for a full 10 minutes, since 03.57. It is therefore clear that the information provided to the ambulance crew was deficient and potentially misleading.

²⁷⁵ Stephen Krebs statement (4 April 1998) CA007 p.18 [00070019]

²⁷⁶ Victoria Drennan statement (4 April 1998) CA007 p.31 [00070032]

- 3.355 It must also be recognised that the question posed by Mr Krebs was vague and did not make clear what he meant by “down”. This could be taken to mean unconsciousness, or to mean not breathing. The paramedic did not seek any further clarification from the officers.
- 3.356 Ms Drennan was the first to start resuscitation, with one of the police officers. Mr Krebs then joined her, and the two ambulance crew worked together. The attempts at resuscitation by the ambulance crew continued until approximately 04.35, when they were abandoned, owing to lack of any signs of life. Although at times the crew believed there were signs of a pulse, as minor electrical activity was detected on the heart monitor, no pulse could be felt. They also described the great difficulties encountered in securing a clear airway, because of the blood and vomit blocking Mr Alder’s throat. Eventually a suction unit was used to remove the fluid that was blocking the airways. Both crew members remained at the police station until 06.07 to give an account of their activities to the forensic medical examiner (FME), Dr Naughton-Doe. They were given permission to remove their equipment from the scene by Inspector John Ford, who was the duty inspector that night, and who had ordered the scene to be secured. This was done in the presence of the FME.

Explanations: PC Dawson

- 3.357 All five officers were to make statements within a short time of the events. All were subsequently interviewed in mid-May 1998. When they were questioned at this time about the decisions taken in the custody suite, the explanations they gave did not entirely match the statements made shortly after the events.
- 3.358 The transcript of the video soundtrack recorded the following comments made by the two arresting officers when they entered the suite:

Dawson: This is acting now
Blakey: ...he’s right as rain well not as right as rain but his
Dawson: But his [he’s] been in hospital
Blakey: This is a show, this
Dawson: [he’s] been abusive to the staff the staff aren’t going to treat him [he’s] got a simple haematoma to the back

- 3.359 And later on:

Blakey: He was on his feet...this is just a
Dawson: This is just an acting thing
Blakey: He kept doing dying swan acts falling off the trolley

3.360 At no point during the transcript is any comment made by either of the two officers to suggest an explanation, other than that Mr Alder is faking unconsciousness. However, when making their statements, in the knowledge that Mr Alder was by then dead, both PC Dawson²⁷⁷ and PC Blakey²⁷⁸ use exactly the same phrases concerning his demeanour. They adopted the explanation that they believed him to be asleep in the van. They said that upon finding him unresponsive in the van:

“Alder did not respond but was snoring loudly...continued snoring but did not wake up”.

3.361 Both also went on to say that, in the custody suite:

“Alder was still snoring deeply”,

and that:

“Alder was continuing to breath/e deeply”.

3.362 When interviewed on 13 May 1998 PC Dawson was questioned about his view of Mr Alder’s condition. He said at that stage that in the van:²⁷⁹

“He appeared to be asleep, snoring very longly [sic] and deeply and didn’t wake up.”

3.363 PC Dawson also agreed²⁸⁰ that the collapse of Mr Alder at the hospital was:

“definitely genuine”,

and when questioned further by Supt Holt²⁸¹ regarding Mr Alder’s condition on arrival, he said the following:

Q Right. Is that what you thought at the time that he was actually snoring and therefore he was asleep?

A He was snoring, Sir.

Q Yeah, but what I’m saying is the assumption then if he’s snoring is?

A He’s asleep.

Q You thought he was asleep?

A Yes.

²⁷⁷ PC Dawson statement CA008 p.17 [00080167]

²⁷⁸ PC Blakey statement CA008 p.16 [00080186]

²⁷⁹ PC Dawson interview (13 May 1998) Tape 1 p.24 [00100027]

²⁸⁰ PC Dawson interview (13 May 1998) Tape 2 p.2 [00100035]

²⁸¹ PC Dawson interview (13 May 1998) Tape 2 p.22 [00100055]

3.364 PC Dawson described PC Blakey's attempts to rouse Mr Alder in the van upon arrival, and said he (PC Dawson) still thought Mr Alder was asleep. He reiterated the view of Mr Alder as being asleep once he was in the station, saying:²⁸²

"He was, he's snoring and he's in sleep seemed very, very deep. He seemed to be in a very, very deep sleep. Now it didn't ring any alarm bells at this stage at all...Erm, I'll be honest in saying that he was, he was definitely asleep because unless he was putting it on which was a possible thingybob and he's going to see what happens to him as he comes in which does happen."

3.365 He agreed that he had described Mr Alder as putting on an act, but said that he laid him on the ground because he was asleep.²⁸³ When he was questioned further the following was said:²⁸⁴

Q ...what you've said in interview is that your considered opinion was that he was, he was in deep sleep. He was one or the other, he was in deep sleep.

A Or pretending to be in deep sleep. I mean, you've seen on the video there that I've said that it's an act, it's – the various stages we've gone through, erm, I've said what I've said on the video that's how I'll have felt at the time. Also the fact that he does appear to be snoring and asleep.

Q Can I just ask you on what basis you formed the opinion that it was acting. What had happened earlier or at any stage during your previous involvement with him where you thought he was acting?

A Anything that anybody asked him to do he did the opposite so, I mean, it might sound sat in this room now farcical but we've asked him "Come on. Stop playing the goat. Wake up". He then does the opposite if you like so we're not saying that he's not asleep but when we ask him to wake up one of the considerations that he's deliberately staying like that because he's throughout the time that we've dealt with him he seems to have done the opposite of what anybody's asked. Erm, these are comments made as we, as we've come in. I've got, I've got no direct answers as exactly what Mr ALDER is doing but an option is he could be coming it I not definitively saying he's comed it [sic] he could be asleep, he could be – because we've asked him to

²⁸² PC Dawson interview (13 May 1998) Tape 2 p.25 [00100058]

²⁸³ PC Dawson interview (13 May 1998) Tape 2 p.27 [00100060]

²⁸⁴ PC Dawson interview (13 May 1998) Tape 2 pp.29–30 [00100062–3]

wake up he's decided to be like that. I've got no cause for concern at this stage.

3.366 PC Dawson was asked about the removal of handcuffs, and indicated that when he had done that:

"I probably in my own mind formulated rather than acting now that he was asleep. At what stage my mind changed I don't know".

3.367 This answer implies that, in fact, rather than initially thinking that Mr Alder was asleep (and **possibly** acting), his initial view was that he **was** acting. This fits more readily with the comments that were actually made in the custody suite.

3.368 The officer continued to maintain, nonetheless, that he had believed that Mr Alder was sleeping. He agreed that he had said that Mr Alder was not fit to be released:²⁸⁵

"Well he obviously wasn't in a state if he's in a deep sleep though, again in the back of my mind maybe through amphetamine that he's not in a fit state to be released".

3.369 PC Dawson went on to state that he was not of the opinion that Mr Alder was in distress, and that Mr Alder would not have been aware of his state of undress if he were asleep.

3.370 PC Dawson was present, however, during the attempts at resuscitation of Mr Alder, when a conversation, probably with Insp. Ford, was recorded on the tape. This occurred at about 04.02. The following words are used ('M' indicates unknown male voice):

M: – I arrested him and then he started to perform and that's how we got the gas...we didn't go in the gas mind cos we said that no struggle and I don't know...but we had to drag him in here because he was
M: refusing to walk
M: Well he was just giving us...all the time
M: Has he just collapsed?
M: He's been laid down there
M: Move his head to the side...it was his own fault

3.371 This indicates that although PC Dawson later claimed that he had changed his mind about Mr Alder's state during removal of the handcuffs, he was still describing the unconscious man in terms of "refusing" to walk, rather than 'unable' to walk.

²⁸⁵ PC Dawson interview (13 May 1998) Tape 3 p.9 [00100081]

3.372 PC Dawson denied in interview²⁸⁶ that he had made the comment to the effect that:

“They don’t show you this on the joining video, do they”.

This comment was made in the custody suite while PC Blakey was engaged in removing the handcuffs. It is not possible to see who makes the comment, but examination of the video suggests that it was his voice, and at the time he was facing away from the camera towards A/PS Ellerington. In response to the comment, A/PS Ellerington looked across at PC Dawson and laughed.

Explanations: PC Blakey

3.373 PC Blakey, in interview with West Yorkshire Police,²⁸⁷ said that when he opened the door of the van:

“Mr ALDER’s still sat in the upright position snoring his head off so I thought he’s fallen asleep so I reached out, shook him by the arm and said you know “Wake up. We’re here now. Out you come” and he still kept snoring away”.

3.374 He went on to say that in the charge room:²⁸⁸

“I couldn’t make my mind up if he was faking this or if he was asleep, genuinely asleep, in a deep sleep but he was snoring away as he was when we left the van, his position hadn’t altered any.”

3.375 Unlike PC Dawson, PC Blakey had not been convinced that the collapses of Mr Alder at the hospital had been genuine; he said that he could not make his mind up about this.²⁸⁹ He was questioned further about his view as to whether Mr Alder was asleep. He said:²⁹⁰

A. He was sat in the same position he was when we closed the doors of the van at the hospital and he was now snoring his head off. I thought he was fast asleep.

Q. Is that the only thought you had that he was fast asleep?

A. Yes Sir.

²⁸⁶ PC Dawson interview (13 May 1998) CA0010 Tape 3 p.14 [00100086]

²⁸⁷ PC Blakey interview (14 May 1998) CA0011 Tape 1 p.10 [00110013]

²⁸⁸ PC Blakey interview (14 May 1998) CA0011 Tape 1 p.11 [00110014]

²⁸⁹ PC Blakey interview (14 May 1998) CA0011 Tape 1 p.20 [00110023]

²⁹⁰ PC Blakey interview (14 May 1998) CA0011 Tape 2 pp.5–6 [00110040–1]

Q. You had no other concerns and no other considerations that made you think anything different from that?

A. No Sir.

Q. Why – it may seem a very odd question – but why did you think he was asleep?

A. His eyes were closed and he was snoring, even breaths, snoring his head off.

Q. Did you try and rouse him?

A. Yes.

Q. How?

A. I believe I shook him by the arm.

3.376 As a result of the failure to rouse him, PC Blakey said that he concluded that Mr Alder was either in a very deep sleep or was pretending to be so. He agreed that the only opinion passed to the custody officer was that it was pretence, and that PC Dawson and he both said this. He insisted nonetheless that he was in two minds, although he had never made that clear to PS Dunn.²⁹¹

3.377 PC Blakey²⁹² said that he could recall that:

“his breathing was even and he was snoring so he was perfectly safe where he was”.

3.378 He also stated that he had no concerns for Mr Alder’s welfare, as he thought that he was safe where he was. When questioned about the snoring that he said he heard, he agreed that the noises that could be heard on the videotape were the same noises that he believed were snoring sounds.

3.379 PC Blakey was insistent, as PC Dawson had been, that had he believed that Mr Alder’s condition was anything other than safe, he would have intervened.

Explanations: PC Barr

3.380 PC Barr made a statement on 1 April 1998, and described the arrival of the two arresting officers.²⁹³ He said that they carried in:

“A black male who appeared to be unconscious”.

²⁹¹ PC Blakey interview (14 May 1998) CA0011 Tape 2 p.13 [00110048]

²⁹² PC Blakey interview (14 May 1998) CA0011 Tape 2 p. ?? [00110052]

²⁹³ PC Barr statement (1 April 1998) CA008 p.2 [00080190]

- 3.381 He went on to describe PC Dawson saying that the behaviour was an act. PC Barr said of Mr Alder²⁹⁴ that:

“He was making loud breathing noises which were similar to snoring sounds.

My initial reaction was that they were intended for our attention, in other words he was putting it on, which fitted neatly into what we had been told by PC DAWSON, then I noticed that he had messed his trousers and became concerned for his welfare.”

- 3.382 It was PC Barr who requested that the handcuffs be taken off Mr Alder. The officer described how the discussion continued behind the counter and accepted that he stood behind the counter, where he could not see Mr Alder, but could hear him. It was PC Barr who said to the other officers:

“He’s not making those noises anymore”.

PC Barr was also the officer who pointed out that Mr Alder was not breathing. Subsequently PC Barr assisted PS Dunn in attempting to resuscitate Mr Alder.

- 3.383 In interview with West Yorkshire Police, PC Barr said that he was not initially concerned about Mr Alder’s condition:²⁹⁵

“because of a number of reasons. Erm, (1) because of the fact that he’d come from the hospital and (2) because he didn’t seem over-serious. I mean we have prisoners brought in, in all kinds of states as you can imagine and he seemed no better or no worse than others that we’d accepted.”

- 3.384 He was questioned about his comment in the statement that he thought the detainee brought in was unconscious, and said of it that:²⁹⁶

“I’ve said he was either unconscious or asleep. Now to me they’re one and the same.”

- 3.385 He went on to say that he did not feel that it was appropriate to rouse Mr Alder at that time:²⁹⁷

“for the safety of everybody in the Charge Room”.

He also expressed the view that:²⁹⁸

²⁹⁴ PC Barr statement (1 April 1998) CA008 p.3 [00080191]

²⁹⁵ PC Barr interview (14 May 1998) CA0012 Tape 1 p.15 [00120018]

²⁹⁶ PC Barr interview (14 May 1998) CA0012 Tape 1 p.18 [00120021]

²⁹⁷ PC Barr interview (14 May 1998) CA0012 Tape 1 p.19 [00120022]

²⁹⁸ PC Barr interview (14 May 1998) CA0012 Tape 1 p.20 [00120023]

A. Because I felt if he'd been drinking that he'd obviously had more than a few to have found himself in that state in the first place. I thought it was drink induced I thought it maybe and without knowing or being that drunk that he's unaware.

Q So what – so is what you're saying to me in your assumption may have been that he was unconscious through drink?

A Yes. I think that's what I thought at the time.

3.386 PC Barr indicated that he was happy that the noises that he heard were snoring noises and that he was certain that Mr Alder was:

“drunk and asleep”.

He agreed that although he thought Mr Alder might pose a threat, he was not searched.²⁹⁹

Explanations: A/PS Ellerington

3.387 A/PS Ellerington described the events in the custody suite in very brief terms, and indicated that he had left the custody suite after the removal of the handcuffs by PC Blakey.³⁰⁰ This he is seen to do [at video counter point 03:51:23]. In his interview³⁰¹ he went into more detail regarding the arrival at the police station:

“initially I actually thought that Christopher Alder was asleep, PC Dawson and Blakey gave the impression or indicated that after they'd asked him to get out of the van and he'd made no response, indicated that he had been feigning illness at the hospital and this was a continuance of that behaviour he was snoring very loudly and erm, so initially I thought he was asleep but he didn't, we'd called for him to get out of the van, he didn't rouse to get out of the van, the officers then picked him up to get him out of the van, he still didn't rouse, and in view of the fact that he had come from the hospital it had been such a short straight forward journey nothing untoward had happened on the journey and that his condition when he'd actually got into the van, I formed the opinion that he was more than likely feigning sleep having said that I kept my mind open to the possibility that it could be something else, but as I say at the time I thought that he was feigning deep sleep.”

²⁹⁹ PC Barr interview (14 May 1998) CA0012 Tape 2 p.6 [00120041]

³⁰⁰ A/PS Ellerington statement (1 April 1998) CA008 p.4 [00080199]

³⁰¹ A/PS Ellerington interview (15 May 1998) CA0013 Tape 1 p.8 [00130011]

- 3.388 If the recollection of A/PS Ellerington is correct in this regard, it would suggest that PC Dawson did believe that the behaviour of Mr Alder at the hospital was pretence; and that PC Blakey shared that view. The opinions of the two arresting officers seem to have helped form the opinion of A/PS Ellerington, who had, to that point, seen very little indeed of Mr Alder.
- 3.389 A/PS Ellerington said that, having followed the two arresting officers into the custody suite, he thought that it was possible that he might be asked to return Mr Alder to hospital. When the handcuffs were removed from Mr Alder, however, he concluded that this was unlikely and that he could return to his other duties.³⁰² A/PS Ellerington played no further part in the events that were to follow, and he was not present when Mr Alder died. He had, however, been present for approximately four and a half minutes while Mr Alder was lying face down on the floor of the custody suite.
- 3.390 Acting Police Sergeant Kevin Bulless was also on duty that night and was present when A/PS Ellerington left the station in response to the call from the hospital.³⁰³ A/PS Bulless was still there when his colleague returned, and said that:
- “He told me that they had brought a prisoner into custody who was feigning injury or something like that. He did not go into detail. It was just a comment. I was doing some paperwork and he also sat down to do some paperwork.”
- 3.391 In interview with West Yorkshire Police, A/PS Ellerington said that his primary belief was that Mr Alder was feigning sleep, although he said that he kept an open mind. He also accepted that he still had a duty of care to Mr Alder, even when he had been carried into the custody suite, but he felt that the sound of “snoring” indicated that Mr Alder was breathing, and therefore that he was not at risk. The situation was summarised by Supt Holt when he questioned A/PS Ellerington:³⁰⁴

Q. Just going back to the explanation given by the officers, it's fair to say that the only comment the only information given to Sergeant Dunn was this was all a play act. There was nothing else, there were no other alternatives put forward, is that right?

A. Yes.

Q. Did that accord with what you were thinking?

A. Yes.

³⁰² A/PS Ellerington interview (15 May 1998) CA0013 Tape 1 p.9 [00130012]

³⁰³ A/PS Kevin Bulless statement (19 May 1998) CA007 pp.180-2 [00070181-3]

³⁰⁴ A/PS Ellerington interview (15 May 1998) CA0013 Tape 2 p.9 [00130034]

- Q. ...you didn't have any other views in mind, that this man was drunk and asleep, or drunk and incapable, drunk and unconscious?
- A. As we've discussed earlier I had an open mind but from what I had seen and the information I had been given, I was of the opinion that he was feigning being asleep.

Explanations: PS Dunn

3.392 PS Dunn³⁰⁵ made his statement on 1 April 1998. He described his first impression of seeing Mr Alder:

“that he was possibly drunk and incapable of looking after himself”.

3.393 PS Dunn noted all of the injuries to Mr Alder that were immediately apparent, and, as is clear from the video, requested that he be taken back to the hospital. He stated that, after his discussion with PC Dawson:³⁰⁶

“At some point I formed the opinion, from what I was told, that the man's behaviour at the present time may be play acting or attention seeking.

I noticed that he was lying still, in the position in which he had been placed. His face was down and he was breathing out into and through the pool of blood on the floor, this was making a gurgling noise and was very loud – this seemed to support PC DAWSON's assertions.”

3.394 PS Dunn then went on to describe his conversations with PC Dawson regarding possible charges, but had no more direct dealings with Mr Alder until PC Barr pointed out that he had stopped breathing. PS Dunn and PC Barr were jointly responsible for the ensuing attempts at resuscitation that were made prior to the arrival of the ambulance crew.

3.395 In his interview with West Yorkshire Police on 15 May,³⁰⁷ PS Dunn said that:

“both he [PC DAWSON] and PC BLAKELY [sic] told me that they were under the impression that Mr ALDER was putting it on, i.e. putting on the fact that he was, he was laid and the floor [sic] and they were making out that he was putting it on”.

³⁰⁵ PS Dunn statement (1 April 1998) CA008 p.2 [00080202]

³⁰⁶ PS Dunn statement (1 April 1998) CA008 p.5 [00080205]

³⁰⁷ PS Dunn interview (15 May 1998) CA0014 Tape 1 p.10 [00140013]

3.396 He went on to say that he was satisfied that PC Dawson had asked the right questions, and that the hospital had said that Mr Alder was fit to be detained. The sergeant referred to the fact that he had worked with PC Dawson in the past, when the PC had carried out the role of warder now being filled by PC Barr. He said of PC Dawson that:

“I know how he works and I’ve obviously worked quite closely with him”,

implying that he trusted PC Dawson’s judgement.³⁰⁸

3.397 He made it clear that he did not have particular concerns, as he thought that Mr Alder was in a safe position; although he went on to comment that:³⁰⁹

“He’d been making these noises which I again interpreted as him blowing [through] the blood and I thought he was doing that, bearing in mind the previous information I’d received I thought he was doing that to try and upset us and rattle us because of the noise he was making by blowing [through] the blood.”

3.398 When pressed by the officers from West Yorkshire Police, PS Dunn stated that he was satisfied that he knew enough about Mr Alder’s condition; he agreed that he did nothing to physically rouse him, but felt there was no need to do so. He was asked:³¹⁰

Supt Holt: Did you ask the officers what condition he’d been in when they placed him in the police van at the hospital, whether he’d been as he was now presented to you?

PS 1028: No I don’t think I did. I think at some stage they did tell me that he’d walked into the van, but I don’t recall actually asking the question.

3.399 PS Dunn was also asked about whether Mr Alder was searched at that stage. PS Dunn agreed he had not been, but that he did not consider Mr Alder to be a threat.³¹¹

3.400 The fact that Mr Alder was doubly incontinent was remarked upon by several of the officers. PS Dunn said in his duty statement that:³¹²

“The first thing that struck me about him was that his trousers and underpants were pulled down to his knees and he had obviously messed himself as there was excretia [sic] in his

³⁰⁸ PS Dunn interview (15 May 1998) CA0014 Tape 2 p.6 [00140030]

³⁰⁹ PS Dunn interview (15 May 1998) CA0014 Tape 1 p.13 [00140016]

³¹⁰ PS Dunn interview (15 May 1998) CA0014 Tape 2 p.9 [00140033]

³¹¹ PS Dunn interview (15 May 1998) CA0014 Tape 2 p.16 [00140040]

³¹² PS Dunn statement (1 April 1998) CA008 pp.2–3 [00080202–3]

underpants. His trousers were also wet as though he had urinated himself.”

3.401 PS Dunn also mentioned this in interview with Supt Holt.³¹³

3.402 A/PS Ellerington said in his statement that:³¹⁴

“In the Charge Room I noted that ALDER was still snoring loudly as if in a deep sleep. I noticed his underpants were soiled with excreta.”

3.403 Neither PC Dawson nor PC Blakey mentioned the incontinence in their statement, and when PC Blakey³¹⁵ was asked, in interview, whether the incontinence had given him any additional cause for concern, he replied:

“Not particularly, no”.

3.404 In the interviews of the officers, the fact that Mr Alder was bleeding from his mouth, leading to a pool of blood forming around his head on the floor, was raised in questions put to PC Blakey, PC Barr and PS Dunn. Both PC Blakey and PC Barr recalled the blood when questioned. PC Blakey recalled it as:³¹⁶

“Only a small amount because I understand he’d had a tooth knocked out when he’d been assaulted earlier so I presumed it was blood from that wound.”

3.405 PC Barr also agreed that he had seen the injury after PC Dawson commented upon it, but that it was not an injury that had caused him concern.³¹⁷

3.406 PS Dunn mentioned the pool of blood himself, and went further in his description, as he recalled Mr Alder blowing through the blood as he breathed out. PS Dunn had interpreted this as being a deliberate ploy to upset the police officers present. He based this belief, seemingly, upon the explanation given to him by the arresting officers.³¹⁸

3.407 Neither PC Dawson nor A/PS Ellerington was asked about the pool of blood in any detail.

³¹³ PS Dunn interview (15 May 1998) CA0014 Tape 2, p.4 [00140028]

³¹⁴ A/PS Ellerington statement (1 April 1998) CA0008 p.4 [00080199]

³¹⁵ PC Blakey interview (14 May 1998) Tape 2 p.19 [00110054]

³¹⁶ PC Blakey interview (14 May 1998) CA0011 Tape 2 p.17 [00110052]

³¹⁷ PC Barr interview (14 May 1998) CA0012 Tape 2 p.11 [00120046]

³¹⁸ PS Dunn interview (15 May 1998) CA0014 Tape 1 p.13 [00140016]

Other explanations

- 3.408 Matron Bridget Winkley had been a civilian employee of Humberside Police for ten years at the time of the death of Mr Alder. Although not a police officer, she was required to work similar shifts, and was designated to work with the same personnel on a regular basis. She appears to have been familiar with the workings of the custody suite and with many of the duties of the officers who were her colleagues.
- 3.409 Matron Winkley had worked with PS Dunn for approximately six months prior to 1 April and with PC Barr for a shorter time. She made it clear in her statement to West Yorkshire Police that she held PS Dunn in high regard, and had great respect for his skills as a custody sergeant. She was trained as a first-aider, and her skills were more up-to-date than the officers, in that she had last been trained two years before, and had a further year to go before she would need to refresh her training.
- 3.410 On the morning of 1 April, Matron Winkley was working the same shift as PS Dunn and PC Barr.³¹⁹ At the time that Mr Alder was brought into the custody suite she was occupied with other tasks, but returned to find her two colleagues talking with PCs Dawson and Blakey, whom she also knew. At the time of her return, PS Dunn was behind the counter area, facing the two PCs on the other side. Her statement indicated that she did not see Mr Alder straight away, and was not involved in their conversation. She did recall that PS Dunn had said something to her about a man not being decent. The video shows that at almost exactly 03.51 [video counter 03:51:00] PS Dunn does make a comment about a man having no trousers on. This may well be the comment, although Matron Winkley is not seen on the video until 03.55.
- 3.411 It is striking that Matron Winkley recalls that the man was making what she described as “ruttling” noises.³²⁰ She commented that:
- “By this I mean a form of gargling noise as if he was snoring when laid on his back”.
- 3.412 She went on to say that this noise was commonly heard from drunks, and thought that there was no immediate danger. Because she was told not to go round to the man, she would not have seen that he was not making these noises while on his back but when face down. Whether this would have influenced her judgement, it is not possible to say. She was well aware of the need to regularly rouse any detainee in a cell who was intoxicated, and could do this on her own initiative, but she did not involve herself in rousing Mr Alder.

³¹⁹ Bridget Winkley statement (1 April 1998) CA007 p.116 [00070117]

³²⁰ Bridget Winkley statement (1 April 1998) CA007 p.119 [00070120]

- 3.413 Matron Winkley was not invited to assist with the management of Mr Alder and played no evident part in the discussion as to his possible charging. She did seek to provide assistance when the officers became concerned at his silence and was party to the attempts by the two officers to try to revive Mr Alder. It was Matron Winkley who later organised the moving of female detainees from the cell block to other police stations.
- 3.414 PC Darren Wildbore had also entered the custody suite, behind the counter, and was involved in completing a search register for a different case. He described his arrival as being at about 03.55, and that all five officers and Matron Winkley were present.³²¹ In fact A/PS Ellerington left the suite at 03:51:23, so his arrival must have been before that time.
- 3.415 PC Wildbore said that when he entered the suite he worked on his search register, and noticed the other officers looking at the ground. He looked over the counter, and at that stage saw Mr Alder still handcuffed on the floor; PC Wildbore described the handcuffs quite clearly. As no attempt to take off the handcuffs was made until 03.50, it is reasonable to assume that the officer who can be seen to look over the counter [at 03:50:07 on the video counter] is PC Wildbore. He describes having little to do with what was going on, and left the custody suite when the ambulance arrived.
- 3.416 Although a second statement was obtained from PC Wildbore on 19 May by Insp. Tolan of West Yorkshire Police, PC Wildbore repeats the assertion that he arrived in the custody suite at 03.55.³²² This assertion goes unchallenged, although it is clearly contradicted by his own description of what he saw, and by his appearance five minutes earlier on the video. PC Wildbore was therefore in the custody suite from within a matter of about two minutes after the arrival of Mr Alder and remained there throughout the crucial period. He was present for far more time than A/PS Ellerington, who had left the room when the handcuffs had been removed.
- 3.417 Inspector John Ford was the 'shift inspector' for the relief who were on duty that night at Queen's Gardens police station. He was to describe hearing a radio message which caused him to attend the custody suite.³²³ As Insp. Ford is first seen shortly after 04.00, it is reasonable to conclude that he heard the call put out for an ambulance. What he subsequently describes is essentially what can be seen on the videotape, and he adds very little to that.

³²¹ PC Wildbore statement (1 April 1998) CA007 p.112 [00070113]

³²² PC Wildbore statement (19 May 1998) CA007 p.115 [00070116]

³²³ Insp. Ford statement (9 April 1998) CA007 p.183 [00070184]

Other events in the custody suite

- 3.418 Although it was not appreciated until a much later stage, other events occurred in the custody suite on the night of Mr Alder's death that were to cause grave concern on the part of his family and many others. These did not come to light properly until nearly four years later, around the time of the eventual trial of the officers in 2002. It flowed from the identification of background conversation and noises that were picked up indistinctly on the audio track of the videotape.
- 3.419 These noises were voices which can be heard at approximately 05.45, although it is not possible to see, on any of the videotape, who was speaking. The reason for this is that the people involved were behind the counter of the custody suite, which is not viewed by the cameras. By the time they occurred, there is no doubt that Mr Alder had been dead for some time. The custody suite had been declared a potential crime scene, and a number of officers were beginning or had already begun work in relation to the investigation started by Humberside Police.
- 3.420 The sounds were picked up by the microphone in the custody suite and clearly represented conversation that could have been no more than a few yards from the body of Mr Alder, which remained where it was, pending the arrival of the FME and pathologist. It was believed that one of the voices was that of PC Barr. The particular words that caused concern were thought at first to include the expression "banana boat" and to be followed by monkey-like noises. If this were the case, the possibility existed that some form of racial abuse had been used in the immediate vicinity of Mr Alder's body. Given that he was the only identified black person in the area of the custody suite during the relevant period, if there were abuse it would have been directed at him.
- 3.421 The issue came to light when Mr Patterson, junior counsel for the Crown at the trial, reviewed the unused material, including the latter sections of the videotape. He believed that the noises may be of potential relevance, not because of racism, but because of conversation involving PS Dunn, in which the officer appeared to be justifying his actions to some other person.
- 3.422 On 22 May 2002, Mr Chris Enzor of the CPS wrote to Ms Alder setting out the subsequent history from that discovery onwards³²⁴ and explaining the reasons for the decisions taken by the CPS. Mr Enzor explained that following preparation of an initial transcript, the words used were believed to be:

"Yeah, that's it, yeah, he's alright, [inaudible] I'm not going on that fucking boat sir, fucking banana boat, I'm not going on one",

³²⁴ CPS letter (22 May 2002) CA002 D17 [00020528-30]

and were thought to have been said by PC Barr. The Crown viewed them as potentially relevant and took steps to have them admitted as evidence, informing the court and defence. The defence, however, disagreed as to the transcript accuracy and contended that the words actually were:

“I’m not going home in that fucking blue suit [laughter], fucking banana boots on, I’m not going home [laughter]”.

3.423 In light of this disagreement, the tape was referred to an independent consultant who specialised in the forensic analysis of speech. Her name was Elizabeth McClelland. Ms McClelland prepared a report dated 21 April 2002.³²⁵ The relevant sections of the tape were examined intensively, and a transcript produced. It was only at this stage, for the first time, that the suggestion arose that the conversation might have included the sound of someone impersonating a monkey. The words studied were rendered as follows in the transcript prepared:

BARR: I’ll not go down in that fucking blue suit [laughter]
fucking banana boat...I’m not going home in
[(one)]

?V: [mimicking sound of a chimpanzee or ape] “hoo
hoo hoo” [approx. 11 times]

[laughter]

?FV (Oh God)

BARR Or if I go I hope the hood goes over me chin

MV ((Stuff)) your [coat]...

BARR [Wrap me coat all around ((put)) two eye holes
in...

[approx. 10 seconds no speech]

3.424 Some words, in double brackets, were very indistinct, and at times there was overlapping speech. The voice marked as “?V” is unknown, and that marked as “?FV” denotes an unknown female voice. MV denotes a male voice.

3.425 Mr Enzor’s letter also explained to Ms Alder that the defence had pointed out, and the CPS had independently verified, that Humberside Police used blue disposable suits and yellow disposable overshoes, when clothing was seized for examination. The overshoes were known as ‘banana boots’ throughout Humberside Police. The assertion that

³²⁵ E McClelland statement (21 April 2002) CA106 pp.128–38 [01060130–40]

PC Barr was complaining about having his uniform seized, and about being given brightly coloured overalls and boots, was therefore supported by the analysis of the tape, and independent evidence.

3.426 It was because of the fuller explanation that the decision had been taken not to use the material during the trial.

3.427 A pair of bright yellow fabric overshoes has been provided to the IPCC by Humberside Police.³²⁶ These overshoes, when unfolded, are 35 cm long and 24 cm high and are elasticated around the top. They are designed to fit over an ordinary shoe of the size worn by a standard man, to prevent contamination at scenes of forensic interest. They are not designed for replacing detainees' shoes. Photographs of these overshoes are attached at Appendix 25.

3.428 On 26 September 2002, after the trial was over, Dr French of J P French Associates received a copy of the tape from C/Supt Everett of Humberside Police, with a view to analysing the noises and voices that had become the subject of controversy. The Deputy Chief Constable of Humberside Police, Gordon Clark, indicated, in a memorandum to the Police Complaints Authority (PCA), that he requested the report from Dr French.³²⁷ Dr French is a leading independent forensic consultant who is an expert in the analysis of sound. His statement was produced, dated 22 November 2002.³²⁸ He was asked to consider in particular the monkey noises. His report provided the following observations:

"The sounds occur at lines 2 and 4 of the transcribed section below.

1. B **I'm not going out in a fucking blue suit.**
 2. [**Questioned** sounds for 3.7 seconds]
 3. B **Fucking banana boots, I'm not going home in them.**
 4. [**Questioned** sounds for 12.3 seconds]
 5. W **Oh, God.**
- (B = PC Barr; W = Matron Winkley.)

At line 2 the sounds are quite clearly laughter. I hear both a woman and a man laughing here. The woman's laugh is considerably louder than the man's. The woman must be Winkley, because she is the only woman present. Given that the laughter appears to be in response to Barr's comment at line 1, it would seem reasonable to suppose the man to be Dunn. This view would also gain support from the fact that when Barr resumes speaking at line 3 – just over 3 seconds later – he is not laughing.

³²⁶ Yellow overshoes CA0033

³²⁷ Humberside Police report (30 September 2002) CA002 D47 [00020443–78]

³²⁸ Dr French report (22 November 2002) CA0002 D59 [00020399–401]

At line 4 I hear someone produce 12 high pitched vocalisations (312–450 Hz). Rhythmically, they are relatively metronomic, the timing between them varying only between 160 and 200 milliseconds. The indications are that the person involved is Dunn. I take this view, firstly, because the first of the twelve vocalisations occurs in overlap with the last word ('them') of Barr's utterance at line 3. This would indicate that it is not Barr. Secondly, the eleventh vocalisation is simultaneous with Winkley laughing on an in-breath. This would eliminate Winkley, and leaves only Dunn.

It is these 12 vocalisations that could most easily be interpreted as a monkey impression. They do appear rather more regular in pitch and rhythmical structure than most people's laughs. However, some people have unusual laughs and without reference samples from the person concerned with which to compare it, I find myself unable to provide a view based purely on the analysis of the sounds."

3.429 Matron Bridget Winkley did agree to be interviewed, and was asked about the incident.³²⁹ Her recollection was as follows:

A. This was me and Matt Barr discussing about monkey suits and banana boots. Have you seen the things? They were yellow to go over your shoes, and the suits were yellow too. They were the ones we give to prisoners when they have their clothes taken off them, and Matt was worried we might have to put them on. That's just the way the clothing was described. Everyone called it that.

Q. Was it you laughing?

A. Yes, it was me. I was just laughing at Matt.

3.430 DCC Clark of Humberside Police had already written to the PCA rejecting the suggestion that the noises were racist. He later sent the report of Dr French to them. The exchanges in relation to this matter, and the conclusions drawn, are set out below, when I consider the disciplinary process that followed the trial of the five officers. It is relevant to note here that the PCA and Humberside Police did agree on this aspect of the events, in that both organisations concluded that the behaviour was not deliberately racist, but that it displayed great insensitivity and lack of respect for the deceased man, who was lying only a few feet from the officers.

³²⁹ Bridget Winkley interview (10 March 2005) CA0138 p.4 [01380006]

New evidence

3.431 One new and surprising piece of evidence that has emerged from the tapes concerns the activity in the custody suite nearly four hours **before** Mr Alder arrived there. This was found as a direct result of the decision to watch all of the custody suite video for the full period of the shift.

3.432 At 23.52 on the evening of 31 March a woman was admitted to custody at Queen's Gardens police station. I shall refer to her by her initials, which were LM. She was arrested by PC Goode and PC Rogers (the same officers who later saw Mr Alder at Hull Royal Infirmary). LM was also arrested close to the infirmary and was described in her custody record as being extremely drunk.

3.433 The video of the custody suite reveals that, having been brought to the station, LM was held in the rear of the van outside the station door, until a juvenile had been moved out of the custody area. Arrangements were then made to bring her in. The van was in the space that could be viewed by CCTV from behind the custody desk, and those inside could clearly view her being brought towards the suite. At one stage, PS Dunn is heard to call out:

“Yes she's running, yes, she's doing a runner.”

3.434 At this point, the sergeant made a series of grunting noises which may well have been intended to be chimpanzee-type noises. He also made monkey gestures with his arms. It is important to note that LM is white, as was every other person seen on the custody suite video.

3.435 This new material permitted a comparison to be performed with the sounds heard later in the night. Obviously, the fact that such noises were made at any point might have rendered it more likely that the noises made several hours later on were monkey noises and, as is concluded by Dr French in his report, that they were made by PS Dunn.

3.436 In order to perform a comparison the IPCC approached Control Risks Group, who in turn commissioned Ms Elizabeth McClelland. It was Ms McClelland who first suggested that the sounds at 05.45 included monkey noises.

3.437 The comparison carried out by Ms McClelland concluded that there was a series of “vocalisations” by PS Dunn, in the earlier incident, but that these were not in her opinion monkey sounds. She maintained, however, that the later noises – which were much more indistinct – were far more likely to be monkey noises. Her summary of conclusions compared Extract 1 (05.45 noises) and Extract 2 (23.52 noises). Her view was that:

- there were auditory-phonetic and acoustic differences between the vocalisations in Extract 1 and Extract 2;
- the vocalisations in Extract 1 were probably intended to be 'monkey' sounds;
- the vocalisations in Extract 2 were probably a comment on someone who the speaker could see 'running/doing a runner'.

3.438 This aspect of the case is one that has caused a great deal of controversy and was one that led to much debate. It is obviously an aspect that would have been raised with PS Dunn and PC Barr, if they had agreed to give evidence to the Review.

3.439 My conclusions in relation to this assessment and the behaviour of the officers in this regard are set out below, as part of Chapter 9.

CHAPTER 4: THE TWO INVESTIGATIONS

Introduction

- 4.1 The death of Mr Alder triggered two separate investigations: the first of these by Humberside Police, as the local force, responsible for investigating whether the blow he sustained outside the Waterfront Club was an unlawful assault and whether it had led to his death. The second investigation, triggered by the fact that he died in police custody, was to be conducted by West Yorkshire Police under the supervision of the Police Complaints Authority (PCA). While there is inevitable overlap between the two inquiries, I have attempted to consider each of the two investigations separately, so far as this is possible. I have also considered the role of the PCA in the early stages of the inquiries.

The Humberside Police inquiry – first steps: notification and scene preservation

- 4.2 At the time of the death of Mr Alder, the senior officer on duty, supervising the custody suite, was Inspector (Insp.) John Ford. Having overheard the radio messages that were being passed at about 04.00, he was one of the first persons to enter the custody suite following the realisation that Mr Alder had stopped breathing. He also witnessed the attempts being made by Police Sergeant (PS) Dunn and Police Constable (PC) Barr at that time to resuscitate him.³³⁰ Present at the time were PCs Dawson, Blakey and Wildbore, and the matron, Bridget Winkley.
- 4.3 Once the ambulance crew arrived, Insp. Ford recalled that he left the room to make arrangements for the preservation of the scene, consulting Acting Police Sergeant (A/PS) Bulless and PS Neal. Although scene preservation was recognised as necessary, the ambulance crew, following the death of Mr Alder, were allowed to remove their equipment and the items that they used for the attempted resuscitation. One aspect of this that was to cause concern later was the removal of the suction equipment used by the two crew members in their attempts to clear the airway of the stricken Mr Alder. The possibility was raised that a second tooth, which was lost at some stage during the course of the evening, might have been sucked up by the equipment and lost.
- 4.4 Insp. Ford, who was interviewed in the course of the Review, did not recall discussing the removal of equipment and recognised with

³³⁰ Insp. Ford statement (9 April 1998) CA007 pp.183–4 [00070184–5]

hindsight that it might have been better if the equipment had been left in situ, given that the room was becoming a potential crime scene.³³¹ Mr Krebs in interview with the Healthcare Commission (HCC) made clear that, in his view, the suction equipment would not simply have 'vacuumed up' a tooth, and that, if the tooth were in the airway of Mr Alder, it would have been seen.³³²

- 4.5 PCs Dawson and Blakey left the custody suite at some stage and wrote notes in respect of their duties over the preceding hours.^{333,334} Apart from the note that PC Dawson described making at the hospital, these notes were the earliest record made by them. A/PS Bulless later countersigned the pocket notebooks of PC Dawson and PC Blakey to confirm the timing of those notes, at 04.45.³³⁵
- 4.6 During the hours following the death of Mr Alder, a team of police officers from Humberside Police were assembled to work on the investigation of the death. The case was treated in the first days, and in practice throughout April, as being a potential murder. Although Humberside Police had changed the charges against Mr Paul from murder to Grievous Bodily Harm (GBH) with Intent on 2 April, the investigation continued to be described as and treated as a murder inquiry. The personnel and resources committed were therefore commensurate with the investigation of a murder.
- 4.7 The senior investigating officer (SIO) was Superintendent (Supt) Ken Bates. He was supported by Detective Chief Inspector (DCI) Paul Davison, as Deputy SIO, and Detective Inspector (DI) David Brookes. Supt Bates, in interview with the IPCC said that:
- "I was at the time one of the, perhaps the, most experienced SIO in the force. I have been an SIO since 1994 at force headquarters...The force at that time had a rota of senior detective officers that were on call...I just happened to be the Detective Superintendent on call at that particular week."³³⁶
- 4.8 DCI. Davison, in interview with the IPCC, recalled that he was appointed at around 06.00 to 06.30 in the morning,³³⁷ and Supt Bates had been called at around 07.00.³³⁸ DCI. Davison was made responsible, over the next few hours, for establishing an incident room, and for setting up an account on the HOLMES computer, the decision having been made to run the investigation on that system. Supt Bates

³³¹ Insp Ford interview (11 March 2005) p.5 [01310007]

³³² Stephen Krebs interview (10 March 2005) Tape 2 pp.5-6 [01200039-40]

³³³ PC Dawson notes CA008 [00080212-19]

³³⁴ PC Blakey notes CA008 [00080220-4]

³³⁵ A/PS Bulless' statement (19 May 1998) CA007 pp.180-2 [00070181-3]

³³⁶ Supt Bates interview (22 April 2005) Tape 1 p.5 [01320007]

³³⁷ DCI Davison interview (10 March 2005) [01360003]

³³⁸ Supt Bates interview (22 April 2005) Tape 1 p.6

was officially confirmed as the SIO to head the inquiry by Assistant Chief Constable (ACC) Michael Speakman later in the morning.

- 4.9 Humberside Police also involved their discipline and complaints (D&C) department because the death involved a death in custody. The fact that the death was in police custody meant that an external police force was invited to carry out an investigation, but the D&C department was to remain nominally involved in the case throughout its entire course, up to and including disciplinary proceedings against the five main officers, which happened five years later.
- 4.10 The Humberside police officers working in the D&C department included C/Insp. Alan Beckett and Supt Michael Brightmore. The D&C department reported to the Deputy Chief Constable (DCC) of Humberside Police. At a much later stage Supt Brightmore was succeeded by C/Supt Andrew Everett.
- 4.11 During the course of the Humberside Police investigation a number of police officers were directly involved in making enquiries. Although not an exhaustive list, there are 17 individual officers below the rank of inspector whose names appear on actions connected with the investigation.³³⁹ The force was also able to call upon other police constables to perform actions such as the preservation of crime scenes. It is evident from the documentation that the Humberside Police investigation was treated very seriously, and considerable time and effort was invested in it by a substantial body of police officers.
- 4.12 The Humberside Police command and control logs list some of the early actions taken in relation to the death of Mr Alder.³⁴⁰ At 04.55 Insp. Ford called DI Brookes (the divisional DI), and by 04.59 the forensic medical examiner (FME), Dr Naughton-Doe, had been summoned. C/Supt Sanderson, the senior officer in 'F' Division of Humberside Police, was notified at 05.10 and at 05.23 C/Insp. Beckett of the D&C department had been contacted. DI Brookes recalled that he gave instructions to Insp. Ford, regarding preservation of the scene, before travelling to the station.³⁴¹
- 4.13 Enquiries at the scene of the initial assault were also commenced promptly. At 04.53 PCs Bennett and Raven were sent to obtain any CCTV footage that could be found from Prince's Quay, opposite the Waterfront Club.³⁴² Tapes were seized from a Mr Jones,³⁴³ but were considered to be of such poor quality that they added nothing to the tapes taken from the Waterfront Club camera. The area around the

³³⁹ Officers Douglas, Adcock, Bennett, Constable, Fountain, Goforth, Mainland, Marsden, Mellors, Naylor, North, Smith, Stainforth, Stephens, Wade, Weir and Woodcock.

³⁴⁰ Command log CA0067 at D9 [00670026-9]

³⁴¹ DI Brookes statement (27 April 1998) CA007 pp.191-3 [00070192-4]

³⁴² PC Bennett statement (1 April 1998) CA0095 p.150 [00950151]

³⁴³ Gary Jones statement (1 April 1998) CA0095 pp.17-18 [00950018-19]

Waterfront Club was closed off and by 07.27 a call was received from the local newspaper, the *Hull Daily Mail*, seeking details of what had happened, although no information was passed out.³⁴⁴

- 4.14 Dr Naughton-Doe, the FME, reached the police station at about 05.30 and David Berridge, the scene of crime officer (SOCO) arrived at 05.45.³⁴⁵ Both men entered the custody suite at 07.15 in company with Detective Sergeant (DS) Dickinson, who was attached to the Scientific Aids Department of Humberside Police.³⁴⁶ Dr Naughton-Doe made a formal declaration of death at 07.20.³⁴⁷ Mr Berridge took photographs of the scene.
- 4.15 DI Brookes consulted with Dr Naughton-Doe, was briefed by DS Dickinson and questioned PS Dunn. DI Brookes was later responsible for briefing C/Supt Sanderson and C/Insp. Beckett, of the D&C department, as to the events of the night.
- 4.16 Humberside Police had notified HM Coroner for Hull and East Riding, Mr Geoffrey Saul, who in turn appointed a pathologist to carry out an initial post mortem examination of the body of Mr Alder. That pathologist was Dr John Chalmers Clark, a senior lecturer in forensic pathology at the University of Sheffield and consultant pathologist to the Home Office. Dr Clark was later able to confirm that he had been called at about 07.00 on the morning of the death, and had attended Queen's Gardens police station, where he met with the coroner and police officers.³⁴⁸ Once he had been briefed on the known facts, he was able to examine the body of Mr Alder in the custody suite at about 10.15. He was accompanied by the coroner, by the coroner's officer, Mr Grimble, and by DS Dickinson.³⁴⁹
- 4.17 Mr Berridge later assisted in placing bags over the hands of the body of Mr Alder, to preserve any potential evidence. He then moved the body into a body bag for removal from the scene, following the examination of the scene by the coroner and the pathologist.³⁵⁰
- 4.18 At 11.00 documents from the Accident and Emergency department at Hull Royal Infirmary (HRI) were seized by Detective Constable (DC) Stephens. The file relating to Mr Alder was handed over by Mr Harper, the general manager of trauma services.³⁵¹ The documents were provided to him by his secretary Victoria Frost,³⁵² who had received

³⁴⁴ Command log CA0067 at D9 [00670028]

³⁴⁵ David Berridge statement (2 April 1998) CA007 p.129 [00070130]

³⁴⁶ DS Dickinson statement (12 May 1998) CA0023 [00230035–6]

³⁴⁷ Dr Naughton-Doe statement (2 May 1998) CA007 pp.126–8 [00070127–9]

³⁴⁸ Inquest Day 15 p.28.

³⁴⁹ DS Dickinson statement (12 May 1998) CA0023 [00230035–6]

³⁵⁰ David Berridge statement (2 April 1998) CA007 p.129 [00070130–1]

³⁵¹ Alan Harper statement (1 April 1998) [00800716–17]

³⁵² Victoria Frost statement (22 April 1998) [00800751]

them from Senior Charge Nurse Lesley Whittaker.³⁵³ The witnesses later confirmed the authenticity of the records to DC Mellors.³⁵⁴

Involvement of the PCA

- 4.19 At some point, in the early hours of 1 April, a call was made to the offices of the PCA in London, to notify the authority that a death had occurred in police custody. Notification was passed to the member of the PCA with responsibility for Humberside Police, Mr Jim Elliott.
- 4.20 The investigation of deaths in custody at the time was carried out within the framework of the Police and Criminal Evidence Act 1984, which established the PCA. The PCA was given powers to supervise police investigations and to make recommendations in relation to police discipline. By 1998, although there was no legal obligation on forces to refer deaths in custody to the PCA, it had come to be accepted practice to do this immediately.
- 4.21 Once a case was referred to the PCA, it would be supervised by a member of the Authority. The PCA had no power itself to carry out an investigation; the most it could do was to supervise a police investigation, and the highest level of independence in a police investigation was the appointment of another police force. No regulations existed for how such supervision would be carried out, but at the end of the investigation the PCA was required to issue an 'interim statement' – a short document which set out whether the investigation had been conducted to the PCA's satisfaction.
- 4.22 This document was required before the Crown Prosecution Service (CPS) could make a decision about whether any criminal proceedings would be taken as a result of the investigation, and in practice an investigation was not submitted to the CPS until the interim statement had been issued. If no proceedings were issued, the investigation file would then pass to the coroner, who would hold an inquest.
- 4.23 After issuing its interim statement, the PCA's role was effectively on hold until any criminal proceedings and the inquest were concluded, a process that could (and in this case did) take years. The PCA was then required to consider a memorandum from the Chief Officer of the force under investigation, with recommendations for discipline against the officers. This was known as the 'misconduct review' stage, and at this point the investigation file was passed to another PCA member to make a decision about the disciplinary aspects. The PCA also had the ultimate power to direct that a misconduct tribunal be convened. It had no powers in relation to the conduct of any proceedings.

³⁵³ Lesley Whittaker statement (22 April 1998) [0080761–2]

³⁵⁴ DC Mellors statement (23 April 1998) CA0095 pp.41–2 [00950042–3]

4.24 The PCA was replaced by the IPCC with effect from 1 April 2004. In contrast to the former approach, deaths in custody **must** be referred to the IPCC, which has the power to investigate them itself. While there has been no change to the involvement of the CPS or the coroner, the IPCC now seeks to liaise with all relevant parties at an early stage to reduce potential delays. The police discipline system remains largely unchanged although it is currently under review.

4.25 Having made contact with the PCA, Humberside Police also approached an outside police service to provide an investigating officer. The service chosen was West Yorkshire Police.

4.26 C/Insp. Beckett of Humberside Police D&C department was asked in interview by the IPCC what the rationale had been in the selection of West Yorkshire Police.³⁵⁵

Q. How did he decide on West Yorkshire?

A. I think the fact that they're close by, so logistically it was a handy force to have investigate. I think we had done an investigation for them or something, so they owed us one. It was that type of decision.

Q. So the return of a favour-type decision?

A. Yeah, it wasn't – there was nothing sort of scientific in it. It was handy. I think we had done them a favour so I think, I don't know why Mr Clark said, "Oh, well, you know, they owe us a favour so we'll ask them to do it."

4.27 West Yorkshire Police appointed an SIO named Supt John Holt (later Chief Superintendent). Supt Holt was appointed on the morning of Wednesday 1 April, and travelled over to Hull that same morning. He brought with him Insp. Keith Tolan and Insp. Paul Morris.³⁵⁶ Supt Holt recalled reaching Hull at about 13.15 on 1 April.

4.28 Supt Holt, Insp. Tolan and Insp. Morris were almost the only officers who worked on the West Yorkshire Police investigation in the following weeks. The only other officer identified as playing a part in the West Yorkshire Police investigation during the month following Mr Alder's death was an Insp. Grubb.

4.29 The terms of reference for the West Yorkshire Police investigation were:

"to investigate the circumstances leading to the death in police custody of Christopher Alder and any other matters arising."³⁵⁷

³⁵⁵ Insp. Beckett interview (11 March 2005) Tape 1 p.17 [01180020]

³⁵⁶ Supt Holt statement (30 June 1998) CA007 pp.205–7 [00070206–8]

³⁵⁷ PCA letter (2 April 1998) CA001 D3 [00010382]

4.30 In discussion with the IPCC, Mr Elliott was later to agree that the terms of reference would have been drafted by Assistant Chief Constable (ACC) Gordon Clark of Humberside Police, and that he (Mr Elliott) would have added the words “and any other matters arising” to allow for some flexibility. (ACC Clark was later to become involved in the disciplinary aspects of the case, following his promotion to Deputy Chief Constable (DCC)). The actual selection of the SIO from an external force would have been subject to the approval of the PCA, and Mr Elliott commented upon this that:

“it was probable that the Deputy Chairman had already agreed to the appointment of Superintendent Holt before I arrived in Hull. I would only have questioned his decision if a very good reason to do so emerged and no such reason occurred in this case.”³⁵⁸

4.31 Mr Elliott recorded his early dealings with the investigation in a draft memorandum prepared on 30 March 2004 in response to a letter from Deighton Guedalla, solicitors.³⁵⁹ Mr Elliott stated that his first notice of the events in Hull came in a pager message as he was on his way to work on the morning of 1 April. That message was forwarded by Molly Meacher, who was another PCA member. He rang his office and was told of the contact from Humberside Police received that morning. He was given the briefest of details of the event of Mr Alder’s death. He decided that it would be appropriate to travel to Humberside immediately, and notified his colleagues of this.

4.32 Mr Elliott went to Kings Cross and travelled by train to Doncaster. Although lacking a mobile phone, he made contact with Humberside Police using the train operator’s radio telephone, and arranged for his collection from the station. He agreed that an external force should be brought in to investigate, and that West Yorkshire Police had agreed to provide ‘an IO and team’.

Division of responsibilities

4.33 At the same time as arrangements were being made for West Yorkshire Police to investigate the death in custody, the Humberside Police investigation into the assault on Mr Alder at the Waterfront Club was gathering pace. From the earliest stages, it was, in practice, treated as a murder inquiry. There were therefore two inquiries into the one death being conducted simultaneously by two separate police forces. In addition, there was the involvement of the PCA, which was the oversight body for the West Yorkshire Police investigation. In the middle of this arrangement was the D&C department of Humberside Police.

³⁵⁸ Jim Elliott written addition to interview notes (27 May 2005)

³⁵⁹ Jim Elliott draft letter (30 March 2004) CA0060 [00600017]

4.34 All of the relevant parties had been notified within a matter of hours and attended Queen's Gardens police station promptly. Work was then allocated and divided between these different bodies.

4.35 The initial division of responsibilities is reflected in the policy log faxed to Mr Elliott from West Yorkshire Police headquarters at 13.15 on Friday 3 April.³⁶⁰ In that document, covering the period until 18.00 on 2 April, Supt Holt wrote:

“Detective Superintendent Ken Bates has been appointed SIO for the initial incident outside the Waterfront nightclub which resulted in the assault of Mr Alder. The IO in consultation with Mr Elliot has discussed the investigation with Detective Superintendent Bates and accepts the criminal investigation will assume primacy with all incoming information being shared. Lines of enquiry when identified for each enquiry will be discussed to avoid duplication.”

4.36 However, Supt Bates told the IPCC that:

“I do not think I ever read John Holt's terms of reference at all. I did not know what the length of them was.”³⁶¹

4.37 He went on to say that:

“Initially I just wanted to actually get the show on the road so to speak, to make certain everything was preserved for West Yorkshire, to talk about what we were going to do later on with the investigating officer from West Yorkshire.”

4.38 Supt Bates met with Supt Holt early in the afternoon of 1 April:

“I think I saw him early in the afternoon to say ‘Hello, how are you?’ Then we decided, we talked about the liaison between the two inquiries. It is always a difficult balance. It certainly was there then. We made the decision to put it on HOLMES. I made certain they had access to the HOLMES database, any statements, attend any briefings and look at anything we gleaned. But there was a real need, and that was stressed to me by Gordon Clark, that the inquiry by West Yorkshire was their inquiry and I should not be seen to be in any way involved in the investigation because it was an investigation of Humberside Police and their handling of the arrest and subsequent death of Christopher in the charge room.”³⁶²

³⁶⁰ West Yorkshire policy log (3 April 1998) CA001 D11 [00010368–74]

³⁶¹ Supt Bates interview (22 April 2005) Tape 1 p.10 [01320012]

³⁶² Supt Bates interview (22 April 2005) Tape 1 p.12 [01320014]

- 4.39 Supt Bates was asked to explain how the division of roles was decided and recorded:

“I don’t think...looking at my policy book I did not actually record a protocol or terms of reference. It was verbal between John Holt and myself. We did talk regularly. John came over some mornings and attended the morning briefing.”³⁶³

- 4.40 He went on to expand upon this:

“I agreed verbally with John, and this is my best recollection, that my investigation would look at the night of Christopher’s death, his demeanour in the nightclub, his aggressiveness to other people...I was going to deal with all that and continue through to his hospitalisation...Then John was going to look after from the police involvement, the start of police involvement, they were called to the hospital, as you know, because of his demeanour in hospital, his abusiveness and aggression. He was arrested by the officers...once he was in custody John was to look after all police involvement from the hospital onward...From arrest onwards...From the police going there and having initial contact with him.”³⁶⁴

- 4.41 The relations between Supt Bates’ investigation and his own force’s D&C department were somewhat different, as described by C/Insp. Beckett in his interview with the IPCC:

“I think I must have liaised with Supt Bates and certainly quite quickly he held a briefing, and I know he was concerned that, in his words, the investigation wasn’t hijacked by Discipline and Complaints. That sort of stuck in me mind a little bit...he was leading a murder investigation and I think at that time that that was his major priority, his investigation. I don’t think he wanted, as he maybe saw it, D&C elbowing their way in and taking over...Those are the words he used in the briefing. He said that he didn’t want the investigation hijacking by D&C.”³⁶⁵

- 4.42 The overall tenor of C/Insp. Beckett’s interview made clear that Supt Bates took control and was vigorously organising the investigation from an early stage. It is clear from his interviews that Supt Bates is a strong character, and was a highly experienced investigator with a clear view as to how he wished his inquiry to be run.

³⁶³ Supt Bates interview (22 April 2005) Tape 1 p.15 [01320017]

³⁶⁴ Supt Bates interview (22 April 2005) Tape 1 p.17 [01320019]

³⁶⁵ C/Insp. Beckett interview (11 March 2005) Tape 1 p.5 [01180008]

Crime scenes and scientific evidence

4.43 Given that Mr Alder had sustained injuries outside the Waterfront Club, the area of the street outside the club was designated a 'crime scene' by Humberside Police, as was the custody area and the police van in which he had been transported. The significance of the designation is not that an assumption was made that a crime must have occurred in that place, but simply that the scene was one which may have held important clues to a possible crime. The hospital where he was treated was not classified as a potential crime scene.

4.44 A crime scene would normally be preserved and kept isolated until such time as any evidence has been gathered. It would have been the decision of the senior officer to 'release' a scene, in that the restriction upon access to it should be lifted. Supt Bates was later to indicate that the scene outside the Waterfront Club was released on his instruction, but that he had waited for the agreement of Supt Holt before allowing the other two scenes to be released.

4.45 Supt Bates was also asked about the hospital as a possible crime scene:

"We considered the hospital as a scene where he was. Although we had been up there, to actually close down a casualty department is a big step. To actually preserve a scene like that would be very, very difficult...I think I discounted the hospital because of the minor forensic involvement it would have...I preserved what I considered to be the most important evidential scenes. They are the three I decided upon."³⁶⁶

4.46 The actual preservation of the scenes had started almost immediately it was realised that Mr Alder was dead. PS Neal was one of the first officers involved, following her initial briefing by Insp. Ford. At 04.25 she took receipt of the rubber gloves worn by PC Blakey.³⁶⁷ She then went to the rear yard of the station at 04.36 and sealed off the Mercedes van used to transport Mr Alder, using police incident tape to mark the area.

4.47 At 07.35 SOCO DC Ward went to the area outside the Waterfront Club and took swabs from blood traces found on the ground outside the club.³⁶⁸ She also took photographs of these stains. While there, between 09.30 and 10.00, SOCO DC Ward examined video evidence and took further photographs outside the club. At 10.10, Richard

³⁶⁶ Supt Bates interview (22 April 2005) Tape 2 p.12 [01320039]

³⁶⁷ PS Neal statement (1 April 1998) CA0095 pp.235-6 [00950236-7]

³⁶⁸ DC Ward statement (2 April 1998) CA0095 pp.43-6 [00950044-7]

Taylor, the manager at the Waterfront Club, was asked for the club's CCTV videotape, number 31, which he gave to DC Naylor.^{369,370} The same officer also received a staff rota book from door supervisor Robert Stevenson at the club at 13.00.³⁷¹ The videotape was made police exhibit RJMT/1 and was passed on to DC Woodcock at Tower Grange police station that afternoon.³⁷² This same exhibit is the main photographic record of the events outside the club in the early hours of 1 April.

- 4.48 At Queen's Gardens police station, the custody suite had been closed off as a potential crime scene. The area immediately around Mr Alder's body was the preserved scene, as subsequent analysis of the tape indicated that people were still in the area behind the custody suite counter for some time after his death. Formal access was granted for the FME and the SOCOs and subsequently the coroner, the pathologist and investigating officers.
- 4.49 Another SOCO, Michael Gallagher, examined the van where it had been parked in the police station yard. Mr Gallagher was a former police officer, with 31 years' service, who was by that time working as a civilian crime scene examiner for Humberside Police. Mr Gallagher took photographs of the inside and outside of the police van at about 09.45 that morning.³⁷³ He went on to examine the van for fingerprints and swabbed what appeared to be three bloodstains that he found inside the van.
- 4.50 Photographs taken by Mr Gallagher are attached as Appendix 17. From the photographs, and from the evidence given by Mr Gallagher, it emerges that the only marks found in the van that appeared to be blood were the mark on the inside wall of the van and two spots of blood seen on the bench where Mr Alder had been sitting.
- 4.51 A forensic scientist from the Forensic Science Service, Mrs Gillian Leak, also attended the scene at the request of Humberside Police, although the individual who had requested her attendance was not identified in her statement.³⁷⁴ In interview with the IPCC she indicated that her files recorded that DS Tony Dickinson of Humberside Police had telephoned her offices at 11.00 on 1 April. She further examined the custody suite, in the company of Mr Berridge, between 13.26 and 14.35, after the body of Mr Alder had been removed.
- 4.52 During her examination she found a linear smear of blood on the door from the yard into the custody suite. She described this as being at

³⁶⁹ Richard Taylor statement (1 April 1998) CA0095 pp.19–20 [00950020–1]

³⁷⁰ DC Naylor statement (1 April 1998) CA0095 pp.233–4 [00950234–5]

³⁷¹ Robert Stevenson statement (1 April 1998) CA0019 pp.35–41 [00190037–43]

³⁷² DC Woodcock statement (1 April 1998) CA0095 pp.51–2 [00950052–3]

³⁷³ Michael Gallagher statement (26 April 1998) CA007 p.131 [00070132]

³⁷⁴ Gillian Leak statement (24 April 1998) CA007 pp.132–7 [00070133–8]

shoulder height. She also found a smear of blood and fingerprint on the left side of the door jamb between elbow and head height, with a further smear of blood inside the doorway on the left.

- 4.53 Inside the custody suite she found old dried blood behind and beneath the bench seat. As this had settled dust on it, she discounted it as being from Mr Alder. There were however what she termed “heavy contact bloodstains” on the floor where Mr Alder had apparently been lying, and two light smears on the floor in the area where his feet would have been. A further stain and what appeared to be faecal staining was found on the floor. Mrs Leak took swabs from the wall and floor of the custody suite, and from the corridor wall. These were handed to Mr Berridge. She commented that:

“Some of the blood appeared watery and to be mixed with a small amount of food type debris (possibly vomit). I was informed that the head of Christopher Alder had covered this bloodstained area.”

- 4.54 Mrs Leak also examined the van. The only blood that she observed was an apparent smear of blood on the wall behind and above the bench seat. This she described:

“Behind and above the right bench seat, in the far right corner, was a heavy contact smear of blood approximately 5 cm x 10 cm. The appearance and distribution of this blood suggested that someone with a head injury had recently been slumped on the seat with their head in the corner.”

- 4.55 She found no other splashes of blood in the van. When questioned about the bloodstain that she saw in the van, during the course of this Review, Mrs Leak added in relation to the stain in the van that:

“The vast majority of it is a contact stain and I still stand by that particular stain being in keeping with somebody leaning against that area whilst they were wet with blood. An observation that I have made subsequent to 1998, and this is partly because of additional work that has been carried out on blood pattern interpretation, is that towards the top edge of this stain there is some very fine spatter. They are quite heavy stains there, that are varied in size. From additional work that has been carried out by others in the blood pattern field but particularly by myself as well, is that the spattered pattern does have an appearance of blood that could have been coughed from somebody’s airways or exhaled from somebody’s airways. Back in 1998 we didn’t have an as detailed understanding of the pattern that could be produced from that type of action. Seeing it again today I am even more convinced that the fine spattering at the top is a result of somebody having their face fairly close to that surface when they have had blood in their airways and they have

exhaled, coughed, breathed out on to that region whilst leaning against it when they were wet with blood.”³⁷⁵

- 4.56 At the inquest Mrs Leak gave evidence regarding this evidence in the van, and was clear that:

“The presence of blood in the van and inside the custody unit supports Christopher Alder having been present in both whilst bleeding freely from his injuries. In my opinion the distribution of the blood strongly supports Christopher Alder having been slumped in the back of the van, as I had been informed, with his head supported in the corner between the front and side wall of the caged region. I found nothing to suggest that he has been assaulted in there whilst he was bleeding. The smears of blood on the door and corridor are what I would expect to find if someone was struggling to support Mr Alder through the doorway as he was injured and bleeding freely. I found no evidence to suggest that any assault had taken place in the doorway or corridor area.

The blood on the floor of the custody unit strongly suggests that it all originated from Christopher Alder and is as a result of him being laid there whilst injured. Again, I found no evidence to suggest that he may have been assaulted in the custody unit area.”³⁷⁶

- 4.57 Mrs Leak also gave evidence that she had not tested any of the blood that she found, but handed samples on to Mr Berridge. During questioning at the inquest it emerged that there were blood spots shown on photographs taken by Mr Gallagher that were not evident to her when she had examined the van. She did know that the van had been examined by Mr Gallagher prior to her arrival, but seemed surprised that some blood spots had disappeared altogether during testing.
- 4.58 The initial concern at the inquest, that there may have been evidence lost or obscured, appears to have been resolved. A clearer picture of what occurred on the day also emerged in interviews with Mr Gallagher and Mrs Leak.
- 4.59 Mr Gallagher made clear to the IPCC that he was not told that there was to be any subsequent examination of the van, and that accordingly he had recorded the position and appearance of all of the blood spots that he found by photographing them. Having done that, he swabbed them for analysis, but had no concerns about the swab obliterating the spots if that was necessary. Mr Gallagher felt that these actions were

³⁷⁵ Gillian Leak interview (9 March 2005) Tape 1 pp.27–8 [01150029–30]

³⁷⁶ Inquest Day 12 p.16

misrepresented at the subsequent inquest when he was asked about “destroying the evidence”.³⁷⁷

- 4.60 Mrs Leak recalled being called out to the police station. Her only information at that stage was that she would be doing a blood search on an inside scene.
- 4.61 On arrival Mrs Leak was given a briefing by officers who were present; she recalled there being a number of officers, but could not identify their names. Her initial brief was to examine the custody suite, although the body of Mr Alder had been removed by then. Her recollection, in interview with the IPCC, was that she had also examined the corridor leading to the custody suite, and that this was probably done on her own initiative.³⁷⁸ She also described a conversation as to possible examination of the area immediately outside the custody suite. In respect of the van, she recalled that the conversation turned to this once the other work was finished:

“I can’t remember who actually asked me and I know, at this stage, there was, again, five or six suited officers that were evidently higher ranks. There was a long discussion that we held in the yard area and I was asked if I’d mind just having a look at the police van. At that stage it wasn’t to do a full forensic on it. It was more a cursory, you know, of interest type of look at the van. So I was walked down to the van and shown it then and a decision was made to let me have a look at it properly.”

- 4.62 This led on to Mrs Leak examining the van.
- 4.63 Supt Bates was questioned about this approach in interview:

Q. So in relation to that was there any particular forensic strategy or decisions that you made in relation to what would be examined and how, what sort of evidence you were trying to get from the various scenes?

A. As the SIO I would not actually go to the scene and say, “I want that, I want that”, you know that. I had complete confidence in the scenes of crime supervisors at those scenes. They knew what they were doing, they were experienced.³⁷⁹

- 4.64 He was also questioned about the fact that Mrs Leak had not been fully informed about the earlier blood spots:

³⁷⁷ Michael Gallagher interview (11 March 2005) Tape 1 p.29 [01170031]

³⁷⁸ Gillian Leak interview (9 March 2005) Tape 1 pp.14–15 [01150016–17]

³⁷⁹ Supt Bates interview Tape 2 p.13 [01320040]

- Q. ...so the concern there is, where was the joined-up forensic strategy about who should examine what and how it should all come together?
- A. Well obviously there were deficiencies in that strategy, weren't there?
- Q. Were the decisions then made about who should examine what and how and what they were looking for?
- A. I would leave that to the forensic supervisor to liaise with his own staff and that would be his role. The supervisor, scenes of crime supervisor Humberside, would carry out that liaison and should have briefed the forensic scientist of what his staff had done. If it was not done then it should have happened and I am surprised it did not because Tony Dickinson is a very, very competent and experienced scenes of crime supervisor.³⁸⁰

- 4.65 Mr Elliott recalled arriving in Hull shortly after midday and the officers from West Yorkshire Police arriving shortly thereafter. The scene log for the custody suite records that Mr Elliott visited the scene with Supt Holt, Insp. Tolan and Insp. Morris of West Yorkshire Police between 14.49 and 14.57 on the afternoon of 1 April. They were accompanied by C/Insp. Beckett.³⁸¹ By this stage, the body of Mr Alder had been removed from the custody suite.
- 4.66 The custody suite remained closed as a potential 'crime scene' until 16.40 on the afternoon of 1 April. PS Dixon began duty as the custody officer that afternoon at 14.00.³⁸² As the suite was not holding any persons in custody, PS Dixon was tasked with maintaining the log of persons who came and went from the premises. The suite was re-opened at 16.40, but briefly closed again between 16.45 and 16.55. PS Dixon subsequently passed the log to DC Mellors,³⁸³ and then on to exhibits officer DC Freer.
- 4.67 A separate line of enquiry was pursued at 12.00 on 1 April, when DC Ward, who had been sent to the Waterfront Club, began a search outside the Waterfront Club for the tooth lost by Mr Alder.³⁸⁴ She searched without success before returning to the police station. Later that afternoon, at 15.40, DC Ward joined other officers making a further search for the tooth, and after consulting with club staff, checked in the bins behind the club. Between 16.45 and 18.10, DC Ward went to a local quarry used for landfill, and with the assistance of staff there identified the section used for depositing rubbish collected in the preceding hours from the centre of the city. After a search, with the

³⁸⁰ Supt Bates interview, Tape 2 p.23-4 [01320050-1]

³⁸¹ Log of scene at custody suite CA0067 at D23 [00670085-9]

³⁸² PS Dixon statement (14 April 1998) CA0095 pp.36-7 [00950037-8]

³⁸³ DC Mellors statement (3 April 1998) CA0095 p.38 [00950039]

³⁸⁴ DC Ward statement (2 April 1998) CA0095 pp.43-6 [00950044-7]

assistance of waste collector Keith Brown,³⁸⁵ she identified and seized a plastic bag containing a tooth.

- 4.68 At 05.57 on 1 April, PS Dunn handed over the tape from the custody suite to the investigating officers, under his own reference (JAD/1).³⁸⁶ At 17.33 on the evening of 1 April the custody suite tapes from Queen's Gardens police station were formally seized by DC Woodcock of Humberside Police.³⁸⁷ These tapes bore the references JAD/1 and GPJ/1 and GPJ/2. They were taken to the Tower Grange police station, and the records show that they were taken to the Technical Support Unit for copying. By Friday 3 April, Mr Hutchinson of the Technical Support Unit had made copies of each of these tapes,³⁸⁸ and the investigation record shows that one copy was delivered to Supt Holt at 09.15 and one to Supt Bates by 10.40. It is likely that each SIO viewed them at some stage on 3 April.

Non-examination of samples

- 4.69 It was later to emerge that, although the van and custody suite were examined by SOCOs, none of the blood samples taken were ever submitted for analysis. Similarly, the tooth recovered from the landfill site, at no small inconvenience, was never tested to check that it was in fact that of Mr Alder. This lack of analysis was pointed out to Mr Gallagher in interview,³⁸⁹ who said that he was "flabbergasted" and commented that:

"I can't imagine why – I just presumed it had been or would be in a normal course of events – I don't honestly know why it hasn't been examined. I would have thought it was of paramount importance that it was examined, but it's not my side of things so...I recover it and it's up to somebody else to get it examined."

- 4.70 The blood swabs taken by Mr Gallagher were recorded as being stored in the SOCO freezer but later being transferred to the 'D' Division exhibits freezer for Humberside Police. They are also recorded as having been destroyed on 22 July 1998.³⁹⁰ The recovered tooth was also destroyed, as were the clothes taken from the body of Mr Alder at the post mortem examination. The major incident report book run by Humberside Police, which lists the exhibits, makes clear that Supt Holt of West Yorkshire Police was consulted in relation to the clothing.

³⁸⁵ Keith Brown statement (7 April 1998) CA0095 pp.159–60 [00950160–1]

³⁸⁶ Humberside major incident record CA070 [00700003]

³⁸⁷ DC Woodcock statement (1 April 1998) CA0095 pp.51–2 [00950052–3]

³⁸⁸ Daren Hutchinson statements (6 May 1998) CA0095 113–16 [00950014–17]

³⁸⁹ Michael Gallagher interview (11 March 2005) Tape 2 p.22 [01170060]

³⁹⁰ Humberside major incident report book CA0070 [00700020]

- 4.71 The destruction on 22 July of a series of scientific exhibits and of the clothing of Mr Alder has all the appearances of a clear-out of storage space by Humberside Police. By that date the decisions had already been taken not to pursue Mr Paul, or any other person, for an assault upon Mr Alder. The Humberside Police investigation was truly at an end. Given that Supt Holt was offered the option of retaining the clothing of Mr Alder, it is reasonable to conclude that he must have been informed of the destruction of the other items at that time as well.
- 4.72 The clothing of the arresting officers was seized at 09.35 on 1 April by DC Stephens and was recorded in the major incident report book. PC Dawson's uniform was handed to DC Stephens, and that of PC Blakey to DC Stainforth. The uniforms are recorded as having been returned to them on 3 April. The uniforms from PS Dunn and PC Barr were not seized that night. Their uniforms were recorded as handed in and returned on 3 April. No seizure of items from A/PS Ellerington was ever recorded.
- 4.73 There is some evidence, albeit not very clear, that the two officers who arrested Mr Alder were sent to HRI to be examined for any possible injuries in the early hours of 1 April. This is contained in two police officer notebook entries, the first being the notebook of DC Stephens.³⁹¹ He stated:
- "10.15: Resume I/C Dawson and Blakey to HRI examination HRI by Dr Grout Negative."
- 4.74 However, the other record of this incident was in the notebook of PC Dawson,³⁹² who stated:
- "09.35: Attend HRI for medical examination by Doctor Knox."
- 4.75 PC Blakey's notebook contained no reference to this at all.
- 4.76 Insp. Tolan was asked to investigate the issue of officers being examined during a meeting on 15 March 2002 held by the CPS, at which Ms Alder was present. He wrote a note to the CPS, dated 12 April, dealing with his enquiries, which apparently were initiated because Ms Alder queried whether PC Dawson attended for treatment or examination.³⁹³ Insp. Tolan also mentioned that the examination was alluded to by Mr Ferm, counsel for PC Dawson, at the inquest, albeit not in detail. He stated that:

"My enquiries with Dr Knox, Dr Gosnold and Dr Loose, all force medical examiners for Humberside Police, have revealed that none of them examined either PC Dawson or PC Blakey on 1

³⁹¹ DC Stephens notes (1 April 1998) CA0067 D78 [00670369]

³⁹² PC Dawson notes (1 April 1998) CA0027 [00270004 & 7]

³⁹³ Insp. Tolan memo (12 April 2002) CA 93 [00930043]

April 1998. The doctors have checked their records in this respect. Dr Gosnold was able to check the records at the Hull Royal Infirmary and informed me that neither officer attended the hospital either for treatment or examination that day.

If either officer was examined that day then the only way to progress the enquiry would be to ask the officers, presumably through their defence teams.”

- 4.77 No evidence has emerged to suggest that the matter was pursued further at that time. Accordingly, as part of the Review, a request was made of the HCC to make further enquiries on behalf of the IPCC relating to this issue. They made an approach to Mr Michael Prince, HRI’s Manager of Claims and Legal Services.
- 4.78 Mr Prince indicated that he had already been asked to look into this matter at the time of the police inquiry (presumably by Insp. Tolan) and he had come to the conclusion that it was just “hearsay” that PC Blakey and PC Dawson attended or were examined at HRI. Mr Prince’s informal enquiries could find no documentation relating to the alleged attendance. They hold no record to show that they were examined by Dr Paul Grout.
- 4.79 Insp. Tolan was interviewed by my staff in relation to this matter.³⁹⁴ He stated that Dr Ann Knox was a GP (now believed to be retired) and a police FME at the time. She indicated that if she had examined the officers it would have happened at her surgery and not at HRI. She had no record of any such examination. Insp. Tolan had also spoken to Dr Grout and another Dr Knox based in Hull. Neither had any record of examining the officers. Our enquiries with Humberside Police reveal that no request for payment for any examination on 1 April was received.
- 4.80 At the subsequent inquest, Supt Holt admitted that he believed the officers had been checked for injuries but had not actually seen a statement to confirm that. The Review has made further enquiries to seek to trace any statement that was made. I can find no evidence that any officer was examined by any doctor in relation to this incident.

Removal of Mr Alder’s body to Sheffield

- 4.81 The body of Mr Alder remained in the custody suite throughout the morning of 1 April until 12.05. The SOCO examination of the custody suite and the examination by Dr Clark, the pathologist, were both able to take place while the body remained in situ. At 12.05, PC Jones of Humberside Police, on the instructions of DS Dickinson, accompanied Mr Roy Todd, a local undertaker, who removed the body of Mr Alder

³⁹⁴ Insp. Tolan interview (14 February 2005) CA0112 Tape 2 p.27 [01120054]

and transferred it to the Medico-Legal Centre in Sheffield for the post mortem examination to take place.³⁹⁵ They reached the centre at 13.36 and passed the body into the care of Mr Ian Crawford, the senior mortuary technician. The reason for holding the post mortem examination outside of Hull was that the local mortuary was undergoing building works at the time and was unusable.

- 4.82 Following the transfer of the body of Mr Alder to Sheffield, a post mortem examination was held by Dr Clark from 17.00 onwards, taking about three hours.³⁹⁶ Mr Saul, the coroner, attended, as did Mr Elliott and Supt Holt. DS Dickinson also recorded his presence.³⁹⁷
- 4.83 Mr Elliott made the point in interview that he was acting outside the normal practice of the PCA at the time in seeking to attend the scene of death, attending the post mortem, and making early contact with the family of the deceased. In these respects he hoped that early intervention would avoid subsequent problems.
- 4.84 During the course of the post mortem examination, the clothing worn by Mr Alder was removed and retained by Humberside Police. There is no evidence to suggest that the clothing was ever subjected to any form of analysis or testing. The only subsequent mention of the clothing came from Supt Holt, who later explained that he had been contacted by an officer from Humberside Police who asked him if he required the clothing to be retained. Supt Holt said that he did not, and he understood that as a result of this the clothing was destroyed on 22 July 1998. This is confirmed in the major incident log kept by Humberside Police.³⁹⁸ In interview with the IPCC, Supt Holt was asked about the clothing of Mr Alder, and he stated that:

“Christopher Alder’s clothing...from my point of view did not progress the investigation one way or the other.”³⁹⁹

He also acknowledged that this had been an error of judgement on his part for which he accepted full responsibility.

- 4.85 At a later stage, queries were raised by the family of Mr Alder as to why they were not present or represented at the post mortem examination at that time. No member of Mr Alder’s family was positively identified by the police until the following day, when his brother, Richard Alder, made contact with Humberside Police.

³⁹⁵ PC Jones statement (1 April 1998) CA007 pp.187–8 [00070188–9]

³⁹⁶ Dr Clark statement (27 May 1998) CA007 pp.138–57 [00070139–58]

³⁹⁷ DS Dickinson statement (12 May 1998) CA0023 [00230035–6]

³⁹⁸ Major incident log CA0070 [00700023–8]

³⁹⁹ Supt Holt interview (8 March 2005) Tape 3 p.7 [01140048]

Arrest of Jason Paul

- 4.86 At 18.19 on the evening of 1 April, Jason Paul was arrested for murder at Tower Grange police station in Hull by police officers DC Mainland and DC Wade.^{400,401} Mr Paul had heard of the death of Mr Alder, and had consulted with a solicitor before voluntarily attending the police station. Two hours after his arrest, at 20.25 the police arranged for Mr Paul to be examined by the FME, Dr Loose,⁴⁰² and photographs and samples were taken by Guy Ottaway.⁴⁰³ Some minor injuries, including cuts to his hands, were noted at the time.
- 4.87 In the very early hours of 2 April, following the arrest of Mr Paul, officers were despatched to search his home address. Those officers, PC Hass and PC Cowell, undertook the search at 01.23 that morning.^{404,405} During that search they seized the jacket and trousers believed to have been worn by Mr Paul at the time of his confrontation with Mr Alder.
- 4.88 Later in the day, after the initial pathologist's report had been received, Mr Paul was de-arrested for murder and arrested for GBH. Between 13.00 and 18.53, Mr Paul was interviewed by DC Mainland and DC Wade. During the course of the interviews, in which he answered the questions posed by the officers, Mr Paul explained that he had been present on the evening in question and that he had become involved in the fracas. He also made clear that he had been acting in self-defence when he struck a single blow to the face of Mr Alder. Following the interviews, at 19.22 on 2 April he was charged with causing grievous bodily harm with intent.

Search of Mr Alder's flat

- 4.89 The decision to conduct a full search of Mr Alder's flat was recorded in the HOLMES records of Humberside Police.⁴⁰⁶ The decision was recorded as being taken at 09.00 on 2 April, and as being taken by DCI. Davison, having consulted with Supt Bates. However, the actual search was delayed until 3 April, the following day. The reasons for the search are recorded as being:

⁴⁰⁰ DC Mainland statement (4 April 1998) CA0095 pp. 81–4 [00950082–5]

⁴⁰¹ DC Wade statement (4 April 1998) CA0095 pp.312–14 [00950313–15]

⁴⁰² Dr Loose statement (2 April 1998) CA0095 pp.85–90 [00950086–91]

⁴⁰³ Guy Ottaway statement (7 April 1998) CA0095 p.79–80 [00950080–1]

⁴⁰⁴ PC Hass statement (2 April 1998) CA0095 pp.34–5 [00950035–6]

⁴⁰⁵ PC Cowell statement (14 April 1998) CA0095 p.170 [00950171]

⁴⁰⁶ HOLMES log [00840019–20]

- a) Search may reveal drugs and/or steroids in flat which may be of assistance to Pathologist in establishing course [sic] of death.
- b) Search may reveal documentation of value to establish family background of Christopher Alder, i.e. believed to have two children.
- c) Search may reveal medical records/history.

4.90 In the hours immediately before the decision to search had been taken, Richard Alder had contacted the police to find out whether it was his brother who had died. This family connection may, or may not, have been known at the time of the decision, but it would have been known by the time of the actual search on the following day. As a reason for the search, the tracing of family members was therefore less of an issue than it had been. Humberside Police had, in any event, gained access to the flat, granted to them by Richard Adams on the afternoon of 1 April.⁴⁰⁷ As Mr Adams had explained, after he contacted the police and told them of his connection with Mr Alder:

“I allowed the officer entry and assisted in gathering documentation to assist the police in locating a member of Chris’ family.”

4.91 Acting Detective Sergeant (A/DS) Sykes of Humberside Police had already seen the flat, as he was the officer who accompanied Mr Adams. Although no witness statement has been seen from A/DS Sykes, DI Brookes recorded on HOLMES that paperwork had been taken from the flat by that officer, who would be making enquiries regarding next of kin. That HOLMES entry was made at 20.37 on 1 April.⁴⁰⁸

4.92 On 3 April, the day after the decision, Mr Alder’s flat at Lisle Court was searched by six Humberside police officers: PC Reynolds,⁴⁰⁹ PC Chapman,⁴¹⁰ DC Marsden,⁴¹¹ DC Woodcock,⁴¹² DC Stainforth,⁴¹³ and DC Stephens (who was the only one of the six who made no statement in relation to this). This search occurred between 15.30 and 16.35. These officers were not accompanied by any representative of West

⁴⁰⁷ Richard Adams statement (1 April 1998) CA0095 p.29 [00950030]

⁴⁰⁸ HOLMES M12

⁴⁰⁹ PC Reynolds statement (3 April 1998) CA0095 pp.48–50 [00950049–51]

⁴¹⁰ PC Chapman statement (3 April 1998) CA0095 pp.59–60 [00950060–1]

⁴¹¹ DC Marsden statement (3 April 1998) CA0095 pp.55–6 [00950056–7]

⁴¹² DC Woodcock statement (3 April 1998) CA0095 pp.53–4 [00950054–5]

⁴¹³ DC Stainforth statement (7 April 1998) CA0095 pp.61–2 [00950062–3]

Yorkshire Police. The officers produced a sketch plan of the flat⁴¹⁴ and a log of the contents seized.

- 4.93 The items seized from Mr Adler's flat included: a green Philips BT Easy Reach pager; a crossbow and arrows, found in a kitchen cupboard; a Filofax; a tray containing two lighters and some Rizla packets; and a 'hiplock' bag, scissors and tobacco, which were found on the kitchen worktop. Also in the kitchen were found and seized two canisters containing yeast tablets. In addition, they seized: a computer mouse, which was found in a kitchen drawer; a "computer processor monitor"; a keyboard and leads; nine 3½" floppy disks; and a hard drive, floppy drive and computer parts, which were all found in the living room.
- 4.94 Following the search, the flat was sealed. A few days later, on 8 April at 11.00, DC Ward returned to photograph the flat, before resealing it.⁴¹⁵ The flat remained sealed off for several weeks before the keys were handed back to Richard Alder.
- 4.95 DCI. Davison was spoken to by the IPCC, and was asked about the decision to conduct such a detailed search of the flat. His response was recorded:

"At the time all this occurred we were assuming that this would be going to trial, if not for murder, then as a Section 18. Any of this information that we gathered might have been used by the defence, so we needed to know about it. I would do the same in any similar case. I authorised the search of CA's flat, but I don't know why the computer was seized. I can't think of a reason why we would want that, or have the hard drive analysed...I don't want to be surprised by the defence in court, and I see this as a reasonable and necessary course of action."⁴¹⁶

Family liaison

- 4.96 The history of the contacts between Humberside Police and the family of Mr Alder is set out in some detail at Chapter 8 of this report. Humberside Police had appointed DC Fountain and PC Beatrice Smith to act as family liaison officers (FLOs). PC Smith recalled, in interview with the IPCC, that she had been ordered to attend a briefing at Tower Grange police station on the morning of 2 April at 09.05.⁴¹⁷ She learnt that DC Fountain had already been appointed as the FLO and that she was to assist him, as the police had not traced any family members at that point. She and DC Fountain were told at that stage that a call had

⁴¹⁴ DC Marsden statement (8 April 1998) CA0095 pp.57 [00950058] and plan CA0077 pp.78–80 [00770079–81]

⁴¹⁵ DC Ward statement CA0095 (7 May 1998) C0095 p.47 [00950048]

⁴¹⁶ DCI. Davison interview (10 March 2005) CA 0136 p.9 [01360010]

⁴¹⁷ PC Smith interview (21 April 2005) CA0139 [01390003]

been received overnight from a person who claimed to be a relative – that person would have been Richard Alder, who had called around that time.

- 4.97 As the case progressed, the larger part of the contact with Richard Alder was undertaken by PC Smith. Once Ms Alder was traced and contacted, she indicated that she did not wish to have the services of any FLO. She also expressed her objections at the fact that a black officer – PC Smith – had been appointed as FLO. The available records show that Richard Alder spent some considerable time with PC Smith, and appears to have been appreciative of the support that she rendered to him and his girlfriend.

The impact of the videotape

- 4.98 The nature of the investigation into the death of Mr Alder was altered by two early events in the inquiry that were at odds with the initial expectations. The first of these was the outcome of the first post mortem examination. Supt Bates was candid in interview in saying that he expected to be told that Mr Alder had died as a result of the blow struck by Mr Paul. The post mortem examination made clear that there was no fracture to Mr Alder's skull and that, although some blood was found in the skull during examination, there was no obvious brain damage from the blow. This was later to be confirmed by the analysis of brain tissue carried out by Dr Walter Timperley at the request of Dr Clark.
- 4.99 The second event came with the initial viewing of the custody suite video on 3 April 1998. Supt Bates agreed that his viewing of the tape changed his perception, so that the focus of the case moved towards being an inquiry into the possible misconduct by police officers.⁴¹⁸ He recalled that Supt Holt saw the tape first and recommended that he watch it:

- A. I remember John saying, I was on the phone, "Yes, it is, you should see it." I then made certain I had a viewing of the tape, a copy of the tape, not the original, brought over and I sat and watched it with my team. I remember the silence in the room as we watched it. Every minute that went by that he was laid on the floor, I was actually willing, I remember mentally willing someone to go and look at him. Eventually they did, but it seemed an age. I remember being shocked.
- Q. Did that in any way change your perception of the events or the focus of the investigations, yours and West Yorkshire's?

⁴¹⁸ Supt Bates interview (22 April 2005) Tape 1 p.20 [01320022]

A. I knew, having viewed the tape, that the question of who may or may not be charged and found responsible for Christopher's death would be very, very unclear.⁴¹⁹

4.100 Supt Bates was asked whether, in light of the emergence of the custody suite tape, the West Yorkshire Police inquiry:

“assumed a new momentum and import?”

His view was:

“It did. It assumed greater proportions altogether. You could see that. You could see what was going to happen. Obviously John's response was to beef up his end and we made certain that he had access to everything before that. There was agreement that he would have access to everything in the inquiry which came in. The HOLMES database, the statements, and he did visit our incident room on a couple of occasions.”⁴²⁰

4.101 It should be noted that, notwithstanding the video and the initial post mortem results, the Humberside Police investigation was being treated as a potential murder inquiry throughout April. Supt Bates was asked about this,⁴²¹ and he observed that:

“I put an entry in here saying that until we had a conclusive cause of death nobody could be charged with murder or manslaughter. We charged him [Jason Paul] with Section 18, wounding, in the hope that the toxicology tests or other tests they were going to carry out on the body tissue of Christopher would reveal something more, in his heart or his brain. It did not.”

4.102 Supt Bates described Insp. Tolan spending periods of time being given access to the HOLMES material collected by Humberside Police:

“Keith Tolan certainly came over more regularly than John [Holt] did.”

4.103 Supt Bates was also asked why, in light of this development, did the Humberside inquiry continue at a relatively high level of activity until the end of April 1998? He pointed out that:

“because right up until the end of that month, there was a possibility that Jason Paul might have been responsible for the death...The involvement by the police officers, whilst obviously contributing, perhaps, to his death, we do not know whether he

⁴¹⁹ Supt Bates interview (22 April 2005) Tape 1 p.21 [01320023]

⁴²⁰ Supt Bates interview (22 April 2005) Tape 1 p.23 [01320025]

⁴²¹ Supt Bates interview (22 April 2005) Tape 1 p.16 [01320018]

was actually in the train of death right from the time he had his head injury and that train of events was going to happen anyway. I think later on in court that was the subject of some discussion by the lawyers. The reason we kept it going was that until the end of April we did not really know that Jason Paul was not going to be the subject of at least perhaps a manslaughter charge.”⁴²²

- 4.104 During the course of April 1998 the Humberside Police investigation pursued a series of lines of enquiry. A certain number of house-to-house enquiries were carried out in the area of the Waterfront Club. In addition, DC Stainforth and DC Stephens examined the Waterfront Club CCTV video evidence and made prints from the video. These were set out on a picture board, and shown to people attending the Waterfront Club on the evening of 21 April between 9.30pm and midnight, in an attempt to identify potential witnesses to the original incident. A large number of witnesses from the club that evening were spoken to by Humberside police officers, including the staff at work and the various club-goers. Other enquiries included the retrieval of DSS and work records for Mr Alder, and his medical records going back as far as his time in the army.
- 4.105 One other line of enquiry that was to cause concern was the retrieval of medical evidence concerning Mr Alder’s family. Nothing was found that was relevant to Mr Alder’s own health. The sheer volume of documentation generated indicates that a large number of officer hours was expended on these tasks.

End of the Humberside Police investigation

- 4.106 The Humberside Police investigation effectively came to an end after four weeks, following a meeting in Wakefield on Wednesday 29 April. On that occasion, Supt Bates and DCI. Davison met with the pathologist, Dr Clark, and with Supt Holt and his team from West Yorkshire Police. At that meeting Dr Clark outlined his full findings, and as Supt Bates was later to describe it, he defined the cause of death as being:

“Died as a combination of respiratory and cardiac failure, a combination of the two.”

- 4.107 Supt Bates described the decision at the meeting, as noted, to be:

“Agreement with Supt Holt, liaise with the PCA and they would do the press release. Meeting with the coroner on Thursday at 1300 hours. Transfer all the data on HOLMES over to West Yorkshire.”

⁴²² Supt Bates interview (22 April 2005) Tape 2 p.2 [01320029]

4.108 On this occasion it was also agreed that West Yorkshire Police would take on the role of family liaison, and that PC Beatrice Smith would relinquish that role. West Yorkshire Police was also to take over any liaison with the local Race Equality Council, which had previously been managed through PC Smith. PC Smith recalled, when interviewed, that she was withdrawn from the case at very short notice around 29 or 30 April, and told that she would have no further dealings with it.⁴²³ She recalled meeting Richard Alder by chance about two weeks later in Hull:

“He said that he had had no further contact from anyone. He had not seen a VLO [victim liaison officer] and had been given no information.”

4.109 During the course of the Humberside Police investigation, all of the statements gathered were entered onto the HOLMES system; these amounted to 237 formal statements in all. In total, 461 actions were generated and over 600 documents identified. The whole of this computerised record was made available to West Yorkshire Police, both during and after the investigation. It was also made available to the IPCC during the course of this Review.

Postscripts to the Humberside Police investigation

4.110 A number of postscripts to the Humberside Police investigation arose in the form of submissions of files to the CPS. Jason Ramm was arrested on 1 May 1998 and interviewed by DC Mainland and DC Wade, on suspicion that his actions might have amounted to violent disorder. He was not charged by the police, but a file dated 16 June 1998 was submitted to the CPS by DS Ralphs of Humberside Police.⁴²⁴ There is no record, that I have seen, that any further action was taken against him.

4.111 Also on 16 June, DS Ralphs submitted the formal file on Mr Paul to the CPS.⁴²⁵ The CPS, in due course, decided that there was no realistic prospect of obtaining a conviction against Mr Paul, and formal charges against him were withdrawn.

4.112 Subsequently, Mr Paul commenced civil proceedings against Humberside Police in respect of his arrest and initial prosecution. The case came before Sheffield County Court in July 2003. The case was heard by a judge and jury. On 28 July 2003, the trial judge, His Honour Judge Heppel, ordered that judgement be entered for the Humberside Police, and withdrew the case from the jury. However, on 24 February

⁴²³ PC Smith interview (21 April 2005) CA0139 [01390005]

⁴²⁴ Humberside Police report (16 June 1998) CA0020 pp.1–11 [00200003–13]

⁴²⁵ Humberside Police report (16 June 1998) CA0019 pp.1–19 [00190003–21]

2004 that decision to dismiss the claim came before the Court of Appeal. In a judgement delivered on 17 March 2004, the Court of Appeal allowed the appeal of Mr Paul against that decision and ordered a fresh trial.⁴²⁶ The retrial took place between 16 to the 27 January 2006. The jury in that trial returned verdicts in which they found that it was more likely than not that:

- The instruction to arrest for murder was given to deflect potential criticism of the circumstances surrounding Mr Alder's death
- DC Wade had not considered the lawfulness of the arrest before his initial arrest of Mr Paul for murder
- DCI Davison did not rely upon the statement of Richard Hillyard when he decided to charge Mr Paul with causing grievous bodily harm, and that
- Mr Paul was charged with causing grievous bodily harm to deflect potential criticism of the circumstances surrounding Mr Alder's death

4.113 During the Court of Appeal hearing, following the first civil trial, it emerged that in a form containing confidential information for the prosecutor of Jason Paul at the Magistrates' Court, DC Mainland had requested that the court should not be told about the death in custody. As the Court of Appeal observed:

“DC Mainland was unable to explain to the jury why these words were written.”⁴²⁷

4.114 The Court also commented upon the fact that DI Brookes had vigorously contested the decision of the CPS in Manchester to abandon the prosecution of Mr Paul. Supt Bates informed my own staff in interview that he had also disagreed with the decision, and felt that it should have been placed before a jury to decide. Their view appears to have been influenced by the force of Mr Paul's blow, and the immediate impact it had upon Mr Alder.

The West Yorkshire Police/PCA inquiry

4.115 As set out above, the West Yorkshire Police officers arrived in Humberside at around lunchtime on 1 April 1998. Supt Holt, Insp. Tolan and Insp. Morris all went to the city, and later that day Supt Holt went on to be present at the post mortem examination carried out in Sheffield by Dr Clark.

⁴²⁶ Court of Appeal judgement (17 March 2004) CA004 D96 [00040017–33]

⁴²⁷ Court of Appeal judgement (17 March 2004) CA004 D96 para. 21 [00040022]

4.116 Supt Bates described the conversations that he had at an early stage with Supt Holt regarding the arrangements that were to be made, and the access that Humberside Police extended to West Yorkshire Police. DCI. Davison was asked about the protocol for sharing information with West Yorkshire Police. He said that:

“I don’t think there was anything formal, but nothing was hidden. We had appointed an office manager who checked all the information coming in, and it all went on the database. There were also regular briefings in the incident room which they could attend, as their office was at the same location, Tower Grange. I’m not aware of any formal structure for their attendance at briefings, and personally I saw little of them. They could have whatever access to data they wanted via the office manager.”

4.117 One difficulty that has emerged in pursuing a review of the West Yorkshire Police investigation is the lack of any proper records of the progress of the inquiry. The Humberside Police decision to employ the HOLMES computer system was not followed by West Yorkshire Police, who may have regarded their investigation as not being sufficiently large to merit use of the system, although they had access to the Humberside Police database.

4.118 Unfortunately, West Yorkshire Police did not employ any system, computerised or paper-based, for recording decisions or actions undertaken, beyond a few brief policy logs that stopped by 16 April 1998. Therefore, while there is some evidence to suggest that they were busy, it is not wholly clear what they were doing.

4.119 One aspect of the West Yorkshire Police investigation that only emerged at the inquest was the fact that, while the West Yorkshire police officers did obtain the duty statements and notebooks of the five officers, this was delayed. Insp. Tolan told the inquest⁴²⁸ that he did not see these documents until 8 April 1998, which was a full week after the death of Mr Alder. No explanation was given, at the inquest, for the delay in obtaining these. The issue was raised with Supt Holt in interview by the IPCC. He stated that:

“The officers were on nights. They were on nights the night after, so in terms of duty statements and pocket books it was again – it was a sort of a couple of days before we started to gather their duty statements and copies of the pocket book entries.”⁴²⁹

4.120 When questioned further on the eight-day delay in obtaining the pocket books and duty statements, he said:

A. I don’t think it affected the course of what was happening

⁴²⁸ Inquest Day 13, p.58

⁴²⁹ Supt Holt interview (8 March 2005) CA0114 Tape 1 p. 9 [01140011]

at all. I did not have a cause of death from John Clark. I was focusing on the lines of enquiry around the hospital and particularly the CCTV and getting the CCTV transcripts. We had got in the very early stages – I think we got pocket book entries from the officers before we got, I suppose, what you would regard as being their duty statements.

- Q. So, to clarify, when you talked at the inquest that you did not receive evidence from the officers until eight days into the inquiry, you had received their original notes?
- A. I think we had got copies of their pocket book entries prior to receiving their statements, because the pocket book – sorry, the pocket books were completed either prior to them going off duty, or as early as possible when they returned to duty the following night, and my recollection is that we had got the copies of the pocket book entries before we got the duty statements.
- Q. So would that have been when you arrived at Humberside on 1 April that you received those, or could you put a date on it at all?
- A. Yes, probably, again, passage of time, I would say by the Friday for the pocket books.⁴³⁰

4.121 There is no record of the briefings that were attended by West Yorkshire police officers, and there was no formal structure for exchange of information beyond access being allowed. No record has been revealed of any system of briefing by the West Yorkshire police officers for their opposite numbers in Humberside Police who might be about to interview witnesses, and there does not appear to be any guidance from the West Yorkshire Police team as to what areas they would wish explored, or what they saw as priorities. The impression given in interviews with Supt Holt and Insp. Tolan was that the coordination was limited to informal discussions between the two SIOs (Supt Holt and Supt Bates) in the early stages.

4.122 The West Yorkshire Police team consisted of the three officers who travelled to Hull on Wednesday 1 April. Although an Insp. Grubb was later to assist for a short period, the team was not expanded from that number during the period of the investigation. Insp. Tolan indicated that an approach for additional staff could have been made to the authorities in West Yorkshire Police, but there is no record that it was. The team was given office facilities in Tower Grange police station in Hull, from where the Humberside Police investigation was being run. Insp. Tolan also confirmed that: “We attended their briefings.” He recalled that he worked from that police station for about four weeks.⁴³¹

⁴³⁰ Supt Holt interview (8 March 2005) CA0114 Tape 2 p.11 [01140033]

⁴³¹ Insp. Tolan interview (14 February 2005) CA00112 Tape 1 p.19 [01120021]

4.123 Insp. Tolan agreed, in interview with the IPCC, that some of the witnesses seen by Humberside Police were also crucial for the West Yorkshire Police inquiry, but he expressed the view that a large team from West Yorkshire Police would not have been as effective as Humberside Police. For this reason he saw no major problem with the Humberside Police investigation taking the lead in obtaining the majority of the statements.

4.124 The approach adopted by the West Yorkshire Police investigation is reflected in the policy log faxed to Mr Elliott from West Yorkshire Police headquarters at 13.15 on Friday 3 April.⁴³² In that document, which reflects the first 38 hours of the investigation, Supt Holt said:

“The IO in consultation with Mr Elliott has discussed the investigation with Detective Superintendent Bates and accepts the criminal investigation will assume primacy with all incoming information being shared. Lines of enquiry when identified for each enquiry will be discussed to avoid duplication.”

4.125 Further on in the policy log, Supt Holt clarifies his position somewhat, when he accepts that:

“There are however different ‘starting points’ for the relevant investigations. Clearly the focus of the Waterfront assault enquiry is centred a [sic] tracing witnesses at that scene to build up a picture to support CCTV and Jason Paul’s admissions. The Investigating Officer has therefore decided that the following are priority lines of enquiry for the Police Complaints Authority investigation, not solely but partly based on the fact they could be lower priority enquiries for the criminal investigation.

- i. Trace and interview other prisoners held in custody at Queen’s Gardens at the time of Mr Alder’s death.
- ii. Trace and interview recorded attendees at HRI at or between the times of the deceased’s attendance at the hospital...
- iii. Viewing of CCTV tapes to establish confirmation of statements taken from witnesses.
- iv. Examination of officers’ statements covering transfer from hospital to police station and action at police station.
- v. Examination of all relevant incident logs.”

⁴³² West Yorkshire policy log (3 April 1998) CA001 D11 [00010368–74]

- 4.126 The Superintendent states that, at the time of the report, tapes from the Waterfront Club and Queen's Gardens police station had been seized, but not yet viewed by West Yorkshire police officers.
- 4.127 Supt Holt did prepare two further documents prior to taking his leave between 6 and 13 April. The first of these was a policy log dated 3 April 1998, and timed at 16.00, indicating that Insp. Tolan would have support from Supt Thompson of West Yorkshire Police.⁴³³ The second was dated 5 April (Sunday) at 14.00, stating that he had watched the custody suite video and had decided that it was not necessary to issue Regulation 7 notices to the officers.⁴³⁴ Such notices, specified under the Police (Discipline) Regulations 1985, were required to be served upon any officer being investigated for any disciplinary offence.
- 4.128 On Wednesday 8 April 1998, Mr Elliott received a telephone call from Insp. Tolan, in the absence of Supt Holt. Insp. Tolan told Mr Elliott that he had viewed the video of the ten minutes between the arrival of Mr Alder and the point at which he first received assistance.⁴³⁵ As Mr Elliott recorded:

“Inspector Tolan was of the opinion that the video indicates possible offences of neglect of duty of care and following discussion it was agreed that Regulation 7 notices would be served on all officers present, stating that the investigation into Mr Alder's death so far indicates that they may have neglected their duty.

The cause of death is not yet known but should be soon once tests have been completed by the pathologist. This will have significant bearing on subsequent investigation and questioning of officers and may require additional Reg 7s to be served.”

- 4.129 Notices were served upon five officers that week. They were not in fact served upon “all officers present”, as PC Wildbore was not served with one. As a civilian employee, Matron Winkley did not fall within the regulations.
- 4.130 Following his return, Supt Holt, in a policy log dated 16 April,⁴³⁶ recorded that the decision to issue Regulation 7 notices had been reviewed, and that the notices had been served:

“both in the interests of fairness and to avoid jeopardising any subsequent proceedings”.

⁴³³ West Yorkshire policy log (3 April 1998) CA0085 [00850009]

⁴³⁴ West Yorkshire policy log (5 April 1998) CA0085 [00850010]

⁴³⁵ PCA file note (8 April 1998) CA001 D161 [00010015]

⁴³⁶ West Yorkshire policy log (16 April 1998) CA0085 [00850011]

- 4.131 In interview with the IPCC, Supt Holt was asked why he had not ordered the service of the Regulation 7 notices.⁴³⁷ He attributed this to:

“my complete misunderstanding of the regulations relating to police discipline and – looking back now that was an error of judgement. Clearly had I been more au fait with police regulations, and been involved in investigations involving police officers, it was clear that they should have had what were then, I think, Regulation 7 notices almost from the outset.”

- 4.132 Following on from the initial few days, the reporting to the PCA appears to have consisted of forwarding copies of statements every week or two. Insp. Tolan confirmed in interview that not all of the Humberside Police statements were forwarded to the PCA.

The absence of investigating officers

- 4.133 From 6 April both Supt Holt and Insp. Morris took annual leave for a period of one week. This left Insp. Tolan in charge of the investigation. Supt Holt appears to have informed Mr Elliott of this absence on Friday 3 April, as Mr Elliott made a note as part of his record of a telephone call. This appears to have been the first notification that Mr Elliott had of the intended leave. Supt Holt was later to tell the IPCC that he had left Insp. Tolan in charge:

“Keith Tolan was very experienced, very professional. I had got every confidence in Keith. I did go to – again, I can’t remember whether it was Keith Thompson or Tom Moran at the time and asked for an additional officer, an inspector, to work with Keith Tolan for the week that Paul Morris and I were away and they arranged for, I think it was...I think it was Dave Grubb who worked with Keith for a week.”

[C/Supt Thompson and C/Supt Moran both held the post of Head of Discipline and Complaints at West Yorkshire Police, at different stages.]

- 4.134 The two absent officers returned to work on 13 April, and the West Yorkshire Police investigation continued throughout that month. During April, statements were taken from a few witnesses, as anticipated in the policy log.

Investigation following the CCTV

- 4.135 As has been mentioned in the context of the Humberside Police investigation, Supt Bates regarded the nature of the inquiry as having

⁴³⁷ Supt Holt interview (8 March 2005) CA0114 Tape 2 p.8 [01140030]

changed from the point when the video was first viewed on 3 April. Supt Holt also described his perception changing at that stage:

“I think the criminal investigation point of things was flagged up in my mind the minute we saw the video and it was around the culpability of the officers in terms of what I perceived to be their negligence in relation to a duty of care around Christopher Alder. So it was the considerations around gross negligence, manslaughter that became a consideration for my inquiry.”⁴³⁸

4.136 Notwithstanding this, Humberside Police continued their investigations with a far larger team than that deployed by West Yorkshire Police. The effect of this was that Humberside Police continued to take the majority of the statements and provide the majority of the workforce for investigations.

4.137 Insp. Tolan, when interviewed by the IPCC, recalled that the initial understanding of the West Yorkshire police officers had been that Mr Alder walked into the custody suite and collapsed:

“...in our initial briefing we were led to believe that Mr Alder had walked into the police station and collapsed at the desk...And that’s, that’s what I was told here on the Wednesday, that’s what we were told at the meeting at Humberside Police on the same Wednesday, and it wasn’t until Friday when we saw the video that we realised that clearly wasn’t the truth, because during that intervening period we were collecting statements, what statements, but again in the early stages of the inquiry stuff were [sic] going through the Humberside Police incident room and it was taking time to filter through to us, and it wasn’t until the Friday after lunch that we realised that it wasn’t quite as, well, it wasn’t, definitely wasn’t as we’d been led to believe, that he’d walked in and collapsed.”⁴³⁹

4.138 The details of the briefing were not recorded in any written form, and therefore I have only the recollection of Insp. Tolan in respect of what was said. He commented that the West Yorkshire Police team had inquired into how this misunderstanding came about, and concluded that it was due to different uses of terminology in briefings:

“although we can’t categorically pinpoint where it was, we did conclude that it was all down to the terminology that was used when different people were being briefed...and it’s just because of the use that’s, the words that are used, and so later that day we hear the words ‘collapsed’ which infers that he’s upright in order for him to collapse.”⁴⁴⁰

⁴³⁸ Supt Holt interview (8 March 2005) CA0114 Tape 1 pp.8–9 [01140010–11]

⁴³⁹ Insp. Tolan interview (14 February 2005) CA0112 Tape 1 p.10 [01120012]

⁴⁴⁰ Insp. Tolan (14 February 2005) CA0112 Tape 1 pp.15 [01120017]

Forensic samples

4.139 Supt Holt was to confirm, at the inquest, that the decision was taken by West Yorkshire Police not to have the blood samples from the swabs taken by Mrs Leak analysed. He had not considered it to be necessary as it was believed that they must have come from Mr Alder.⁴⁴¹ He also confirmed that he had authorised the return of clothing to the officers, on the basis that he did not regard it as being of potential forensic significance. Supt Holt had in fact recorded the decision to return the clothing as part of the policy log on 2 April 1998.⁴⁴² This decision, which he described as being:

“following discussion with Mr Elliott”

was made because:

“There is no suggestion at this stage of malpractice or criminal conduct by any of the officers involved, to retain clothing under these circumstances could create unnecessary concerns amongst those involved and could be considered grossly unjust.”

4.140 Supt Holt was questioned about this in interview with the IPCC.⁴⁴³ He explained that he did not regard the officers’ clothing as being relevant, because he already knew that the officers had been in contact with Mr Alder. He added that he had ruled out a second assault upon Mr Alder based on the post mortem evidence and the evidence from the forensic scientist:

“I accept now in hindsight that the timing of that and the apparent speed in which the uniform was returned is an issue of some contention. But, again, it was done at the time on the basis of its usefulness as a line of enquiry.”

4.141 Mr Elliott was asked about this clothing during his interview with the IPCC.⁴⁴⁴ His recall was as follows:

“I remember speaking with John Holt about it, I think, and I remember the reasoning, I think, was that as they had clearly been in contact with him, and hadn’t denied it, and that was clearly the case on video, there was little to be gained by any further examination of them...I’m reasonably sure, I think he discussed it with me before it was done. I would have expected that.”

⁴⁴¹ Inquest Day 21, p.20

⁴⁴² Policy log (2 April 1998) CA001 [00010373]

⁴⁴³ Supt Holt interview (8 March 2005) CA0114 Tape 3 p.4 [01140045]

⁴⁴⁴ Jim Elliott interview (31 January 2005) Tape 2 p.19–20 [01100050–1]

4.142 Supt Holt confirmed to the inquest that in July 1998 he had been contacted by Humberside Police to ask him whether he required the retention of Mr Alder's clothing.⁴⁴⁵ He had told them that he did not, and he was aware that as a result of this Mr Alder's clothing was destroyed.

4.143 Mr Elliott was also asked about this by the IPCC.⁴⁴⁶ He stated that:

“That decision wasn't an issue with me. Whether I'd have suggested anything different at the time I'm not sure. I mean I would have done subsequently having learnt a lot more about how families relate to these things. But as to a decision not to forensically examine them, again I don't remember that being specifically discussed or agreed.”

4.144 This was later the cause of some criticism from the family of Mr Alder, and in a letter to Harrison Bunday, solicitors for Ms Alder, dated 25 January 2000, Supt Holt apologised for having allowed this to happen.⁴⁴⁷

West Yorkshire Police and family liaison

4.145 Family liaison, as already mentioned above, and described in Chapter 8, was dealt with by Humberside Police throughout April, apart from the involvement of Mr Elliott of the PCA. There is no record of West Yorkshire Police briefing the Humberside police officers who dealt with the family, as to the progress of their inquiry.

4.146 There is no record of any meeting between officers from West Yorkshire Police and any member of the family of Mr Alder prior to 27 April 1998, when Supt Holt met with Richard Alder. That meeting, attended by PC Smith of Humberside Police, is described by her as having been fraught. PC Smith was withdrawn by Humberside Police from around the end of April, and all responsibility for family liaison was passed to West Yorkshire Police.

4.147 Neither force informed the FLO that the five officers were to be suspended from duty, and PC Smith indicated in interview that the sudden announcement of this news caused her considerable and long-lasting embarrassment with the black population in Hull, because those with whom she had been communicating interpreted the news as showing a lack of candour on her part.⁴⁴⁸

⁴⁴⁵ Inquest Day 21, p.22

⁴⁴⁶ Jim Elliott interview (31 January 2005) Tape 2 p.25–6 [01100056–7]

⁴⁴⁷ West Yorkshire Police letter (25 January 2000) CA001 [00010107–9]

⁴⁴⁸ PC Smith interview (21 April 2005) CA0139 [01390004]

4.148 There is no indication that any formal meetings took place between West Yorkshire police officers and Ms Alder, possibly because she had already expressed her antipathy to the Humberside Police FLO system. A PCA file note shows Jim Elliott and Supt Holt met Richard Alder at the offices of Mr Holland, a solicitor with Stamp Jackson & Procter, on 20 May 1998.⁴⁴⁹ The meeting was used to provide information and explanations of medical terms from the post mortem report.

4.149 Mr Elliott recorded in relation to the contacts with Ms Alder that:

“I agreed with Superintendent Holt that there was little to be gained by seeking to arrange for a police family liaison officer to make contact with Janet Alder as she made it clear she would not find such an arrangement acceptable.”⁴⁵⁰

Interviews with officers

4.150 In the course of the West Yorkshire Police investigation, it was decided that all five officers should be interviewed. The interviews eventually took place in mid-May 1998. The interviews varied in length, from under one and a half hours (PC Barr) to over two and a half hours (PS Dunn). It is clear that there was some considerable preparation undertaken for the interviews, in that lengthy and detailed interview plans were prepared in handwriting by Supt Holt. No secondary interviews were held with the officers after the interviews were over, and it is not possible to establish to what extent the results of the interviews were analysed and compared with one another.

Report to the PCA

4.151 Following the interviews, the report of the investigating officer was prepared and submitted to the PCA on 30 June 1998. Following the submission of the report, the PCA requested a number of additional matters to be investigated. The PCA file notes from this time indicate that during discussions between Mr Elliott and Mr Johnston of the PCA concern was raised about the continuity of the videotapes (as there was thought to be a gap when the tapes were changed over by PS Dunn, subsequent to Mr Alder’s death). He also raised the issue of CS incapacitant spray and timings on tapes. Insp. Tolan was asked to deal with these issues, and a number of other queries.

4.152 Insp. Tolan sent a short supplementary report, dated 7 August 1998. This dealt with: the issues of CS incapacitant spray (see below); the route from hospital to police station; and the tapes from the

⁴⁴⁹ PCA file note (20 May 1998) CA001 D158 [00010020]

⁴⁵⁰ Jim Elliott notes re. interview (27 May 2005) p.5

Humberside Police Communications Centre. He also performed an analysis of the timings for the tapes from the communications room and the custody suite video. He concluded that there was no significant discrepancy between them.

- 4.153 Copies of the reports by Supt Holt and by Insp. Tolan are attached as Appendix 30 to this report.
- 4.154 Following the submission of the reports, Insp. Tolan was called upon again by various parties to assist in the handling of the case. The CPS requested his help on occasions, as did the coroner. One notable exercise that he was requested to carry out by the CPS was the test for the time of travel between the hospital and police station. This was undertaken by Insp. Tolan, assisted by other West Yorkshire Police officers, in March 1999. The results of those tests are set out in Chapter 3, dealing with the van journey.

CS spray

- 4.155 The PCA raised the issue of the possible discharge of the CS incapacitant spray carried by one or other of the officers (sometimes wrongly referred to as 'CS gas'). In response to this, further enquiries were made by Insp. Tolan. There is evidence from both the police officers concerned and two of the HRI medical staff⁴⁵¹ who were in close proximity to the incident that PC Dawson did verbally threaten Mr Alder with the use of CS spray. The police officers also stated that they threatened it again outside the hospital as a compliance tactic. They did not say it was discharged, and no witness claims to have seen the spray actually discharged at the hospital, or elsewhere.
- 4.156 It was the procedure in Humberside Police at that time for a 'Use of force report' to be filed by any officer who had either drawn or used CS spray. No such report was ever found by Insp. Tolan in relation to the incident in question.⁴⁵²
- 4.157 The testing of the CS canisters allocated to PCs Blakey, Dawson and Ellerington was conducted on 4 August 1998 by Malcolm Dunne, a PT instructor employed by Humberside Police, at the request of Insp. Tolan. The tests conducted were described by Mr Dunne as being those recommended by the manufacturer, but appear rather rudimentary. The tests involve the weighing of the canister and a gravity test involving floating it in a beaker of water and ascertaining the point on a scale on the side of the canister at which the canister floats steadily. The weight of an unused canister should be 50g plus or minus 2g. The point at which an unused canister floats should read 1 on the gravity test scale indicator.

⁴⁵¹ Dr Aamer Khan and Staff Nurse Helen Townend

⁴⁵² Inquest Day 13 p.41

- 4.158 At the inquest both Insp. Tolan and Mr Dunne gave evidence that none of the canisters in issue to the officers at the time of the incident had been used. Many pages of the inquest transcript revolve around Insp. Tolan's actions in locating the correct canisters issued to the three officers concerned, the delay in the performance of the tests, and the issue of PC Blakey having two CS canisters in his possession.
- 4.159 By his own admission, Insp. Tolan only located the second of PC Blakey's canisters as a result of a letter from Harrison Bunday, the solicitors for Janet Alder. He performed the tests himself, having observed Mr Dunne do so previously, on 26 June 2000. Again the test indicated that the canister in question had not been used.
- 4.160 I have been unable to physically examine the Issue and Return Register for CS spray at Queen's Gardens police station, although copies of it were issued to Counsel at the inquest. It was not amongst the evidence obtained as part of this Review.
- 4.161 I have been shown the instructions for testing, as issued in 1998 and the 2005 version. Both recommend that to test for usage, the canister should be weighed and that several other canisters in the same sequence be weighed and the weight averaged out.
- 4.162 There is no evidence to suggest that either Mr Dunne or Insp. Tolan undertook the recommended 'control test weighing' of canisters with serial numbers above or below those subject to testing in the instant case. Therefore an accurate average weight was not established prior to the commencement of the testing, and the test undertaken represents a flawed methodology. Insp. Tolan acknowledged the shortcomings in the tests in his report to Mr Elliott,⁴⁵³ and commented that:
- "there is no method of examination which would be able to show categorically that a canister had, or had not, been used".
- 4.163 The forensic evidence adduced at the inquest from Dr John Clark, was that the tests for CS gas performed by him during the first post mortem were negative in both the blood and stomach contents, although he acknowledged that CS gas is notoriously difficult to analyse post mortem. There was no visible evidence of the kind usually associated with exposure to CS spray upon examination during the autopsy. Such evidence would typically be reddening of the eyes and inflammation of the upper respiratory passages.⁴⁵⁴

⁴⁵³ Insp. Tolan report (7 August 1998) CA009 [00090003]

⁴⁵⁴ It was accepted that other associated exposure indicators, such as red blotches and blistering to the skin, usually occur only in people of Caucasian origin

- 4.164 There is no evidence to suggest that those who came into contact with Mr Alder noticed in him any signs of the effects of CS spray exposure. There is also no evidence to suggest that any of those persons suffered any of the usual irritant effects of CS spray themselves.
- 4.165 Mr Michael Gallagher who examined the police van for fingerprints and blood was asked if he had noticed any residue of CS gas. He said that he would have noted it if he had done so, but had no such note. He would have expected the smell to linger for some time.⁴⁵⁵
- 4.166 Scientific analysis of the physical samples obtained at the post mortem was undertaken with a view to seeing whether there was any trace of CS or its solvent in Mr Alder's body. It is recognised that CS in biological materials is broken down very quickly by the natural enzymes in the body, hence the difficulty in detecting the presence of such post mortem. It is, however, perfectly possible to detect the presence of methyl isobutyl ketone (MIBK), the solvent mixed with CS, in post mortem tests, as it is known to remain in biological matter for a longer period and hence has better detection rates, although there is little experimental evidence as to how long traces will linger.
- 4.167 An expert in toxicology, Professor Forrest, was asked to consider the issue of CS exposure in May 1998, at which time he advised Dr Clark that the chances of getting a positive result were virtually zero. Professor Forrest did not detect either CS or the solvent MIBK⁴⁵⁶ in the samples provided by Dr Clark. Dr Paul Rice was later instructed⁴⁵⁷ by Insp. Tolan to provide expert opinion regarding the CS issue. He concluded that:
- “the actual use of CS spray against Mr Alder during his arrest in the early hours of 1st April 1998 is extremely unlikely”.
- 4.168 Had the clothing of Mr Alder been seized by the SOCO at an early stage and stored in the appropriate packaging, this would have presented the best opportunity of detecting the presence of CS or MIBK, if the spray had been discharged. In the event, this opportunity was lost because, although Mr Alder's clothes were seized, no forensic examination of the clothing took place, and it was subsequently destroyed.

⁴⁵⁵ Michael Gallagher interview (11 March 2005) Tape 2 pp.9–10 [01170047–8]

⁴⁵⁶ The spray used at the time contained a mixture of CS incapacitant, in crystal form and MIBK (methyl isobutyl ketone), which is the solvent carrier used to disperse the CS

⁴⁵⁷ 27 January 2000

The PCA interim statement

4.169 The reports produced by Supt Holt and Insp. Tolan were submitted to Mr Elliott of the PCA. On 13 August the PCA issued an interim statement, confirming that it was satisfied that:

“the investigation into all the circumstances of the death of Christopher Alder is complete”.

4.170 A copy of the investigating officer’s report and supporting evidence was then forwarded to the CPS for consideration. As is now known, that process was to take nearly a year before the first decision was taken.

4.171 Following the issue of the interim statement, the formal role of the PCA effectively came to an end until such time as the criminal process was resolved. Although that would not have been known at the time, it would be four years before that came to pass. Mr Elliott continued to correspond by post and telephone with Ms Alder, and with Mr Peter Pike MP, who was Ms Alder’s local Member of Parliament.

CHAPTER 5: MEDICAL HISTORY OF CHRISTOPHER ALDER AND POST MORTEM MEDICAL EVIDENCE

Introduction

- 5.1 Because the reasons for the death of Christopher Alder were to prove elusive, and difficult to determine, it was appropriate to consider whether there were any pre-existing factors or medical conditions which might have had a bearing on his death and his behaviour at the hospital. These are best reduced to the questions which were asked during both the police investigation and the medical assessments of the post mortem evidence. I then go on to consider the medical evidence in chronological order. The reason for this is to help understand the gradual and emerging picture which was formed during the course of the investigation and hearings.
- 5.2 For the benefit of those without medical knowledge, the Healthcare Commission (HCC) kindly assisted in providing a glossary of medical terms, which is attached at Appendix 9.

Christopher Alder's medical history

- 5.3 **Did Mr Alder have any pre-existing heart condition?** On 25 November 1981, shortly after he had left the army, Mr Alder made an application to Test Valley Borough Housing Department for priority housing on medical grounds.⁴⁵⁸ Mr Alder cited a "heart condition" as the reason for this. His address at the time was given as being in Launcelot Place, King Arthur's Way, Andover. This was said to be a council property. He would be leaving the property with no other accommodation to go to.
- 5.4 The council wrote to his GP, Dr Hamilton, asking for his comments.⁴⁵⁹ Dr Hamilton responded on 2 December 1981, stating that Mr Alder had visited him for the first time in November 1981.⁴⁶⁰ He knew that Mr Alder had not been invalided out of the army, and that his only complaints had been minor ones. He went on to say:

"He made no mention of his declared heart condition. I think it is unlikely that he would be accepted into the armed services with a heart condition."

⁴⁵⁸ Application form CA0089 p.205 [00890049]

⁴⁵⁹ Letter (date unclear) CA0089 p.206 [00890050]

⁴⁶⁰ Letter (2 December 1981) CA0089 p.210 [00890054]

- 5.5 He concluded that he knew of no medical grounds for advising re-housing, although:

“He may have a condition which I am unaware of.”

- 5.6 In fact, medical records released by the army indicate that on 8 November 1976, approximately two months after he joined the army, a report was prepared on the 16-year-old Mr Alder by a consultant cardiologist.⁴⁶¹ This report appears to have been called for by, and is addressed to, the Medical Officer at Browning Barracks in Aldershot, where Mr Alder was based. The cardiologist stated that:

“No cardiac abnormality has been detected previously and there is no relevant or past history. He is fit.”

- 5.7 A manuscript note adds:

“His heart appears to be normal.”

- 5.8 The existence of this report suggests that a concern was raised, although no indication is given as to the source of the concern. Mr Alder clearly remembered this investigation, but perhaps not the resolution of it by the cardiologist. I have found no record of Mr Alder ever mentioning this claim of a heart condition subsequent to the housing application, and he did not mention it when he registered with a GP in Hull in 1992.⁴⁶²

- 5.9 **Did Mr Alder have any pre-existing respiratory problems?** In the final weeks of his army service, Mr Alder was referred to a specialist in ear, nose and throat (ENT) medicine.⁴⁶³ The ENT specialist referred to:

“remarks by Col. Hughes regarding the problems in respiration”.

- 5.10 The conclusions drawn by the consultant were that:

“there is obvious broadening and distortion of the nasal bridge. The history is of trauma to the nose on at least three occasions. He complains of intermittent nasal obstruction, alternating between right and left sides, and is a constant mouth breather.”

- 5.11 The report goes on to recommend possible corrective measures, in the form of minor surgery, and the consultant stated that he had suggested to Mr Alder that he seek assistance once he had left the army. There is no evidence that Mr Alder ever had this corrective work done.

⁴⁶¹ Outpatient record (8 November 1976) CA0082 [00820028]

⁴⁶² Clinical notes CA0077 pp.47–8 [00770048–9]

⁴⁶³ Outpatient record (1 June 1981) CA0106 p.150 [01060152]

- 5.12 **Did Mr Alder suffer from panic attacks, particularly in hospital?** Mr Alder's medical records from the 1980s reveal only minor and irrelevant medical problems, and he appears to have been a man who enjoyed good health. In 1988 he dislocated his shoulder and was treated at hospital. The notes of the incident provided by Winchester Health Authority indicate that he told the doctors that this was not the first time that he had dislocated the shoulder.⁴⁶⁴ After initial attempts failed, it was decided to resolve the dislocation under general anaesthetic.
- 5.13 Mr Alder dislocated his shoulder again in September 1991, and found himself, once again, at the hospital in Winchester. On this occasion, following similar problems in returning the shoulder to its correct position, Mr Alder was sedated to allow resolution, although not given general anaesthetic. It is noted in the hospital records that he was "violent & attempted to kick Dr in face".⁴⁶⁵ The notes also record him as having had "one previous" dislocation, rather than two as previous notes would suggest, and as being a "very reluctant historian"; later on, the doctors noted that he gave different explanations as to the source of the injury at different times.
- 5.14 Jennifer Hobson, his former girlfriend, described an incident, which she believed to have taken place in 1990, when she had called the ambulance for Mr Alder following a dislocation of his shoulder.⁴⁶⁶ She said that he "freaked out" when told, and did not wish to attend hospital. He was persuaded to go in the ambulance, but she recalled him "sweating and kept complaining that his mouth was dry". Ms Hobson described his behaviour as a panic attack, and that she had to assist in calming him at the hospital, which took 45 minutes. Mr Alder was, as she recalled, shouting and refusing to be X-rayed. Ms Hobson was allowed to attend the X-ray process to hold his hand.
- 5.15 After the X-ray, she recalled that Mr Alder kicked the doctor who tried to treat him. It is noteworthy that the hospital allowed two hours to pass before agreeing to her request for a general anaesthetic, but that several persons had to hold down Mr Alder, who was screaming and shouting, while the anaesthetic was administered. Even after the procedure, when he regained consciousness, Mr Alder apparently panicked again and demanded to be taken out of the hospital.
- 5.16 No medical record has been identified for such an incident in 1990, although this may be the same 1991 hospital visit. The fact that Ms Hobson described a full general anaesthetic rather than merely sedation, as recorded by the medical reports, perhaps suggests that this may have been another occasion or another hospital.

⁴⁶⁴ Medical notes (11 September 1988) CA0089 pp.217–28 [00890061–2]

⁴⁶⁵ Winchester Health Authority medical notes CA0089 p.230 [00890074]

⁴⁶⁶ Statement of Jennifer Hobson (23 April 1998) CA0095 p.13 [00950014]

- 5.17 Ms Hobson recalled, in the context of what appeared to her to be a panic reaction, that Mr Alder regularly showed symptoms of panic when in lifts and that he left all the doors open at home. She believed him to suffer from claustrophobia, and said that he did not like to wear clothes that touched his neck. Mr Alder was not prepared to discuss these fears with her.
- 5.18 When questioned about it, both Janet Alder⁴⁶⁷ and Richard Alder⁴⁶⁸ dismissed the possibility that their brother might have suffered from claustrophobia, although neither had lived with him for several years.
- 5.19 While the general reaction of Mr Alder to the ambulance crew, and doctors, is discussed elsewhere, it is worth noting in particular that while he was waiting for the ambulance on 1 April, lying outside the Waterfront Club, one of the staff, named Karen Mills, was with him.⁴⁶⁹ Ms Mills had been reassuring him, but observed that:
- “He then began to breath [sic] differently. He began to pant and breath in a short manner, as if he was becoming panicked. I stroked his shoulder and told him to calm down and breath slowly, which he soon did.”
- 5.20 She did not relate having mentioned this reaction to the ambulance staff, and therefore it was almost certainly not passed on to the hospital staff.
- 5.21 Between 1992 and 1997, Mr Alder was registered with a GP in Hull. Again, there is no record of any significant illness or injury from that period.
- 5.22 **Was there any basis for believing that Mr Alder might have suffered from any mental illness?** During the investigation into the events surrounding his death, Humberside Police made enquiries regarding the mental health of Mr Alder.⁴⁷⁰ They sought to establish whether there was any evidence that he was suffering from any mental illness that might have had a bearing on his death or on his behaviour in hospital. The ultimate conclusion was that there was not. I have seen the evidence gathered in relation to this point, and I am satisfied that, while it was proper to explore the matter, this was the correct conclusion. I do not believe it is necessary to repeat this very personal information in this report.
- 5.23 Shortly before the inquest into his death, the coroner for Hull also requested a psychiatric report on Mr Alder. This was prepared by a

⁴⁶⁷ Inquest Day 1 p.27

⁴⁶⁸ Richard Alder statement (20 July 2000) para.14 [00820033]

⁴⁶⁹ Karen Mills statement (5 April 1998) CA0019 p.197 [00190199]

⁴⁷⁰ DCI Davison letters (15 April 1998) CA0067 D48/D49 [00670203–7]

consultant psychiatrist named Dr Keith Rix.⁴⁷¹ Dr Rix's assessment was made without the benefit of meeting or interviewing the deceased, and was necessarily based on the descriptions by Ms Hobson and others, together with available records of Mr Alder's medical history. His view was that Mr Alder may have suffered from:

“a form of phobia and perhaps, but not limited to, claustrophobia”.⁴⁷²

He went on to state that the aversion to wearing items that touched his neck might indicate a past incident of attempted strangulation at some stage in Mr Alder's past.⁴⁷³ Dr Rix went on to rule out as very unlikely the possibilities of Mr Alder suffering from “paranoid personality disorder” or schizophrenia. He said that a more likely cause of paranoia would have been the misuse of stimulant drugs, although it was known by then that no trace of such drugs was found in Mr Alder's body at the post mortem. Dr Rix went on to say:

“it is not possible to rule out a paranoid state of mind brought about by such drugs but persisting after they had left the body”.⁴⁷⁴

5.24 This, in turn, gives rise to the further question, which had already been considered by the police:

5.25 **Was Mr Alder under the short-term influence of drugs, or suffering from their long-term influence?** The police had searched the flat of Mr Alder twice, and appear to have expected to find some evidence of drug use. The initial search of the flat by Acting Detective Sergeant (A/DS) Sykes at 14.25 on 1 April found “roach ends” on a tray in the kitchen, which he believed to be cannabis, but these were not analysed.⁴⁷⁵ No other evidence of drug use was found, either in that search or in the more thorough search that was made a couple of days later.⁴⁷⁶

5.26 A/DS Sykes also recorded that Richard Adams told him that Mr Alder used both cannabis and amphetamines. Mr Adams, however, made a statement in which he said that:

“Chris was careful in relation to the amount of alcohol he consumed, he would never get blind drunk...”

and

⁴⁷¹ Report of Dr Rix (22 April 2000) CA0023 [00230185–209]

⁴⁷² Report of Dr Rix (22 April 2000) p.13 [00230197]

⁴⁷³ Report of Dr Rix (22 April 2000) p.15 [00230199]

⁴⁷⁴ Report of Dr Rix (22 April 2000) p.16 [00230200]

⁴⁷⁵ A/DS Sykes HOLMES report (15 April 1998) R4

⁴⁷⁶ Policy document (re 2 April 1998) CA0084 Decision No 18 [00840019–20]

“Chris was also conscious about taking any illegal substances, the only thing I’m aware of he would take was some cannabis, I don’t think he did this on a regular basis but I was aware he used it.”⁴⁷⁷

5.27 Christopher Baynes, a friend of Mr Alder, was interviewed by the police and said that he was aware of Mr Alder’s interest in body building, but that Mr Alder had never mentioned taking steroids.⁴⁷⁸

5.28 The only evidence to suggest that Mr Alder might have taken such drugs was that of Leonard Bottomley, a friend from college, who said that:

“He told me that he used to take ‘steroids’ earlier in 1997, but that he had stopped but he didn’t say why he had stopped. He told me to stay away from steroids because they were no good for me.”⁴⁷⁹

5.29 The issue of possible steroid abuse was explored more fully at the inquest, without any firm conclusion being drawn. This was a cause of some distress to his family, who felt that Mr Alder was being treated as a suspect rather than as a victim.

The post mortem evidence

5.30 The most basic question arising from the death of Mr Alder has remained the most elusive, and the most difficult to answer: what was the physical cause of his death? At no point in the days, weeks and years since the sad death of Mr Alder has a single, agreed cause of death been identified. Many cases of sudden death require the involvement of one or more pathologists, skilled in the science of post mortem analysis. In the case of Mr Alder I have identified 17 experts, each of them highly qualified doctors, who contributed to the investigation.

5.31 A list of all the doctors who provided expert medical advice, showing their qualifications and on whose behalf they were originally instructed, is set out at Appendix 4 to this report. A brief chronology of the medical reports provided can be found at Appendix 5. A tabular summary of the main findings at each stage is provided at Appendix 6. At Appendix 7 is an analysis of the medical evidence produced on behalf of the IPCC by Dr Richard Shepherd. This document provides an overview and commentary on the methods used and the approach of the doctors

⁴⁷⁷ Richard Adams statement (1 April 1998) CA0095 p.24 [00950025]

⁴⁷⁸ Christopher Baynes statement (5 May 1998) CA0095 p.143 [00950144]

⁴⁷⁹ Leonard Bottomley statement (16 April 1998) CA0095 p.152 [00950153]

involved. At Appendix 9 I have included a glossary of medical terminology.

- 5.32 The reason that Mr Alder died cannot be reduced to a single, straightforward explanation. The consensus of evidence presented was to point to a distinction between two questions: firstly, why did he lose consciousness in the police van; and secondly, why did he die in the police station? The first question proved the more difficult. It was agreed that it was almost certainly a combination of factors, and that the combined effects of alcohol and the blow to his head may have been responsible. Some thought inhalation of vomit may have been a factor. Some experts saw it as probably a problem with his heart, leading to an uneven heartbeat and consequent unconsciousness. Others favoured a convulsive fit.
- 5.33 What was almost universally agreed was that the level of uncertainty as to what caused his unconsciousness meant that it was not possible to say whether Mr Alder was, or was not, actually dying by the time that he was taken from the van. It was thought possible that his death might have been contributed to, or hastened by, the position that he was placed in at the police station and by the lack of care he received from the police officers. Measuring and determining the extent of the contribution proved to be the hardest task of all.
- 5.34 This chapter aims to set out in more detail the analysis, debate and conflicting views of the medical experts. In large part, the medical opinion concentrated on the factors leading to, and possibly contributing to, the death of Mr Alder, although to some extent they also touched on the quality of care prior to death, even if that was not deemed to be a factor that contributed to his demise.

First post mortem examination

- 5.35 The first post mortem examination took place on the afternoon of 1 April 1998, the same day that Mr Alder had died. Geoffrey Saul, the Coroner for Hull and East Riding, instructed Dr John Chalmers Clark to carry out the post mortem examination. Dr Clark was the Senior Lecturer in Forensic Pathology at the University of Sheffield and a Home Office consultant pathologist.
- 5.36 Prior to the examination, Dr Clark attended the custody area at Queen's Gardens police station while Mr Alder's body was still there, at 10.15. The post mortem examination began at 17.00 that afternoon at the Medico-Legal Centre in Sheffield. Dr Clark did not produce a written report on the post mortem examination until 27 May 1998, but as an interim measure, to enable the investigating officers to provide correct disclosure prior to the interviews of the five officers, an agreed

summary was countersigned by Dr Clark and faxed to Supt Holt.⁴⁸⁰ That document, dated 13 May 1998, confirmed that Mr Alder did not die of the physical injuries received in the assault; that Mr Alder:

“did not suffer any significant physical injuries other than those recorded by the paramedics at the Waterfront”;

that he suffered from no evident natural illness leading to his death; and that his respiratory failure was brought about by a combination of factors, one of which was the position he was placed in on the charge room floor. The pathologist stated that, in his view, earlier medical intervention, following arrival at the station, would have increased the chance of his life being saved.

5.37 The actual post mortem report was dated 27 May 1998.⁴⁸¹ Dr Clark set out in that report the details of his examination of the body of Mr Alder, in situ at the custody suite, shortly after 10.15 on the morning of 1 April. He described the clothing as seen by him at the time, and the signs of medical treatment left by the paramedics. He was also able to describe a number of small, old scars on the body of Mr Alder.

5.38 He described the obvious injuries to Mr Alder’s body as being:

“Short, very fine, diagonal laceration, 1 cm in length, at the front of the head in the midline with the lower end to the left.

Superficial grazed abrasion, 1 cm in diameter, on the middle part of the upper lid of the right eye.

In the mouth:

Ragged, deep vertical laceration, 1.5 cm in length, on the inner surface of the left side of the upper lip near the midline, running forwards to the lip margin where there was an abrasion, 0.8 cm in diameter.

Tiny bruise on the inner surface of the upper lip to the right of the midline.

Left upper 1st and 2nd teeth dislodged and missing, with bleeding from both sockets.

Full thickness ragged laceration on the left side of the lower lip near the midline, measuring 0.5 cm in length on the outer surface and 2 cm in length on the inner surface.

At the back of the head, 1 cm to the left of the midline and level with the upper half of the ear, a circular superficial abrasion, 3 cm in diameter, with an overlying ragged superficial vertical laceration, 1 cm in length, which was oozing blood. There was a large underlying bruise, 8 cm in diameter.

Arms

Abrasion, 1 cm in diameter, on the outer aspect of the left arm below the elbow.

⁴⁸⁰ Faxed report (13 May 1998) CA0106 [01060141–2]

⁴⁸¹ Dr Clark report (27 May 1998) CA007 pp.138–57 [00070139–58]

Tiny abrasion, 0.2 cm in diameter, on the back of the left hand between the base of the index and middle fingers.

Asphyxial signs

In addition to the injuries there was a single petechial haemorrhage on the inner surface of the lower lid of the left eye. No other petechiae were seen and there were no other asphyxial changes.”

- 5.39 The post mortem examination was clearly as important for what it did not find, as for what it did. Although there was internal bruising in the scalp there was no fracture of the skull, and the meninges were intact; there was no surface damage to the brain and, apart from the injuries to the mouth, there were no injuries to the bones or the deep tissues of the face. Three small haemorrhages to the strap muscles around the throat were found, but no other throat injury. Ribs, pleural cavities, heart, aorta and oesophagus were normal. Dr Clark commented that:

“The air passages contained a small amount of bloodstained watery fluid. Both lungs (right 657g, left 540g) showed areas of inhalational haemorrhage in each of the lobes, with associated mild oedema.”

- 5.40 The delay in producing the report had allowed for completion of specialist analysis of samples taken, and Dr Clark was able to incorporate the findings of examinations into the brain (neuropathology), heart and other internal organs (histology), blood (haematology), and for the presence of poisons or drugs (toxicology). None of these revealed any cause of death.

- 5.41 In his conclusions, Dr Clark was able to state that the head injury did not kill Mr Alder:

“The injury was therefore a relatively minor one, which would be insufficient to account for his final collapse and death, albeit it probably initiated the chain of events ultimately leading to this. It would be entirely consistent with him having been punched once in the face and fallen backwards. The punch had dislodged two teeth and caused tears in his lips, and so must have been a reasonably forceful one.

Other injuries

The only other injuries were a short scratch at the front of his head and small grazes on his right upper eyelid, at the left elbow and on the back of the left hand. These were all very minor and could have been caused in various ways including in a struggle, from contact with the ground, or even during medical treatment. They were not suggestive of any prolonged assault or restraining, there being a specific absence of gripping or other pressure marks on his back or arms.”

- 5.42 Dr Clark excluded natural disease as being the cause of death, and stated that the heart appeared largely normal, with some minor variations. He could not say how significant the minor issues were, as there appeared to be some old damage, pre-dating the events leading to death. He was also able to exclude drugs or alcohol as being the causes of death. Dr Clark went on to say that:

“Excluding those conditions which probably did not contribute to his death is perhaps not too difficult. Establishing what precisely did kill him is less easy. Most difficult, and most crucial, to understand is what happened to him in the police van, between him leaving the hospital and arriving at the police station. He was apparently ‘well’ when he got into the van, but when the doors were opened a few minutes later he was described as unresponsive, still sitting in the same position. Either he became acutely unwell there, going from being ‘normal’ to unconscious within a matter of minutes, or something else happened. The latter would obviously have to exclude the possibility of him having been injured or restrained in some way such that he was rendered unconscious.

Whatever it was that happened to him, it is important to clearly identify and separate it from anything which may have happened subsequently in the police station. Thus, he collapsed because of something which happened in the van, while his actual death in the police station may or may not have been contributed to by additional factors acting there.”

- 5.43 Thus from an early stage, the distinction was being drawn between the factors that led to Mr Alder’s unconsciousness in the van, and the cause or causes of his death. Dr Clark pointed out that there was no strong evidence to suggest the use of undue physical restraint, nor of the use of CS spray.

- 5.44 He concluded that unconsciousness was therefore probably due to either a ‘cardiac event’ or acute alcoholic intoxication. He stated that alcohol alone was unlikely to have made him pass out, but coupled with an adrenaline surge this might have happened. The alternative, in the view of Dr Clark, was:

“a cardiac arrhythmia, i.e. a disturbance of heart rhythm, brought on by his excitable state”.

- 5.45 Dr Clark thought that this might be induced by an “excited delirium”, which is a recognised situation that can lead to arrhythmia and collapse. On balance, Dr Clark regarded the arrhythmia as the most likely reason for the collapse.

- 5.46 Dr Clark said that Mr Alder clearly had inhaled some vomit, as his airway had to be cleared at the police station. However, the doctor

thought that the inhalation was more likely to be a result of the collapse than a cause of it.

5.47 As regards Mr Alder's death, he felt that other factors also came into play. The alcohol intoxication and inhalation of vomit were two of these, coupled with an element of postural asphyxia and the lack of medical treatment. Dr Clark could not make any definitive assessment of the influence of the latter two factors. He said that being left lying face down may have disadvantaged chest expansion and made breathing more difficult, and lack of even basic first aid for ten minutes may have been a factor in his death.

5.48 Notwithstanding this, Dr Clark conceded that it was always possible that Mr Alder might not have recovered, whatever was done for him, and therefore his treatment at the police station may or may not have been relevant to his death. Because of all of the uncertainties, the assessment of cause of death was therefore recorded as being:

“undetermined (probably multi-factorial)”.

Second post mortem examination

5.49 The second post mortem examination was authorised by a telephone call on 9 April between the coroner and Messrs Williamsons, solicitors. Williamsons were acting at the time for Mr Paul.⁴⁸² The examination took place on 10 April 1998 and was carried out by Dr Carl Gray.⁴⁸³ He was commissioned on behalf of Williamsons, and he makes clear in his report that following discussion with Stamp, Jackson and Proctor, solicitors for the family of Mr Alder, it was agreed that the report:

“would serve the interests of both defendant and family”

and that he would accept instructions from the second firm as well. That report was dated 27 May, and also took into account his presence at the third post mortem examination.

5.50 The second examination was at the Medico-Legal Centre in Sheffield and took place between 14.00 and 15.10, with Dr Clark in attendance. Dr Gray examined the body of Mr Alder, and was subsequently able to examine the van in which he had been transported and to view the tape of his death in the custody suite. Dr Gray's opinion was that cause of death was:

“undetermined (multiple factors present)”.

⁴⁸² Williamsons letter (9 April 1998) CA0067 D43 [00670176]

⁴⁸³ Dr Gray' report (27 May 1998) CA001 D29 [00010283–304]

- 5.51 He listed as possible contributory factors: alcoholic intoxication, excited state/hyperadrenalism, inhalation of gastric contents, assault and/or postural asphyxia. Dr Gray commented on these factors as follows:

“Alcoholic intoxication

Alcoholic intoxication has contributed to death by the following mechanisms:

Phase VI:	nausea and vomiting, inhalation of vomit
Phases VII & VIII:	respiratory depression

In addition, alcohol would have contributed to the excited state...increasing the body’s demand for oxygen.

Excited state/hyperadrenalism

Mr Alder was certainly in an excited state owing to the assault and the minor injuries sustained, and his aggressive and uncooperative behaviour during his time in the hospital. The effect of excitement is to increase heart rate and oxygen demand in the body, with the release of adrenalin and related hormones, which cause the ‘flight or fight’ reaction. This is a protective reflex which has ill effects in some circumstances...

Inhalation of gastric contents

...Mr Alder had inhaled significant gastric contents and this must have contributed to the terminal respiratory failure and may have contributed to the collapse in the van.

Assault

The assault...injuries would have caused pain and discomfort. Pain and discomfort would have contributed to his excited state. The whole aggressive episode following the assault can be interpreted as a man in a post-concussive state: a state of mild confusion and disorientation following the bang to the head...

Postural asphyxia

Postural asphyxia was undoubtedly present on the charge room floor and may have contributed to the fatal outcome. Alcoholic intoxication also contributed to postural asphyxia by respiratory depression.”

- 5.52 He concluded that:

“overall it is indeterminable which event occurred in the van. The two most likely were inhalation of vomit and sudden cardiac dysrhythmia.”

- 5.53 He also gave the opinion that it was indeterminable from the medical evidence whether Mr Alder’s death could have been averted by prompt and efficient medical intervention. He also expressed the very firm view that there was “undoubtedly failure of the duty of care in police custody”.

Third post mortem examination

- 5.54 The third post mortem examination occurred at Hull Public Mortuary on Wednesday 20 May 1998 between 13.00 and 14.00. It was carried out by Dr William Lawler at the request of a firm of solicitors named Whittles, representing some or all of the police officers.⁴⁸⁴ Dr Clark and Dr Gray were also in attendance. Dr Lawler was able to examine the police van and the custody suite, and viewed the video of the custody suite at the time of Mr Alder’s death. He was given a history of Mr Alder, as known to the other pathologists.

- 5.55 Following examination of the body of Mr Alder, and photographs taken at the earlier examinations, Dr Lawler agreed that the cause of death should be categorised as “undetermined”. He commented that:

“Like Dr Clark and Dr Gray, I have no doubt that this man’s death was the result of a combination of several factors, and, unfortunately, I do not think that it is possible to quantitate [sic] the contributions made by each of these various factors.

I have absolutely no doubt that the events in the police van were crucial to this man’s death, as there is no escape from the conclusion that his condition deteriorated from being fully conscious when put into the van to what was quite obviously, at least in retrospect, unconsciousness on arrival at the police station.”

- 5.56 Dr Lawler went on to express the view that the psychological or emotional state of Mr Alder may have been one of the most important factors in his demise. Dr Lawler, who acknowledges that he is not a psychologist, and that Mr Alder:

“had no long-term psychiatric problems requiring treatment”,

was nonetheless concerned by Mr Alder’s history of being agitated and anxious when in hospitals. Having considered the behaviour of Mr Alder as related by witnesses, he stated that:

⁴⁸⁴ Dr Lawler report (20 May 1998) CA0009 [00090024–45]

“I am certain that this man was in an abnormal, very excited state, and that, as a consequence, he would have had very high levels of adrenaline and similar hormones circulating in his blood – thus producing an increase in heart rate and an increase in demand for oxygen by his body. There is no doubt that, under these circumstances, the heart may develop one or more rhythm disturbances, and that, although very unusual, relatively sudden and unexpected collapse and death can occur.”

- 5.57 Dr Lawler agreed that the head injury in itself did not contribute directly to the death, but felt the assault was significant in that it necessitated hospital treatment which, in turn, contributed to Mr Alder’s:

“abnormal emotional state”.

He also thought that alcohol may have contributed to that state.

- 5.58 Dr Lawler was of the view, since an abnormal degree of excitement can produce a form of cardiac arrhythmia, that:

“it is most likely to have been some arrhythmia which was responsible for his very rapid clinical deterioration”.

- 5.59 He went on to say that the inhalation of gastric contents may have been a factor in the collapse of Mr Alder; he ruled it out as a significant factor, due to the absence of vomitus on the floor of the van or on the clothing of Mr Alder. He acknowledged that vomiting is a well-known complication following collapse and consequent cerebral hypoxia. Other factors that may have contributed to his abnormal excited state were identified as his confinement in a small space, in the dark, travelling sideways. Dr Lawler excluded natural disease (including sickle cell disease), other drugs, physical injury, and carbon monoxide poisoning as factors in the death of Mr Alder.

- 5.60 Once at the police station, in the view of Dr Lawler, it was possible that Mr Alder was already dying. Three factors there that were likely to have contributed, to some extent, to his death were the inhalation of gastric contents, which would have further inhibited his airways; the intoxication of alcohol, which would have promoted inhalation of gastric contents and would have depressed respiration to some extent; and his posture once he had been placed prone and handcuffed on the floor.

- 5.61 Dr Lawler agreed, therefore, that several factors led to the death of Mr Alder, but that identifying the relative impact of the different factors was not possible. He concluded that the excited state in which Mr Alder was seen had led to his collapse following cardiac arrhythmia, possibly contributed to by minor pre-existing cardiac disease. He also expressed the view that, even by the time of his arrival at the police station, Mr Alder had:

“sustained significant cerebral hypoxia”,

such that his treatment at the station may have contributed to his death, but did not necessarily do so.

- 5.62 A fourth post mortem examination was carried out by Dr P N Cooper on behalf of Harrison Bunday, solicitors representing Ms Alder. This examination did not take place until 13 January 1999, and is dealt with below.

Subsequent analysis: Professor Alexander Forrest

- 5.63 As part of the post mortem analysis, Dr Clark had requested the assistance of Professor Alexander Forrest, a clinical chemist and toxicologist based at the Royal Hallamshire Hospital, Sheffield. Professor Forrest undertook tests on samples of blood obtained from Mr Alder, and produced three short reports. The first of those, dated 6 April 1998, dealt with the possible presence in the blood of a range of commonly found drugs.⁴⁸⁵ Specifically he checked for opiates, benzodiazepines, barbiturates, cannabinoids, methadone, cocaine metabolites and amphetamines. None of these were found, and the only detected drug in the samples was alcohol.

- 5.64 A later report, dated 7 May 1998, concerned the possible use of CS spray.⁴⁸⁶ Professor Forrest stated that:

“No ‘CS’ was detected in blood or stomach content.
NB. This compound hydrolyses very rapidly and this does not preclude the possibility that the deceased was exposed to ‘CS’.”

- 5.65 The third of these reports, dated 3 June 1998, stated that the level of carboxyhaemoglobin found in the blood was less than 5 per cent of total haemoglobin (concern having been raised as to whether carbon monoxide poisoning might have been a factor in the unconsciousness of Mr Alder).⁴⁸⁷

Dr Nathaniel Cary

- 5.66 Following the first three post mortem examinations, Dr Clark asked for an opinion from Dr Nathaniel Cary, another consultant pathologist, based at Papworth Hospital.⁴⁸⁸ Dr Cary examined the heart of Mr Alder and concluded, in a report dated 21 October 1998, that his heart was

⁴⁸⁵ Professor Forrest report (6 April 1998) CA0076 [00760525]

⁴⁸⁶ Professor Forrest report (7 May 1998) CA0076 [00760524]

⁴⁸⁷ Professor Forrest report (3 June 1998) CA0080 [00800441]

⁴⁸⁸ Dr Cary report (21 October 1998) CA001 D62 [00010219–22]

slightly larger than the normal range for a man of his size, but that was probably due to Mr Alder's fitness. Microscopic changes that he found were, in his view, insignificant and would not be the sort that would lead to sudden death.

5.67 This view was not shared by his colleagues: both Dr Lawler and Dr Clark disagreed with Dr Cary, although Dr Cary was the more established expert in this field. Dr Lawler regarded the minor abnormalities (the "mild concentric left ventricular hypertrophy" and the "two separate small microscopic foci of scarring") as being potentially significant.⁴⁸⁹ He believed that they may represent an increased susceptibility to the arrhythmic effects of an excited state.

5.68 Dr Cary, in his report, also expressed the opinion that the loss of consciousness suffered by Mr Alder was probably due to alcohol abuse, coupled with "re-bound hypoglycaemia", which is a lowering of the blood glucose level sometimes seen in those coming down from an intoxicated state. This would then have led to possible aspiration of vomit, and this situation would not have been helped by the position in which he was laid on the floor.

5.69 Dr Cary concluded that:

"this man's loss or impairment of consciousness whilst in the police van is most likely to be related to alcohol abuse. His subsequent downhill course and failure to recover would appear to be related, at least in part, to the lack of proper attention that he received thereafter in terms of receiving no specific attention and not even being put into a proper protective three quarters prone recovery position."

5.70 Following a case conference on 18 December 1998 with Counsel, Mr Hilliard, and having had the chance to view the custody suite video, Dr Cary provided a second opinion on 15 February 1999, at the request of the Crown Prosecution Service (CPS).⁴⁹⁰ Dr Cary was very critical of the position in which Mr Alder was laid by the officers, and expressed the view that:

"in my opinion the proper cause of death to record is:
Ia Postural asphyxia with aspiration of stomach contents due to or as a consequence of
Ib Alcohol intoxication
II Concussive head injury".

5.71 In his conclusions he stated that:

⁴⁸⁹ Dr Lawler post mortem report CA009 p.16 [00090039]

⁴⁹⁰ Dr Cary report (15 February 1999) CA001 D75 [00010198–200]

“In my opinion a lack of care during the period in the custody suite was a major contributory factor to death and in particular gave rise to the immediate cause of death in this case given above of la Postural asphyxia and aspiration of gastric contents.

The deceased was put into the dangerous position in which he died by those involved and was not rescued from that position in time to prevent death.

Death due to an unfavourable body position and particularly in association with aspiration of gastric contents is well recognised in alcohol intoxication...”

Dr Walter Timperley

5.72 A detailed analysis of the brain of Mr Alder was carried out by Dr Walter Timperley, a consultant neuropathologist, who provided a neuropathology report dated 1 April 1999.⁴⁹¹ The report concluded that the brain was anatomically normal, with no significant pathological abnormalities and no evidence of trauma. This effectively ruled out brain injury as being a cause of death.

Dr Graham Cook

5.73 While the reports referred to above were being prepared, Mr Elliott of the Police Complaints Authority (PCA) had consulted a further doctor, named Dr Graham Cook, who was a director and consultant in the A&E Department at Maidstone Hospital in Kent. Mr Elliott had seen Dr Cook on 16 December 1998, and on 17 December he forwarded a note of his discussions to Supt Holt.⁴⁹² Dr Cook later prepared a formal statement, dated 11 March 1999, setting out his views more fully.

5.74 Dr Cook’s view was that the cause of death of Mr Alder was properly categorised as multi-factorial, but he was critical of the care given to Mr Alder and expressed the view that none of the factors were irremediable. He took the view that the behaviour of Mr Alder at the hospital may have been due to his head injury, and concussion, and that the hospital staff did not seem to recognise this.

5.75 In his report, Dr Cook highlighted the fact that the hospital medical staff did not seem to have been told that their patient had lost consciousness for up to 11 minutes, and that the fact would have influenced them towards keeping him in, if they had known. Dr Cook also concluded that Mr Alder sustained some minor additional injuries after leaving the hospital. In his view, the unconsciousness suffered by

⁴⁹¹ Dr Timperley report (1 April 1999) CA0080 pp.517–19 [00800436–8]

⁴⁹² PCA file note (17 December 1998) CA001 D60 [00010224–7]

Mr Alder in the van could have been due to some intracerebral bleeding, or to hypoglycaemia.

- 5.76 Dr Cook was very critical, overall, of the attempts made, too late, to revive Mr Alder. He described the police efforts as being:

“very disorganised and not delivered in a systematic way”.

- 5.77 Dr Cook was later to produce a summary of his report, on 14 May 1999, in which he stated that:

“In conclusion, I consider that Mr Alder most likely died as a result of an obstruction to his airway, at times partial and possibly at times complete, resulting in brain damage and finally cardiac arrest. Should Mr Alder have received the appropriate first-aid care of being placed in the recovery position and clearing his airway when he first arrived at the police station, then transported by ambulance back to hospital, it is most likely that he would have survived.”⁴⁹³

Fourth post mortem examination: Dr Peter Cooper

- 5.78 Dr Peter Cooper was appointed by Harrison Bunday to carry out a further post mortem examination on behalf of Janet Alder. His examination took place on 13 January 1999, and his report was issued on 9 April 1999.⁴⁹⁴ He had the advantage of seeing all the previous post mortem reports, and was able to examine Mr Alder’s heart separately. He gave as his conclusions the following:

“CONCLUSIONS

I agree with Drs Clark, Gray, Lawler and Carey [sic] that it is not possible to be certain exactly what caused Christopher Alder’s death but that a number of factors are likely to be relevant...

SUMMARY

Of the many possible factors in Christopher Alder’s death I believe that trauma played no direct part. In particular, the head injury and the other minor injuries he sustained did not contribute to death and there was no evidence of abnormal restraint or of his neck having been squeezed. There is nothing to indicate that pre-existing natural disease contributed but the heart did show mild abnormalities of dubious significance and a fatal cardiac arrhythmia cannot be entirely excluded. The history of the death is certainly not typical of sudden death associated with the condition known as exited [sic] delirium.

⁴⁹³ Dr Cook summary report (14 May 1999) CA0080 pp.589–92 [00800508–11]

⁴⁹⁴ Dr Cooper report (9 April 1999) CA0080 pp.593–611 [00800512–30]

The evidence suggests that the death was the result of respiratory depression. It is likely that postural asphyxia contributed to the respiratory problem in the Police Custody Suite and possibly in the van. Inhalation of vomit probably also contributed, certainly in the Custody Suite and probably in the van. Prompt medical treatment might have effected a better outcome.

The ultimate question, having said all the above, is what caused Christopher Alder to pass from a state of semi-alertness to one of deep unconsciousness and respiratory compromise during the short trip in the van. The one thing we have definite evidence of is acute alcohol intoxication. This would seem the most likely ultimate cause of death with the provisos that the blood alcohol level was comparatively low and the loss of consciousness comparatively sudden.”

Dr Mark Dearden

5.79 On 10 May 1999, a further report was produced by Dr N Mark Dearden, a consultant anaesthetist from Leeds General Infirmary, at the request of the CPS.⁴⁹⁵ Dr Dearden was requested to answer a series of specific questions concerning the handling of Mr Alder, and to give an assessment of the events from the perspective of an anaesthetist experienced in trauma management. Dr Dearden stated that:

“I believe Mr Alder died from a number of possible interacting causes during a sequence of events that put him at considerably greater risk than he should have been.”

5.80 Dr Dearden was quite clear that Mr Alder should not have been discharged from the hospital when he was.

“Current guidelines on management of minor brain injury, defined as patients with a Glasgow Coma Sum Score (GCSS) of 14 or 15 (some authorities also include 13), suggest that patients should be admitted for a period of at least 24 hours observation if there is continuing confusion especially in the presence of alcohol even in the absence of a skull fracture... This is because agitation and confusion may be features of either brain injury or alcohol intoxication.

It is also recommended that patients with a lesser problem... can be sent home after a period of at least 6 hours observation with an information sheet. Despite Mr Alder’s undoubted aggressive behaviour he should have been admitted, especially as the

⁴⁹⁵ Dr Dearden report (10 May 1999) CA0080 pp.612–37 [00800531–56]

possible existence of a skull fracture, which increases the chances of intracranial pathology many fold... Further reasons for admission were the fluctuating behaviour that could have indicated other toxic substances or hypoglycaemia.”

5.81 Dr Dearden was also concerned that Mr Alder was discharged without evidence of an accompanying adult, and without being given the chance to settle down after urinating, which could have been the cause of some of his upset. He went on:

“There was a disturbing and obvious difference of perception between the medical staff, who felt that Mr Alder was too aggressive for them to handle and therefore needed to be kept in police custody, and the police, who, having been assured that Mr Alder was safe to be escorted out of the hospital, were prepared to let Mr Alder walk away from a ‘place of safety’.”

5.82 Dr Dearden was highly critical of the medical assessment made of Mr Alder, and particularly of the decision to discharge him from the hospital, which he described as negligent. After analysing the evidence, Dr Dearden concluded that it was not possible to say whether there was still blood circulation to the brain of Mr Alder at the time he was removed from the van. If it had stopped, his death would have been inevitable, although this could not be known. If it had not stopped, there would have been an opportunity to save his life, although the life-saving skills and training of the officers were probably not up to that task. Nonetheless, it remained a possibility, in his view, that Mr Alder would have died, even if he had received the best possible care at the police station.

First joint report

5.83 On 19 May 1999, a meeting of doctors took place to discuss their reports on Mr Alder. A note of that meeting was prepared, dated 4 June 1999.⁴⁹⁶ The note of the meeting provided to us is not signed, although it appears to have been arranged under the auspices of the CPS, as, on 7 June, Mr Fleming of the CPS faxed a copy of this document to Supt Holt.⁴⁹⁷ The persons present are identified in a statement prepared by Dr Cary as being himself, Dr Clark, Dr Dearden and Dr Cook.⁴⁹⁸ Dr Clark confirmed that he was a signatory, in a letter to Mr Saul dated 27 April 2000⁴⁹⁹ and in his statement of 23 November 2001.⁵⁰⁰ Dr Dearden confirmed that he was a signatory, in a letter of 10

⁴⁹⁶ Joint report (4 June 1999) CA0001 D89 [00010144–6]

⁴⁹⁷ CPS fax (7 June 1999) CA0001 D126 [00010071]

⁴⁹⁸ Dr Cary statement (27 November 2001) CA0099 pp.324–5 [00990179–80]

⁴⁹⁹ Dr Clark letter (27 April 2000) CA0023 [00230026–7]

⁵⁰⁰ Dr Clark statement (23 November 2001) CA099 pp.324–5 [00990161–2]

January 2000⁵⁰¹ and in his statement of 27 October 2001.⁵⁰² Dr Cook confirmed that he was a signatory, in a letter to Inspector (Insp.) Tolan dated 22 October 2001,⁵⁰³ and in his statement dated 5 November 2001.⁵⁰⁴

5.84 The joint report meeting was designed to consider:

“Whether or not causation could be proved for the purposes of possible criminal proceedings; in other words, whether it could be proved beyond reasonable doubt that if the police were in breach of their duty of care towards Mr Alder, the breach(es) had caused his death; or whether it may reasonably be the case that by the time he arrived at the police station, Christopher Alder was already dying from a cause which rendered any inadequacies in his care immaterial.”

5.85 The opinion expressed by the four doctors was that:

“We are all of the view on the available evidence that it is most likely that the primary cause of Christopher Alder’s unconsciousness in the van was a convulsive fit related to head injury. If adequately cared for in such a situation, we would expect an individual to survive.”

5.86 They went on to consider other possibilities and then stated:

“We all feel that in this case heart rhythm disturbance leading to unconsciousness and death...is less likely. Nevertheless, we do not feel able to exclude the possibility of it beyond reasonable doubt.

Accordingly, it is our view that in a criminal prosecution for manslaughter it would not be possible to prove beyond reasonable doubt that any inadequacies in the care of Mr Alder at the police station must have contributed to his death. Although we think it less likely, we cannot exclude as a reasonable possibility the fact that his death at that stage might have been inevitable.”

5.87 The one expert who had not been part of the group that met in May was Dr Cooper. However, Dr Cary was provided with a copy of the report by Dr Cooper, at the request of Counsel, Mr Hilliard, and as a consequence wrote a letter to Mr Fleming of the CPS on 6 July 1999.⁵⁰⁵ In that letter Dr Cary points out the similarities in analysis

⁵⁰¹ Dr Dearden letter (10 January 2000) CA0023 [00230029]

⁵⁰² Dr Dearden statement (27 October 2001) CA0099 pp.296–318 [00990133–55]

⁵⁰³ Dr Cook letter (22 October 2001) CA0093 [00930096]

⁵⁰⁴ Dr Cook statement (5 November 2001) CA 099 pp.277–95 [00990114–32]

⁵⁰⁵ Dr Cary letter (6 July 1999) CA001D124 [00010083–4]

between the report of Dr Cooper and the joint report. He acknowledges the slight differences as follows:

“Dr Cooper emphasises the possibility of alcohol related collapse to unconsciousness. Whilst I myself took this view originally, following discussions at the joint meeting of experts I think that alcohol as a sole cause of such collapse is unlikely. Whilst persons under the influence of alcohol may lapse quite rapidly into a state of semi-consciousness they would usually be expected to be rousable during the period when the blood alcohol level is falling.

In conclusion taking account of all the expert opinions including Dr Cooper’s, it would appear that it cannot be said with certainty firstly what the cause of unconsciousness was and secondly and in part following on from this that it cannot be stated with confidence that had Mr Alder received the best primary medical care available at the time he became unconscious that he would have necessarily have survived.”

- 5.88 As is set out elsewhere, the CPS decision to prosecute only for ‘misfeasance in public office’ was notified on 23 July 1999.⁵⁰⁶
- 5.89 In early 2000, with arrangements for an inquest being made, Dr Dearden wrote to the coroner on 10 January.⁵⁰⁷ In that letter he expressed the view that proving that the inadequacies in the care of Mr Alder contributed to his death could not be achieved if the standard required was “beyond reasonable doubt” but that it would be possible to prove it “on the balance of probabilities”. Dr Cook also wrote to the coroner on 20 January 2000 and expressed the same view,⁵⁰⁸ as did Dr Clark on 27 April 2000.⁵⁰⁹

Dr Paul Rice

- 5.90 In the lead-up to the inquest, two additional specialist opinions were obtained. The first of these was from Dr Paul Rice, a pathologist and toxicologist. The request for a report came from Supt Holt, who informed Harrison Bunday that a meeting with Dr Rice was arranged for 9 February 2000.⁵¹⁰ Dr Rice was asked to consider whether there was any evidence that Mr Alder had been exposed to CS spray.⁵¹¹ Dr Rice considered the videotape of the custody suite, and the findings of the original post mortem examination. In a statement, dated 13

⁵⁰⁶ PCA file note (23 July 1999) CA001 D91 [00010142]

⁵⁰⁷ Dr Dearden letter (10 January 2000) CA0023 [00230029]

⁵⁰⁸ Dr Cook letter (20 January 2000) CA023 [00230028]

⁵⁰⁹ Dr Clark letter (27 April 2000) CA0023 [00230026–7]

⁵¹⁰ West Yorkshire Police letter (25 January 2000) CA001 D109 [00010107–9]

⁵¹¹ Dr Rice report (13 February 2000) CA0089 pp.939–40 [00890006–7]

February 2000, he gave his conclusion that, based on the evidence, the use of CS against Mr Alder “is extremely unlikely”.

Dr Keith Rix

5.91 The second specialist opinion was that of Dr Keith Rix, a consultant forensic psychiatrist.⁵¹² At the request of the coroner, Dr Rix prepared a report, dated 22 April 2000, on Mr Alder, based on the known information. Dr Rix addressed the issues surrounding the unusual behaviour of Mr Alder on the night of his death, and the question as to whether he was behaving in a paranoid fashion in the hours and days prior to dying. Dr Rix dismissed the likelihood of Mr Alder suffering from an undiagnosed mental illness as being extremely unlikely. However, he did comment that:

“In the deceased’s case a far more likely cause of behaving in a paranoid manner is the misuse of stimulant and/or other drugs. He is known to have a history of amphetamine misuse. There was no trace of stimulant drugs or their metabolites in the deceased’s urine and this makes it very unlikely that his mental state in the hours preceding his death was due to the toxic effects of stimulant drugs but it is not possible to rule out a paranoid state of mind brought about by such drugs but persisting after they had left the body. In view of the deceased having a long history of physical fitness training, having such marked body musculature and having a heart which was possibly enlarged as a result of physical exercise, this is a case in which consideration should be given to the likelihood that the deceased used anabolic steroids when he was training.”

5.92 Dr Rix’s information on amphetamine abuse was based on the hospital records from Andover at the time of Mr Alder’s admission with a dislocated shoulder.

5.93 Following on from Dr Rix’s opinion, Dr Clark wrote to the coroner, clearly in response to a query raised.⁵¹³ Dr Clark indicated, by his letter of 27 April 2000, that no tests for anabolic steroids had been carried out following the post mortem examination. Subsequently, Professor Forrest was requested to report on this matter.⁵¹⁴ He produced a statement, dated 25 May 2000, in which he stated:

“No synthetic anabolic steroids or their metabolites were detected.”

⁵¹² Dr Rix report (22 April 2000) CA0023 [00230185–209]

⁵¹³ Dr Clark letter (27 April 2000) CA0023 [00230026–7]

⁵¹⁴ Professor Forrest report (25 May 2000) CA0023 [00230117–18]

- 5.94 However, the test results were not wholly conclusive and he was of the opinion that:

“it cannot be deduced from all these results that Christopher Alder is likely to have used anabolic steroids. They do not totally exclude the possibility that he may have used anabolic steroids at some time in the past.”

Dr Janet Porter

- 5.95 Hempsons, a firm of solicitors, were instructed on behalf of the Hull and East Yorkshire Hospitals NHS Trust, and they commissioned Dr Janet Porter, a consultant in A&E medicine, to advise. Dr Porter issued a report on 16 June 2000,⁵¹⁵ in which she dealt principally with the opinions given in the reports of Dr Cook and Dr Dearden in respect of the actions of the ambulance crew and the medical staff at the hospital. Dr Porter defended the actions of the staff. The observation of Dr Dearden regarding the police at the hospital was agreed:

Assertion (Dr Dearden) That once outside the department Mr Alder expressed a wish to return to the department for care and should have been allowed to do so.

Response: Agreed. Mr Alder’s willingness to modify his behaviour and cooperate with treatment should have been explored and one of the A&E staff called to speak to him again. Dr Khan had apparently made clear in the hearing of the police his willingness to continue the patient’s care if he agreed to cooperate and this should have been acted on.”

- 5.96 One should, however, bear in mind the fact that the evidence on Mr Alder’s “wish to return” is not wholly consistent. Dr Porter went on to comment on the behaviour of the officers on arrival at the police station:

“Comments on Events in the Police Station

Assertion:(Police) That it was reasonable for the police to be reassured about his condition on arrival at the police station by the fact that he had been deemed fit for police custody by the hospital.

Response: On arrival at the police station Mr Alder was clearly in a very different condition from that in which he had been deemed to be fit for police custody. He was unresponsive with obstructed breathing and had been incontinent. Any prudent person would have assessed him as requiring further medical care. There is no basis for PC Dawson’s reported comment that the hospital had ‘refused to treat him’. It had been made clear to

⁵¹⁵ Dr Porter report (16 June 2000) CA0023 [00230119–42]

all concerned that the hospital were unable to treat him while violent but had asked him to return when sober.

Assertion:(Police) That there was no action the police could effectively take to improve Mr Alder's chances of survival once he had reached the police station.

Response: As I have discussed, there is no convincing evidence in my view that on his initial arrival Mr Alder was suffering from anything other than respiratory depression and airway obstruction. He had had at most 5 minutes of only partial oxygen deprivation.

There was a trained first aider in the police station and all officers present were aware of the recovery position. It was indeed mentioned by one officer but not actioned.

I am of the opinion that the prompt restoration of normal ventilation, by repositioning Mr Alder, stimulating him, and assisting his breathing via an external airway adjunct if necessary would almost certainly have prevented his immediate death. His subsequent chances of recovery from the effects of possible aspiration of vomit are less certain."

Dr Alan Crosby

5.97 The Tees East and North Yorkshire Ambulance Service NHS Trust, acting through solicitors, Dibb Lupton Allsop, also appointed an A&E consultant to advise them. He was Dr Alan Crosby, of the Sheffield Northern General Hospital, who provided a report dated 19 June 2000.⁵¹⁶ Dr Crosby's report restricts itself strictly to the efforts made by the ambulance crew upon arrival at Queen's Gardens police station to resuscitate Mr Alder. He disputed the assertion that it would have been best to remove Mr Alder immediately to hospital. He did not fault the decisions and actions taken by the ambulance crew, and said of them that:

"I do not feel the actions of the ambulance crew contributed to Mr Alder's death and their best efforts could not prevent it."

Professor John Crane

5.98 Harrison Bunday commissioned a report from Professor John Crane, the State Pathologist for Northern Ireland and Professor of Forensic Medicine at the Queen's University of Belfast. Professor Crane produced a report that is undated, but seems to have been issued in mid-2000 on behalf of Ms Alder. It is clear that this was communicated

⁵¹⁶ Dr Crosby report (19 June 2000) CA0023 [00230178-84]

to others, because Insp. Tolan referred to forwarding a set of post mortem photographs in a letter to the coroner dated 21 February 2000.⁵¹⁷

- 5.99 In a letter of 11 May, again to the coroner, Harrison Bunday indicated that an interim report was ready, but that Professor Crane wished to see the video and other reports.⁵¹⁸ On 7 June 2000, Insp. Tolan wrote to Mr Fleming at the CPS indicating that he expected to receive the report of Professor Crane, and some other material, at the pre-inquest hearing of 19 June,⁵¹⁹ and Supt Holt faxed a copy of the report to the CPS on 14 July 2000.⁵²⁰
- 5.100 Professor Crane stated in that report that he found no evidence to support cardiac arrhythmia or excited delirium as being factors in Mr Alder's death.⁵²¹ He was equally clear that stimulant drugs played no role at all, and said that there was nothing to suggest that CS spray had been used on Mr Alder. He regarded the relevant factors as being the head injury, the acute alcoholic intoxication, the inhalation of blood associated with upper airway obstruction, and postural asphyxia.
- 5.101 Professor Crane went on to point out that there was little evidence of an epileptic fit, although it remained a possibility, and no evidence to suggest that undue restraint had been applied to Mr Alder. He did, however, point to the possibility of an additional blow to the mouth, either accidental or deliberate, which would explain the more extensive injuries seen at the post mortem examination compared with those recorded by Dr Aamer Khan, senior house officer. Professor Crane concluded by saying:

“I have no doubt that whatever the cause of his loss of consciousness his death was ultimately due to upper airway obstruction as a result of his airway being partially obstructed by his posture and secondly due to inhalation of blood from the gum lacerations and the bleeding tooth sockets. This respiratory obstruction was exacerbated by his posture on the floor whereby movement of his chest was reduced by his face-down position on the floor and the weight of his body interfering with expansion of the chest cage. There was clear evidence of blood in the upper air passages and having been inhaled deeply into the small air passages of the lungs. It was this obstruction of the upper air passages by blood which can be heard on the soundtrack of the video.

⁵¹⁷ Insp. Tolan letter (21 February 2000) CA0098 p.142 [00980155]

⁵¹⁸ Harrison Bunday letter (11 May 2000) CA 0098 pp.49–50 [00980064–5]

⁵¹⁹ Insp. Tolan letter (7 June 2000) CA0098 p.18 [00980033]

⁵²⁰ Supt Holt fax (14 July 2000) CA0100 [01000012–19]

⁵²¹ Professor Crane Report (undated) CA0023 [00230171–7]

Whatever the cause of Alder's loss of consciousness there would appear to be no reason to preclude his recovery had he received appropriate medical attention if his airway had been cleared and he had been placed in a correct recovery position prior to his removal to hospital."

Professor Vivian James

5.102 A further report on the effects of anabolic steroids was obtained at the request of Whittles solicitors, acting for a number of the police officers. That report, dated 6 July 2000, was prepared by Professor Vivian James, Emeritus Professor of Chemical Pathology at the University of London.⁵²² The report addressed the question as to whether use of anabolic steroids would increase the risk of heart failure. Professor James noted that in the case of Mr Alder there was no trace of such steroids in the blood samples analysed. Professor James pointed out that orally administered steroids clear from the system after about two weeks, and therefore the test might not detect any such drugs taken before such a period.

5.103 She also commented that:

"Since there is such widespread abuse of these drugs, and there are relatively few reports of these adverse cardiac effects in anabolic steroid abusers, it would seem that the risk, if any, is probably very small. To what extent it persists after discontinuing steroids is unknown. It has not been possible to recognise any predisposing factors."

In conclusion, she said:

"Summary

Androgens have well recognised effects on the central nervous system, and there are convincing clinical reports which support the view that anabolic steroids taken in large doses can cause serious changes in mood and result in aggressive, violent or irrational behaviour.

Anabolic steroid abuse has been associated with the occurrence of unexpected cardiac deaths in healthy young subjects. Cardiac hypertrophy and structural changes have been found. There is no direct evidence that anabolic steroids are the cause but it could be related to the unfavourable effects of anabolic steroids on blood clotting, or on lipid concentrations, or to direct cardiotoxic effects of the steroids."

⁵²² Professor James report (6 July 2000) CA0023 [00230155–62]

Dr Porter's final report

5.104 The final additional report produced prior to (and issued during the course of) the inquest was an updated report by Dr Porter, dated 21 July 2000.⁵²³ Dr Porter gave evidence about one week later. In this, her second report, she advanced the opinion that, having seen the evidence of Jennifer Hobson, she believed that claustrophobia might provide another possible explanation for Mr Alder's sudden loss of consciousness. She stated that:

“It is not uncommon for patients to hyperventilate to a point where they lose consciousness.”

5.105 Dr Porter also expressed the view, having seen the video, that by the time the ambulance crew had arrived at the police station Mr Alder had already:

“suffered oxygen deprivation of an extent and duration which was incompatible with successful resuscitation”.

The inquest

5.106 At the inquest, held from 3 July 2000 onwards, the coroner took evidence from a series of doctors. These were Dr Clark, Dr Dearden, Professor Timperley, Dr Cary, Dr Gray, Professor Crane, Dr Cooper, Professor Forrest, Dr Porter, Professor James, Dr Cook, Dr Crosby, Dr Rix, Dr Lawler and Dr Rice.

5.107 The coroner summed up the evidence received before the jury in the following terms:

“Now, none of the experts told us they could be sure, applying the same standard of proof as you have to, that even if Christopher had got the best available care in the police station he would have survived. Whatever happened to him in the van, whatever that was, might have been so catastrophic that he was already doomed to die.

All the experts agreed that the lack of attention to his airway and the position he was in was deleterious to him.

Dr Clark said he could not be sure that even the promptest of medical attention at the police station could have saved him, but on the lower test of the balance of probabilities he thought it might well have done.

⁵²³ Dr Porter report (21 July 2000) CA0023 [00230143–54]

What did the other experts say?

Dr Dearden could not be sure prompt action would have saved him, but he thought it possible if he received quality resuscitation. The quality of the resuscitation is a key factor in his chances of survival, and I will come back to that concept later on, members of the jury. He – I am still with Dr Dearden – gave as a likely scenario that if on arrival at the police station he had been put into a proper coma position, his breathing had been supported, someone had checked his pulse, and if he had not got one started CPR and at once turned round and taken him back to hospital, that would have given him the best chance of quality survival. He went on to say that judging from the video the police understandably – he was not being critical – the police understandably, not being experts, achieved only a substandard effort at resuscitation when compared with his own skill and experience. He thought the quality of the resuscitation, not just its timing, to be important.

Dr Cary thought it was more likely that early appropriate action in the charge room would have saved him, but in the absence of knowing precisely why he was unconscious he could not be absolutely certain he would have survived. He said it was highly likely that postural asphyxia contributed to his death and hastened it, and it was a very important contribution in that regard, and in a way the most important factor. Undoubtedly the upper airway obstruction would be detrimental to him.

Dr Gray said that whilst in his view postural asphyxia was undoubtedly present in the custody suite and there were clear omissions by the police at the charge room, it was undeterminable medically whether he could have been saved by prompt and efficient resuscitation.

When Mr Thomas asked him if he could be sure that the position he was put in was a contribution to his eventual demise, he replied, 'I think it's one of the factors that has contributed and has brought his death more rapidly than it otherwise would have been. Had he been placed in a more favourable position he might still have died, because he might already have had an established hypoxic brain injury for reasons we do not know.'

Professor Crane said he had no doubt that whatever the cause of his loss of consciousness, death was ultimately due to upper airway obstruction from his position on the floor and inhalation of blood from the gum laceration and the bleeding tooth sockets. He was sure that the partial upper airway obstruction was detrimental to Christopher and hastened his death. He was also sure that the posture was detrimental and hastened his death, and that both these facts were more than minimal or negligible.

That said, he still could not exclude totally the possibility that what had happened in the van was so catastrophic that he was no longer recoverable, and that whilst he could not preclude his recovery, he agreed he could not preclude his death either.

Dr Cooper said, and I quote, 'Assuming the likely thing, which is that we've got respiratory depression as he's lying on the floor, due to a combination of alcohol, vomit and/or blood in the airway and possible asphyxia, then medical treatment would be very likely to have helped at that stage, in that his problem was lack of air getting into his lungs.' He thought it was very very likely that had he, instead of being lying face down on the floor and essentially ignored for a time, been put in the right position and resuscitation commenced straightaway, he could have survived.

To Mr Thomas he agreed that Christopher's position on the floor was very likely to be a more than minimal contributory factor to his death. He said 'The only way that could be altered was if something had happened that was going to kill him inevitably within a matter of minutes, and I think that is very unlikely.'

Dr Porter agreed with Mr Thomas that in her opinion Christopher's positioning on the floor was detrimental to him and was such that his airway was obstructed. In her opinion it hastened his death, but when Mr Thomas asked her if she could be sure about that, she refused to go that far, saying 'Doctors are reluctant to be sure about anything, correctly, because we can always be wrong.'

Dr Cook thought it was the angle of Christopher's neck which was more deleterious to him than his actual position because he saw the chest going in and out. He said, 'I think it is likely he would have survived, but with the very infrequent rate of breathing I think that I couldn't categorically say he would survive, whatever the care, and that's where the problem is.'

When asked by Mr Thomas if the position of Christopher contributed materially to his death, he said, 'It could well have done because if he'd been in a better position with his airway clear, then an ambulance called giving support, because the heart was beating, he would have been given a better opportunity of survival. Now whether that would have occurred, I don't know. There's nobody can answer that,' he said.

Dr Lawler said that the effect of Christopher's position on the floor could well have been marginal. He would not like to put it any higher than that. He went on to say he thought it was possible that he could have been dying already when taken out of the van, and in those cases none of the potentially contributing factors of inhalation of gastric contents, alcohol

intoxication and his position on the floor would have been particularly relevant. The position Christopher was in would become more important if his condition was reversible.

It was Dr Lawler's belief that Christopher would have probably died on arrival at the police station come what may because of oxygen deprivation. That even if appropriate medical assistance had been sought, either by calling out the emergency services or taking him straight back to hospital, he thought further cerebral hypoxia would have occurred and either that would have proved fatal almost at once, or later, as a direct consequence of severe irreversible brain damage."⁵²⁴

5.108 Further on, the coroner pointed out that:

"On the one hand, none of the experts can be sure that even if he had received the best possible immediate care in the custody suite he would have survived. They cannot rule out that on arrival at the custody suite he might have already sustained such a catastrophic medical event in the van that he was effectively doomed to die.

Nobody knows what happened, medically speaking, in the van and the experts tell us we will never know that. If he was doomed to die, that would be because of the degree of oxygen deprivation he would have suffered.

The experts cannot be sure that his condition was survivable, although the consensus is that it probably was...

On the other hand some experts, notably perhaps Professor Crane and to a lesser extent possibly Dr Cary, approached this problem – and problem it surely is – from a different direction. That approach is as follows.

We will never know what the cause of the unconsciousness in the van was, but we do know that Christopher was in a deleterious position on the floor and his upper airway was obstructed to some degree.

Professor Crane said that no matter what the cause of unconsciousness was, death was ultimately due to upper airway obstruction from his position on the floor and inhalation of blood. It was he who suggested the immediate – and I stress the word 'immediate' – cause of death as 'upper airway obstruction, inhalation of blood and postural asphyxia, with head injury and alcohol contributing'. It was his opinion that whatever the reasons for loss of consciousness, the position in which

⁵²⁴ Inquest Day 32 pp.24–8

Christopher was placed hastened death significantly, and both these factors were more than minimal or negligible.

I suggest you ask yourselves this question members of the jury, as you wrestle with this difficult concept of causation: If the experts cannot be sure that his condition was survivable come what may when he arrived at the custody suite, can you in turn be sure, as a jury, that any hastening of the death you may find by omitting to place him in the recovery position and check his airway etcetera, caused his death more than minimally, trivially or negligibly?

His death may have been hastened by his position but can you say that caused his death more than minimally if, because we do not know the cause of his unconsciousness, we cannot rule out as a reasonable possibility that he might have died shortly anyway?"

5.109 This was later described by Mr Justice Jackson as:

“an admirably concise summary of the medical evidence bearing on causation”.⁵²⁵

5.110 The outcome of the inquest was a verdict of ‘unlawful killing’, which, in light of the summing up, and the responses given by the jury, must have been based on gross negligence on the part of the officers.

Professor Roger Hall

5.111 After the inquest, the CPS commissioned a report from Professor Roger Hall, who was Professor of Clinical Cardiology at Hammersmith Hospital in London.⁵²⁶ Professor Hall was provided with the coroner’s summing-up and the evidence from the inquest of Professor Crane, Dr Cary and Dr Clark, together with the details of the original post mortem examination and the custody suite video.

5.112 Professor Hall was of the opinion that the loss of consciousness was likely to be due to either cardiac arrhythmia or a convulsion. He was satisfied that Mr Alder did not simply fall asleep, but was deeply unconscious when taken from the van. He concluded that:

“The only two mechanisms likely to produce such a sudden collapse are a serious heart rhythm disturbance such as ventricular tachycardia or a convulsion in the van. Whatever the mechanism, his chances of survival were made worse by the position in which he was placed.

⁵²⁵ Judgement of Mr Justice Jackson (9 April 2001) para.67 [00050290]

⁵²⁶ Professor Hall report (27 February 2001) CA0093 [00930117–23]

In the case of a cardiac cause, Mr Alder's chances of survival would still have been much less than 50% even if he had been given all possible first aid.

If, however, the mechanism was respiratory (alcohol, head injury, vomit) or neurological (a convulsion in the van), then Mr Alder would probably have survived if help had been called and he had been put into the recovery position.

After reading the evidence supplied to me and seeing the videotape, I remain uncertain as to the mechanism of the collapse in the police van."

Second joint report

5.113 On 6 March 2001, a further case conference of experts was called by the CPS to seek to identify any common views as to the cause of Mr Alder's death. At that meeting were Dr Cary, Dr Clark, Dr Dearden, Dr Cook, Professor Hall and Professor Crane.⁵²⁷ Also present were Mr Curtis QC and Mr Hilliard of counsel, and Mr O'Doherty of the CPS.⁵²⁸ The outcome of that meeting was the issue of a further joint report.⁵²⁸ The conclusions in that report were as follows:

"All were agreed that it was not possible to prove to the criminal standard what it was that caused Christopher Alder to become unconscious by the time he arrived in the charge room of Queen's Gardens police station. With the exception of Prof. Crane, all were agreed that it could not be excluded as a reasonable possibility that he had suffered a fatal heart rhythm disturbance.

All were agreed that it was not possible to prove to the criminal standard that had Christopher Alder been properly cared for while at the police station he would necessarily have survived.

With the exception of Prof. Crane, all were agreed that it was not possible to prove to the criminal standard that had Christopher Alder been properly cared for while at the police station he would necessarily have survived for longer than he did.

Having seen and considered Prof. Hall's report of 27 February 2001, Dr Cary did not adhere to the view that he had expressed at the inquest that it was possible to be sure that the positioning and lack of care of Christopher Alder by the police at the police station had hastened his demise. It was now his view that this

⁵²⁷ Dr Cary statement (27 November 2001) CA099 p.342 [00990179-80]

⁵²⁸ Joint report CA0099 pp.651-3 [00990271-3]

could not be proved beyond reasonable doubt. He attached weight to Prof. Hall's opinion that the mechanism of death was not inconsistent with a fatal heart rhythm disturbance, and that in the event death could have occurred at any time, irrespective of any failures in care on the part of the police.

Prof. Crane was of the opinion that it could be proved to the criminal standard that the positioning and lack of care of Christopher Alder by the police at the police station had hastened his demise. However, he was unable to give any idea of the timescale involved, whether seconds, minutes, hours or days.

All were agreed that there was no medical basis for inferring to the criminal standard that Christopher Alder had been assaulted in some way while in police custody or care so as to account for his condition on arrival in the charge-room.

All were agreed that there was now no area of medical inquiry relative to these issues which had not been explored.”

5.114 Having seen Professor Hall's opinion, Dr Cary also wrote to the CPS on 6 March 2001 to amend his opinion.⁵²⁹ He stated that:

“It is clear from Professor Hall's opinion, that he is of the view that it is plausible though not necessarily most likely that Christopher Alder was unconscious due to an alcohol induced heart rhythm disturbance. Furthermore, such a rhythm disturbance could have caused Mr Alder's death including around the time that he actually died. This would include the possibility that death occurred in the absence of the deceased having been placed in a compromising position on the floor. With this in mind, in my opinion it cannot be said with certainty that the actions or omissions of the police officers involved in this case contributed to the cause of death or hastened it. Although this opinion is broadly in line with my opinion given at the coroner's inquest, there is an important difference which I wish to highlight, namely that there is a realistic possibility that Mr Alder could have died anyway at around the time he did from a heart rhythm disturbance even if he had been given the best possible care from his moment of reception in the custody suite.

Please will you make the appropriate authorities aware of this modification of my view in the light of Professor Hall's evidence as it could have a bearing on any judicial review of the coroner's inquest verdict.”

⁵²⁹ Dr Cary letter (6 March 2001) CA0106 [01060172-3]

Professor Jennifer Adgey

5.115 Although it is not recorded in formal terms, I understand that Professor Crane recommended to the firm of Harrison Bunday that they consult a professor of cardiology based in Belfast named Professor Jennifer Adgey. As a result of that consultation, Professor Adgey produced a report dated 3 August 2001.⁵³⁰

5.116 She agreed that there were three most likely causes of collapse (excess alcohol coupled with vomiting and inhalation while unconscious; an epileptic fit; or ventricular tachycardia (VT)) but that she was:

“unable to weight any of these three causes of collapse as each event or a combination thereof could have contributed to the collapse”.

5.117 She agreed with Professor Hall that a sudden onset of cardiac dysrhythmia could not be ruled out, but regarded it as unlikely. Most importantly, Professor Adgey was of the view that Mr Alder was not in cardiac arrest on arrival at the police station. She concluded, therefore, that:

“from all of the evidence both medical and at post mortem, the initial resuscitative process of the late Christopher Alder would have been successful provided the unconscious state on removal from the van had been recognised promptly and basic life support instituted”.

5.118 Professor Hall was shown Professor Adgey’s report and asked for his comments. He responded by letter of 13 September 2001 to Mr O’Doherty of the CPS.⁵³¹ In that letter he agreed with the three possible causes of unconsciousness, but felt he could go further, because in his view the ‘drink/vomiting’ option would not lead to such sudden loss of consciousness, and an epileptic fit would almost certainly have led to him falling off his seat in the van:

“This led me to the conclusion included within Professor Adgey’s comments that left ventricular tachycardiac [sic] was the cause. Therefore I did feel in a position to weight these possibilities and felt that the cardiac arrhythmia was most likely.

In my report I stated that if the cause had been either epilepsy or respiratory obstruction, then proper basic life support in the custody suite would have led to survival. As mentioned in my previous report, the chances of surviving out-of-hospital cardiac arrests are very low indeed. Although ventricular tachycardia

⁵³⁰ Professor Adgey report (3 August 2001) CA0086 [00860003–9]

⁵³¹ Professor Hall letter (13 September 2001) CA0091 [00910030–1]

would not necessarily be regarded as being cardiac arrest as such until it generates into ventricular fibrillation, this is in fact is [sic] what did happen in the custody suite. Basic life support would not have prevented this progression into ventricular fibrillation and therefore this case has to be regarded as being out-of-hospital cardiac arrest...

I don't believe there is much difference between my views and those of Professor Adgey except in relation to the fact that if this had been ventricular tachycardia, basic life support would have led to survival. In my view it would not have done."

Dr Porter's response

5.119 On 5 October 2001, Dr Porter produced three statements for the CPS. The first of these was her report of 16 June 2000 reduced to statement form.⁵³² The second was a reduction, to statement form, of her supplementary report, originally produced on 21 July 2000.⁵³³ The final statement⁵³⁴ was prepared specifically for the purpose of criminal proceedings. In this statement Dr Porter stated that:

"Having seen a video reconstruction of Mr Alder's journey to the police station I am quite certain that he would have been thrown from his seat into the seat well of the vehicle had he lost consciousness during the journey. I am accordingly of the opinion that whatever caused Mr Alder's loss of consciousness occurred less than 2 minutes from the time of his transfer into the custody suite, this being the time estimated to open the van, remove him, and carry him down the corridor."

5.120 Dr Porter went on to explain that three possible reasons for sudden unconsciousness were an epileptic fit, a sudden disturbance of cardiac rhythm, or hyperventilation leading to blackout:

"Of these conditions the only one that was inherently fatal was a sudden cardiac arrhythmia. Any such arrhythmia must, however, in my opinion, have been associated with at least some cardiac output initially in that Mr Alder continued to make respiratory efforts for at least 8 minutes after his collapse and the presence of respiratory effort indicates some persistent blood supply to the respiratory centre in the brain stem. Had Mr Alder's heart stopped completely, e.g. with an arrhythmia of asystole or ventricular fibrillation, breathing would not have continued for more than 2 to 3 minutes at most. While respiratory efforts were

⁵³² Dr Porter statement (5 October 2001) CA099 (was 00230119-42) [00990039-62]

⁵³³ Dr Porter statement (5 October 2001) CA099 (was 00230143-54) [00990063-73]

⁵³⁴ Dr Porter statement (5 October 2001) CA099 pp.237-42 [00990074-9]

still being made any cardiac arrhythmia present would have been potentially treatable.”

- 5.121 Dr Porter took a similar view to Professor Adgey, in that she did not think that the low rate of survival for out-of-hospital cardiac arrests was relevant, but thought that an arrhythmia in a fit young man could almost certainly have been successfully treated. She went on to say that if paramedics had been called immediately upon his arrival at the custody suite, they would “almost certainly” have succeeded in resuscitating him. In summary she concluded that:

“I share Professor Adgey’s view that had basic life support been available Mr Alder’s survival would have been beyond reasonable doubt, regardless of which of the suggested causes of his collapse is accepted.

I consider that the failure of the police to assess Mr Alder’s level of consciousness or to place him in the recovery position was grossly negligent and was the direct cause of his death.”

Third joint report

- 5.122 A further combined case conference of experts was called for 9 October 2001. Present on this occasion were Dr Cary and Professors Hall, Crane and Adgey, together with Mr Curtis QC, and Mr O’Doherty and Ms Armitage of the CPS.
- 5.123 At that conference, which produced a joint report,⁵³⁵ consideration was given to whether it could be said that the actions or inactions of the officers contributed more than minimally to his death, or hastened his death so as to deny him the opportunity of medical assistance. All the experts agreed that it was impossible to say what caused Mr Alder’s deep unconsciousness. Professors Hall and Adgey differed over the likely cause: Professor Hall thought cardiac arrhythmia leading to VT most likely. This meant that, even with proper care, his chances of survival were less than 50 per cent, and that he would have suffered brain damage in the process. Professor Adgey accepted that a combination of factors was possible, but VT alone was unlikely to be the cause.
- 5.124 Professor Crane and Dr Cary tended to support the view that VT was possible, but a low possibility, and that whatever caused the unconsciousness, respiratory failure caused the death. All the experts agreed that if the unconsciousness was not caused by a heart problem, then proper care and attention would have at least afforded him access to medical help:

⁵³⁵ Joint report (9 October 2001) CA0105 [01050004–11]

“All agreed that the depth of Christopher Alder’s unconsciousness was more readily explicable by reference to a greater degree of head injury (coupled with the high blood-alcohol content) than has hitherto been established. If there had been a second blow to his head, whether deliberate or accidental, for example while he was lolling about un-strapped in the van, it might well be more consistent with his depth of unconsciousness.

It was further agreed that in that event Christopher Alder would have had a chance of ultimate survival, provided that he had received enough care and support in the police station...

All the experts agreed that they could rule out the theory propounded by Miss Porter, A&E Consultant, of the deep unconsciousness being caused by hyper-ventilation arising from a panic attack.”

5.125 The experts’ report went on to state that:

“All the experts were agreed that the primary or instant cause of Christopher Alder’s death was respiratory failure, and that he had been put and left by the policemen in a position which impaired his ability to breathe properly.

[Professor Adgey and Professor Crane] maintained their view that, although it remained impossible to state the reason for Christopher Alder’s unconsciousness, or indeed for how long he would have continued to live, nevertheless without doubt the policemen had prevented his initial survival.

Accordingly, there were sufficient grounds for asserting to the criminal standard of proof that the actions and the neglect of the policemen had contributed more than minimally to the causes of his death.

All the experts were agreed that they could be sure that, granted that the causes of Christopher Alder’s unconsciousness are and were then unknown, in effect his chances of survival would be equally unknown. Therefore the actions of the policemen in their positioning of him, coupled with their failures to monitor him, for example to take his pulse, or to render him any first aid whatever, effectively deprived him of the very chance of living, or the chance of having his life saved by emergency medical intervention.

Specifically, Professor Crane pointed out, and all agreed with him, that Christopher Alder had at least a chance of survival, which was denied to him by the actions and inaction of the policemen. Professor Adgey summarised it as follows: no one

could say what percentage chance of survival Mr Alder had, but anything which interrupts his pathway to proper treatment deprives him of his opportunity to live, which is his right. All were agreed that if there were no medical intervention, he had no chance of survival...

In summary, on this analysis, if the deprivation of the chance to survive amounted to a more than minimal contribution to death, all the experts were agreed that they could say that the actions and inaction of the policemen did satisfy this criterion, to the criminal standard of proof. Further, in any event. Professor Adgey and Professor Crane were content to state that they were sure that the conduct of the policemen amounted to a more than minimal contribution to the primary cause of death, namely asphyxia. Thus far, Professor Hall and Dr Cary were minded to agree with them. It was only if the test became 'was there a possibility that he would have died at about that time anyway?' that they could not rule this out to the criminal standard of proof."

- 5.126 As is set out elsewhere in this report, it was this third joint consultation that finally tipped the balance in favour of the addition of a count of manslaughter to the indictment facing the officers.

Preparations for trial

- 5.127 The report of Professor Adgey dated 3 August 2001 was reduced to statement form and signed on 9 October 2001.⁵³⁶ In a further short statement of 26 November 2001, Professor Adgey confirmed her agreement with the account of the 9 October consultation.⁵³⁷ Dr Dearden's report,⁵³⁸ Professor Crane's report,⁵³⁹ and Dr Carl Gray's report⁵⁴⁰ were all reduced to statement form in October.
- 5.128 On 20 November 2001, Dr Peter Cooper made a statement based on his report of 9 April 1999.⁵⁴¹ On 21 November 2001, he added a further short statement to take account of his additional evidence given at the inquest to the effect that he had revised his view of the extent to which the head injury had played a role in the death of Mr Alder.⁵⁴² Initially, Dr Cooper was told that Mr Alder was briefly unconscious; he was later told that this period may have lasted up to 11 minutes, and that Mr Alder may have suffered some amnesia. This led him to revise his view.

⁵³⁶ Professor Adgey statement (9 October 2001) CA099 pp.326–31 (was 0080003-9) [00990163–8]

⁵³⁷ Professor Adgey statement (26 November 2001) CA099 p.332 [00990169]

⁵³⁸ Dr Dearden statement (27 October 2001) CA099 pp.296-318 [00990133–55]

⁵³⁹ Professor Crane statement (29 October 2001) CA099 pp.267–76 [00990104–13]

⁵⁴⁰ Dr Gray statement (31 October 2001) CA099 p.243 [00990080]

⁵⁴¹ Dr Cooper statement (20 November 2001) CA099 pp.244–65 [00990081–102]

⁵⁴² Dr Cooper statement (21 November 2001) CA099 p.266 [00990103]

5.129 In November and December 2001, Dr John Clark,⁵⁴³ Professor Adgey,⁵⁴⁴ Professor Hall⁵⁴⁵ and Dr Cary⁵⁴⁶ wrote statements endorsing the records of the joint meetings, and Professor Hall adopted his earlier report. Dr Cary made a brief statement on 7 May 2002, setting out the history of his involvement in the case and his attendance at the various meetings.⁵⁴⁷ On 14 May 2002, Professor Forrest prepared a statement summarising his earlier reports.⁵⁴⁸

Dr Dearden's hypothesis

5.130 On 14 May 2002, Dr Dearden made a further statement, reflecting a recent case that he had experienced.⁵⁴⁹ That incident involved the death of a young man in the intensive care unit of his hospital. The unfortunate victim had sustained a severe brain injury, and, while under the care of the hospital, his breath slowed to two to eight breaths per minute with a heartbeat also slowed to 20 to 50 beats per minute. At that stage the blood pressure and cardiac output had fallen to almost nil, so that, although the heart was beating, blood was not flowing. The heart then stopped, but breathing continued for a further 13 minutes.

5.131 Having considered this, Dr Dearden stated that:

“In the light of this experience of preserved respiratory effort despite cardiac arrest of a similar pattern to that I saw on the police video, I now believe that a dysrhythmia causing loss of effective cardiac output could have caused Christopher to become rapidly unconscious and yet continue breathing as he did for 11 minutes in police custody.”

5.132 Although he had not been part of the final joint consultation, Dr Dearden had seen the note of the meeting, and he commented on it that:

“I believe the overall opinion of this joint group was that if death had resulted from respiratory failure then the failure of the police to immediately resuscitate Christopher more than minimally contributed to his chances of survival, and I agree with that view. In contrast, I agree with Professor Hall that if the cause of unconsciousness was a severe dysrhythmia then his chances of survival were much lower and accordingly I do not believe that

⁵⁴³ Dr Clark statement (23 November 2001) CA099 pp.324–5 [00990161–2]

⁵⁴⁴ Professor Adgey statement (26 November 2001) CA099 p.332 [00990169]

⁵⁴⁵ Professor Hall statement (3 December 2001) CA099 pp.333–41 [00990170–8]

⁵⁴⁶ Dr Cary statement (27 November 2001) CA099 pp.342–3 [00990179–80]

⁵⁴⁷ Dr Cary statement (7 May 2002) CA0099 [00990231–2]

⁵⁴⁸ Professor Forrest statement (14 May 2002) CA0099 [00990227–8]

⁵⁴⁹ Dr Dearden statement (14 May 2002) CA0106 [01060143–5]

failure to immediately offer Christopher Alder resuscitation would have influenced his likelihood of survival. I am also of the view that this latter scenario is more likely than I previously suggested in the light of the experience outlined above.”

- 5.133 A number of the medical experts were asked for their comments on the new views expressed by Dr Dearden. Dr Cook was consulted by telephone on 17 May by Supt Holt.⁵⁵⁰ In the note of that conversation made by Supt Holt, he recorded Dr Cook’s thoughts as being:

“No problems with Dearden’s use of dysrhythmia. Everyone dies from change in heart rhythm. Still think primary problem is fit and poor airway – could have been obstructed airway for whole of van journey.

Sequence preferred: fit as a result of head injury, leads to blocked airway leads to cardiac dysrhythmia. Agonal breathing may have started in van.”

- 5.134 Dr Cook was clearly of the view that the poor airway, suffered by Mr Alder as a result of a fit, had not been recognised or addressed when he was placed on the floor.
- 5.135 Dr Porter was provided with a copy of Dr Dearden’s statement and her comments were sought.⁵⁵¹ She stated that she disagreed with his analysis, as it could not be known with certainty which of the facts of his case reflected the facts of Mr Alder’s case, given that Mr Alder did not have brain damage. She also stated that:

“...the continuation of breathing indicates that the brain area responsible for controlling breathing is still obtaining oxygen, even if this is coming from a static circulation. I would argue that, while there is still sufficient oxygenation of the brain to maintain some breathing, any heart arrhythmia present remained reversible. A sudden cardiac arrest in a fit young man like Christopher Alder would have been ventricular tachycardia/ventricular fibrillation beyond reasonable doubt. It would only have degenerated into asystole later as a result of hypoxia (lack of oxygen)...

Ventricular fibrillation lasts an average 8–10 minutes before diminishing gradually in amplitude and converting to asystole. While ventricular fibrillation persists, defibrillation (electric shock treatment) has a good chance of restarting a heart. Carried out within a few minutes, with a heart that is healthy and with immediate basic life support, recovery rates of 90% are reported.”

⁵⁵⁰ Supt Holt file note (17 May 2002) CA0106 [01060154]

⁵⁵¹ Dr Porter statement (20 May 2002) CA0099 [00990240–1]

5.136 Professor Crane made a statement on 16 May 2002 in which he dealt with theories put forward by other medical professionals:

“In considering the cause of death of Christopher Alder, I have been aware of the possibility, raised by Professor Hall, of the deceased having developed a cardiac arrhythmia, ventricular tachycardia, as a cause of his unconsciousness when admitted to the police station. I further understand that it is suggested that this cardiac arrhythmia might therefore have been responsible for his death. It is my opinion that ascribing the loss of consciousness to a serious cardiac arrhythmia, such as ventricular tachycardia, is a remote possibility and one for which there is no objective evidence.”⁵⁵²

5.137 Professor Crane stated that, even if VT were the cause of unconsciousness, with correct treatment he could have recovered from it:

“Whilst the ventricular tachycardia theory for Alder’s unconsciousness is speculative, what is not obviously speculative is the evidence both from the video and the autopsy findings that Alder’s breathing was compromised. He was deeply unconscious and unable to protect his airway by coughing etc, he was placed face downwards on the floor thereby reducing his chest expansion during breathing, he was not in a semi-prone position to allow secretions to drain from his mouth and his tongue prevented from obstructing the back of his throat, and the autopsy revealed blood in the large air passages and indeed blood in the small air sacs of the lungs. There can be no doubt in my opinion that this combination of factors was responsible for the death which occurred in the custody suite.

Since we cannot be certain of the cause of Mr Alder’s unconsciousness it is not possible to be 100 per cent sure that he would have survived had he been removed to hospital and received appropriate medical attention.

Nevertheless it is my view that survival was highly likely since the autopsy failed to reveal any obvious abnormality such as severe disease or injury which would have precluded his survival.”

5.138 Professor Crane went on to consider the case cited by Dr Dearden, and commented on it that:

“whilst I cannot completely exclude the cardiac theory as a cause for Alder’s unconsciousness, I think there is, in my

⁵⁵² Professor Crane statement (16 May 2002) CA0099 [00990236–9]

opinion, no objective evidence to support this. Clearly, whatever the cause for the unconsciousness, it was the failure to initiate the proper care required for an unconscious individual, i.e. ensuring a clear airway and seeking urgent medical attention, which was ultimately responsible for his death.”

5.139 Professor Adgey was also asked to comment further, in response to the new statement from Dr Dearden.⁵⁵³ Her statement, dated 22 May 2002, explained the different forms of VT, and stated that while this phenomenon has several causes, it is “clearly reversible with treatment”.

5.140 She continued:

“The steps to death in this case were the rapid development of unconsciousness, the prone position that the body was placed in on the floor of the custody suite with blood and possibly mucus and vomitus coming out of the mouth with the obstructed breathing pattern and finally agonal respiration leading to death.

Whilst medical science is not 100% absolute and criminal standard of proof as I understand it is beyond reasonable doubt (not with scientific certainty), then if basic life support had been provided shortly after collapse, Christopher Alder would not have died at that time.

Christopher Alder’s ultimate survivability cannot be prejudged by those carrying out basic life support. However, as I have indicated, his ultimate survival depended on the cause/causes of his collapse in the van and his bodily response to vomiting and inhalation.”

5.141 In a separate document headed “witness statement”, but undated, she commented that the information provided in the statement of Dr Dearden would require more exploration before it could usefully be considered in the context of Mr Alder’s death.⁵⁵⁴ She was, however, adamant that:

“Whilst patients can continue to breathe or gasp for a short period of time after a cardiac arrest occurs suddenly (which did not occur here as there was a period of slow respiration in association with a slow heart rate and blood pressure and cardiac output almost nil), nevertheless patients do not continue to breathe for a further 13 minutes when pump function of the heart has totally ceased as would happen in a cardiac arrest.”

⁵⁵³ Professor Adgey statement (22 May 2002) CA0099 [00990243–5]

⁵⁵⁴ Professor Adgey statement (undated, post 14/5/02) [01050013–14]

The trial

5.142 The trial of the five officers commenced on 10 April 2002. During the weeks of the trial the various doctors gave evidence based on their statements made to the CPS. The doctors who gave evidence at the trial were Dr Clark, Dr Cooper, Dr Gray, Dr Cary, Dr Cook, Dr Forrest, Dr Timperley, Dr Dearden, Dr Gosnold, Professor Crane, Dr Porter, Professor Adgey and Professor Hall. Professor James and Doctors Rix, Rice and Lawler, who had been at the inquest, were not called.

5.143 All of the doctors were called by the CPS as prosecution witnesses. The prosecution case also included the various witnesses of fact, who saw Mr Alder on the evening of his death. At the close of the prosecution case, and before the defence case opened, defence barristers made legal submissions to the judge, arguing that there was no case to answer. This is done in many cases and is a legal argument, decided upon by the judge in the absence of the jury. The argument was that the prosecution case, taken at its highest, did not contain the necessary evidence to prove the charges.

5.144 The medical evidence was summarised in the judgement following submissions.⁵⁵⁵ The judge described it in the following terms:

“The medical evidence called by the prosecution in this case falls into two groups. The first consists of those doctors whose ultimate view is that they cannot be sure that the actions, or inactions, of the police contributed more than minimally to Mr Alder’s death. The doctors in that group are Dr Clark, Dr Cooper, Dr Gray, Dr Dearden, Dr Cook, and Professor Hall. Within this group there are differing opinions as to the answers to the main questions which arise in the case and the level of the police officers’ contribution to the death of Mr Alder. But ultimately their opinions all fall short of the standard necessary for the prosecution to successfully pursue manslaughter, and on their evidence the prosecution would not have been mounted. The second group of medical witnesses consist of Dr Porter, Dr Cary, Professor Crane and Professor Adgey, all of whom state that they are sure, that is to the criminal standard of proof, that the conduct of the defendants more than minimally contributed to the death of Christopher Alder.

On this matter they all agree, although within this group also there are differing opinions on central issues, such as the cause or causes of Mr Alder’s unconsciousness.”

5.145 The judge then went on to consider the evidence of each of the doctors in the second group to see whether they provided as a group, or in conjunction with the first group, a *prima facie* case to leave to the jury

⁵⁵⁵ Judgement of Mr Justice Evans (21 June 2002) CA064 D2 [00640340–68]

(that is a case to answer). He summarised each doctor's evidence in turn, starting with Dr Porter:

“She is the only witness who gives, as the most probable cause of Mr Alder's unconsciousness, hyperventilation brought on by a panic attack. No other witness supports her view...She was sure that the failure of the police to provide Christopher Alder with an airway was the cause of death, and had one been provided it would have allowed Christopher Alder to recover.

She could not, however, exclude a cardiac arrhythmia as the cause of unconsciousness: She thought it possible, but unlikely. If such was the cause then had Christopher Alder been assessed on arrival at the police station, basic life support administered and an ambulance called, which took the eight minutes or so to arrive that the ambulance which was later called actually took to arrive, the chances of Mr Alder surviving would have been below 50%. She cannot, therefore, exclude a scenario inconsistent with the prosecution case.”

5.146 Of Professor Crane he said:

“Professor Crane was of the opinion that the probable cause of unconsciousness was a combination of head injury and alcohol, although he expressed a reservation about this conclusion because of the rapidity of the descent into unconsciousness. A cardiac event in the van would, however, explain the rapid onset of unconsciousness. On the other hand he thought a cardiac event was highly unlikely but still a possibility. The immediate cause of death was respiratory, and he maintained his views expressed in the consultation of 6 March 2001, to which I have earlier referred, about the chances of survival and the impossibility of saying for how long.”

5.147 He summarised Professor Adgey thus:

“Professor Adgey considered that there were three possible causes of Christopher Alder's unconsciousness. Firstly, excess alcohol leading to sleep, leading to vomit inhalation, and leading ultimately to unconsciousness. Secondly, an epileptic fit secondary to head injury and/or alcohol. Thirdly, a cardiac event.

She was unable to weight any of these three causes as each event, or a combination of any of them, could have contributed to the collapse. She was sure that whatever the cause of the unconsciousness, the immediate cause of death was respiratory, and with proper care someone in the position of Christopher Alder was initially capable of being resuscitated in over 90% of cases. Ultimate survival, however, was another

matter. That depends upon the cause of the collapse to unconsciousness, which is not known. She was sure that Christopher Alder was capable, with proper care, of immediate survival. This immediate survival would be for a matter of minutes and would allow Christopher Alder to be taken to hospital, where his condition could be investigated and proper treatment given, but she could not say that he would thereafter survive for hours, days, weeks or months.”

5.148 The judge said of Dr Cary that his views evolved, and might evolve again, but he understood that Dr Cary’s evidence to the jury had been as follows:

“Although previously unable to rule out a cardiac event, he had always thought it unlikely...Now, however, having read all the documents in the case, he alone was able to exclude a cardiac event and was sure that the failure of the police to provide proper care was a more than minimal contribution to death. He thought that he was able to rule out the possibility, upon which he had earlier agreed with Professor Hall, that Christopher Alder would have died at about the time he did die regardless of what care had been given him at the police station, but he was unable to say how soon after that point Christopher Alder might have died. He thought it very likely that Christopher Alder would – I quote – ‘effectively have been reversed, at least partially, for many hours to days’, and that it was the lack of care of the police that gave rise to Mr Alder’s initial failure to survive.”

5.149 The judge explained the submissions of both parties to the case. The defence position was that, given the divergence of expert opinions, and the fact that the issues were outside the ordinary experience of a jury, there was no benchmark against which they could assess the competing views. The prosecution view was that the jury should have regard to the expertise of the differing witnesses and the logic employed in reaching their conclusions.

5.150 There was also a dispute about the prosecution approach: the defence said that the jury could not aggregate the “possibles” and the “sures”. The Crown said that the experts all gave evidence from within one spectrum, albeit at different points on that spectrum, and that the jury could take account of that.

5.151 There had clearly been debate concerning the de minimis principle as regards the causation of death; in effect, this came down to the question as to whether the actions of the officers might have contributed to the death of Mr Alder no more than in a minor or marginal way. Therefore, if the failure of the officers to act meant that Mr Alder died when he would otherwise not have done so, that could constitute manslaughter, whereas if their failure meant only that he

died slightly earlier than he would have done in any event, that would not necessarily be enough to make out the charge.

5.152 Mr Justice Evans concluded his judgement on the issue of causation in the following terms:

“Ultimately, I have to consider the whole of the evidence and decide whether the jury could safely convict a defendant on the evidence presently available. Has the prosecution proved causation beyond the *de minimis* principle? In terms of hastening death, which, in large measure, is what the evidence has focused on, there is no authority which seeks to define *de minimis*. Some assistance, however, can be found in the unreported case of Sinclair, decided on 21 August 1998 in the Court of Appeal, Criminal Division, where issues not dissimilar to those raised in this case were considered.

In Sinclair, the Court entertained doubt as to whether evidence of causation was safe to leave to the jury where the medical evidence was that, given prompt medical care, life might have been prolonged by a few hours or a few days.

In my judgement, the evidence here does not take this case beyond the *de minimis* principle and there is no evidence upon which a jury could safely conclude that the conduct of a defendant, in the sense to which I have referred, more than minimally caused his death. I am, therefore, going to direct the jury to acquit of manslaughter, but as a result it is not necessary for me to reach a conclusion on the other submissions made to me.”

5.153 The five officers were accordingly acquitted of the counts of manslaughter on the direction of the judge.

5.154 Mr Justice Evans went on to dismiss the other counts of misconduct in public office on other, unrelated, legal grounds. This decision turned on the interpretation of the offence, which is part of the Common Law. The offence was not one that was used frequently, and identifying a clear definition of the elements of the offence was not straightforward. The judge indicated that the accepted and correct view of the law was that for the offence to be proven there had to be evidence that the alleged misconduct of the defendants was deliberate (“wilful”) or was “reckless”. While indicating that there was evidence that they were negligent in their behaviour, he held that there was not sufficient evidence that they were recklessly misbehaving in the execution of their duties. For this reason the charges were withdrawn from the jury.

Healthcare Commission report

5.155 At the request of the IPCC, the HCC produced a report dealing with the handling of Mr Alder by healthcare professionals during the course of the early hours of 1 April. Specifically this covers his interaction with the ambulance crew who took him to hospital, his treatment by doctors and nurses while at the hospital, and the subsequent call-out of an ambulance crew who attempted to resuscitate him at the police station. As is now known, the same ambulance crew dealt with him on both call-outs, which were a little over one and a half hours apart. The executive summary to that report is attached as Appendix 8.

5.156 The recommendations made by the HCC are as follows:

Actions for Hull and East Yorkshire Hospitals NHS Trust (which includes Hull Royal Infirmary)

- In light of the findings of this report, Hull and East Yorkshire Hospitals NHS Trust, which includes Hull Royal Infirmary, must review the role of the police liaison officer to ensure that the role promotes and supports effective working arrangements between the trust and Humberside police.
- The trust must develop clear written guidance as to the circumstances in which junior doctors should seek help from senior medical staff.
- A review of the training in triage must be undertaken to ensure that information about patients' confidentiality, the duty of care owed to patients when they are discharged, professional standards of documentation and communication with ambulance staff and police, is included.
- Where patients refuse treatment or a decision is taken to withhold treatment, this (including the reason why) must be documented in the patient's notes.

Actions for the Tees East and North Yorkshire Ambulance Service NHS Trust (formerly Humberside Ambulance Service NHS Trust)

- The ambulance service must review training for staff in relation to skills in clinical assessment and taking a history to ensure that theory is translated into practice.

- The ambulance service must implement and monitor the Joint Royal Colleges' Ambulance Liaison Committee pre-hospital guidelines v2 with support and training for all staff and a clinical audit programme with clear priorities to support implementation.

Actions for both trusts

- Given the criticisms of the actions taken by the nursing, medical and ambulance staff, both trusts must consider how they will support staff to reflect on their performance in order to improve their future practice.
- Individual staff, in consultation with professional bodies or their employing trusts, should act on their needs for training or other learning identified through the key findings of this report.
- Both trusts must review their systems for debriefing after critical incidents to enable staff to learn from incidents.
- Both trusts must ensure that staff attend training on the prevention and safe management of violent and aggressive behaviour.
- Both trusts must review their systems for being alerted to serious untoward incidents to assure themselves that if a similar incident were to occur it would be identified in a timely manner to ensure that appropriate reviews are undertaken.
- A regular audit of record keeping and documentation should be conducted to assist staff to review and reflect on their practice.

National recommendations

The Healthcare Commission expects all NHS organisations and police forces to review the findings and recommendations of this report, particularly the following recommendations:

1 When a person has attended hospital for any medical reason, and that person leaves hospital under police escort (whether or not under arrest), the responsible doctor must provide a report confirming fitness for detention and instructions for the custody officer. Guidance about under what circumstances this should be given must be available for staff. Police officers must ensure that

this information is provided and that they understand the information given and are satisfied that it is within their ability to deliver.

2 Staff in A&E must ensure that patients whom they consider to be aggressive or violent are assessed as to their fitness for discharge by a senior doctor prior to their leaving the department, particularly where there is a risk of a head injury. The assessment must be recorded in their notes.

3 Guidance and training must be developed for staff on the function, role and responsibilities of the police when called to assist in A&E. This should include information about when to seek assistance from the police, the grounds on which the police can legitimately detain people, the role of the police in preventing a breach of the peace, patients' confidentiality, use of restraint, care of patients under arrest and the duty of care owed to patients when they are discharged from hospital.

4 NHS organisations must work jointly with local police forces to develop guidance on the management of patients who are violent or aggressive and require medical treatment.

5 If a person who has recently received treatment from a healthcare organisation dies in custody, a joint inquiry into the death must be carried out immediately by the local organisations involved.

6 NHS organisations and police forces must agree arrangements where appropriate, for jointly reviewing serious incidents and complaints.

7 All NHS organisations must ensure that their policy on the discharge of patients includes a section covering responsibilities of staff when discharging patients from the A&E department and discharging patients into the custody of the police.

8 All NHS organisations need to ensure that their policy for zero tolerance of violence and aggression towards staff is balanced between protecting the healthcare staff and protecting patients' rights. There should be a section covering the A&E department and local police forces should be consulted about this.

Dr Richard Shepherd

5.157 I also requested the assistance of a senior and highly distinguished consultant forensic pathologist, Dr Richard Shepherd, in reviewing the evidence. Dr Shepherd's full report is attached as Appendix 7. He made recommendations in his report which are incorporated into those made by the IPCC at the beginning of this report.

CHAPTER 6: THE HEARINGS

Introduction

- 6.1 Three hearings were held to investigate and adjudicate upon the death of Mr Alder. These were an inquest in 2000, a trial of the five officers in 2002 and a disciplinary hearing in 2003. In addition there was a judicial review hearing of the inquest in 2001 and an appeal on one of the legal rulings in the trial, heard in 2004. The approach in each of these hearings was different, and the outcome of each also varied. The purpose of the inquest was to seek to determine the cause of death of Mr Alder, without seeking to allocate blame. The trial was to establish whether the five officers were, individually, guilty of the charges brought against them, being manslaughter and misconduct in public office. The disciplinary hearing was to establish whether they had, individually, been guilty of neglect of duty.

The inquest

- 6.2 Inquests adopt an inquisitorial process, in which the coroner presides over the proceedings and asks the main questions, but may generally permit interested parties to put additional questions to the witnesses. In certain cases, including this one, a jury may be used to establish the facts. Inquests usually last from a few hours to a few days. In the case of Mr Alder the inquest ran for nearly seven weeks, which was exceptionally lengthy.
- 6.3 On 23 August 1999 Supt. Holt wrote to the Coroner for Humberside, Mr Geoffrey Saul, concerning the decision to prosecute the five officers for misconduct in public office.⁵⁵⁶ Supt. Holt acknowledged in that letter that it would be:

“9–12 months before a trial commences”.

- 6.4 He went on to deal with the sensitivities of the case, and pointed out that although the cause of death, which remained uncertain, was unlikely to be central to a trial on misconduct in public office, it would be central to the concerns of the family. Supt. Holt anticipated, correctly, that with a trial outstanding, officers would be advised not to answer certain questions at the inquest. He also expressed concern that an inquest verdict might risk influencing a future criminal jury. On these bases, he strongly recommended that there be no inquest until after the trial was over.

⁵⁵⁶ West Yorkshire Police fax (6 September 1999) CA001 D96 [00010134–6]

- 6.5 The coroner decided, nonetheless, to proceed. On 8 December 1999 the coroner wrote to Jim Elliott of the Police Complaints Authority (PCA) informing him that the inquest would precede the trial, and that there was to be a pre-inquest review on 11 January 2000, which Mr Elliott was invited to attend.⁵⁵⁷ On 22 December Mr Saul wrote to Insp. Tolan of West Yorkshire Police, regarding the date for the review and seeking his assistance.⁵⁵⁸ Over the coming months Insp. Tolan corresponded closely with Mr Saul, and undertook much of the work in organising the inquest. The coroner had a series of small queries arising from documents, with which Insp. Tolan was able to assist.
- 6.6 The review of 11 January 2000 coincided with a mention of the officers' criminal case at the Hull Magistrates' Court. It is clear from the correspondence that security was becoming an issue at court hearings. Insp. Tolan therefore requested Humberside Police to extend its security to cover the inquest review.⁵⁵⁹
- 6.7 The pre-inquest review had in fact been used to discuss the issue of the inquest preceding the trial, and Mr Saul had said in open court that he had discussed the matter with the CPS and decided that there was no obvious prejudice to the officers if the trial came second.⁵⁶⁰ He gave all parties 14 days to object in writing to the decision if they so wished. No evidence has been disclosed to me that suggests that any of the parties did raise written objections. Further discussions also took place regarding the arrangements for representation and the ordering of witnesses at the hearing.
- 6.8 Although I have not seen any correspondence from the officers, Mr Chris Enzor of the CPS told the IPCC, in discussing the Review, that the officers had been keen to hold the inquest first. This was confirmed, on Day 4 of the inquest,⁵⁶¹ when Mr Ferm, on behalf of PC Dawson, said to the coroner:

“this Inquest is of interest not only to the family but to the police officers who we represent, who see this forum – which, incidentally, we have requested and brought about rather than anyone else – which we on behalf of the police officers have requested and helped to bring about. It was our application originally that there should be an Inquest...We also have an interest in it, because the officers hope through this to clear their names of the slurs and implications that have been hanging over them for a couple of years, which they have not so far had the opportunity to rebut...”

⁵⁵⁷ Coroner's letter (8 December 1999) CA001 D101 [00010126]

⁵⁵⁸ Coroner's letter (22 December 1999) CA0098 pp.186–7 [00980199–200]

⁵⁵⁹ Insp. Tolan letter (5 January 2000) CA0098 p.183 [00980196]

⁵⁶⁰ Humberside Police letter (19 January 2000) CA001 D104 [00010120–2]

⁵⁶¹ Inquest Day 4, p.2

- 6.9 Following the pre-inquest review, according to the letter written by the coroner on 14 January, he met with Ms Janet Alder and her legal representative to discuss the Alder family's concerns. In the ensuing days and weeks, there was an exchange of correspondence to confirm the witness requirements for the inquest. By a letter of 26 January 2000 to Mr Elliott, the coroner confirmed the fixed date for the inquest of 3 July 2000.⁵⁶²
- 6.10 Evidence was obtained from Andover District Community Health Care NHS Trust, comprising the case notes from Mr Alder's attendances at the War Memorial Hospital in 1988 and 1991. These were forwarded to the coroner on 10 February 2000.⁵⁶³
- 6.11 Insp. Tolan made efforts to trace Mr Paul, as a potential witness for the inquest. Following those attempts, Mr Paul's solicitors, Messrs Williamsons, wrote to the coroner on 15 March 2000.⁵⁶⁴ In the ensuing exchange, it was made clear that Mr Paul would cooperate with the inquest but would only be contacted via his solicitors. Jason Ramm was also contacted on 10 May by Insp. Tolan, having moved to Leeds to study. A further pre-inquest review was set down for 19 June 2000.⁵⁶⁵
- 6.12 The inquest began on Monday 3 July 2000. It is, of course, not a function of this Review to comment upon the inquest, nor in any way to perform any form of critique as to the way it was performed. The inquest itself was unusually long, lasting for 33 days in total. A number of different parties were represented at the hearings. Each of the five officers was separately represented by counsel. The Chief Constable of Humberside Police was represented, as was the ambulance trust and the health authority. Mr Leslie Thomas of counsel appeared on behalf of the family of Mr Alder, taking instructions from two firms of solicitors, representing Janet and Richard Alder respectively. Finally, Mr Paul was allowed to appear in person.
- 6.13 The transcript of the inquest hearings discloses that there was a tense atmosphere at times and that emotions ran high. For understandable reasons, those close to Mr Alder found the experience of the inquest to be difficult and traumatic.
- 6.14 The full list of witnesses called for the inquest is attached to this report at Appendix 27. The pattern of evidence, as appears from that list, was that the court heard from Janet Alder initially. The witnesses from the nightclub and the hospital were then called, followed by witnesses from the police station and the ambulance crew. Insp. Tolan and Supt Holt gave evidence, followed by a series of medical experts dealing with the

⁵⁶² Coroner's letter (26 January 2000) CA001 D99 [00010130]

⁵⁶³ Insp. Tolan letter (10 February 2000) CA0098 p.164 [00980177]

⁵⁶⁴ Williamsons letter (15 March 2000) CA0098 pp.131-2 [00980146-7]

⁵⁶⁵ Coroner's letter (1 March 2000) CA0098 p.140 [00980153]

issue of cause of death. The final major group of witnesses, who gave evidence towards the end of the inquest, were the five officers who had been charged with misconduct.

- 6.15 As foreshadowed in the letter of Supt Holt, each of the five officers, on legal advice, exercised his right to decline to answer questions in light of the outstanding criminal charges. This meant that very little evidence of any substance was given by the five officers, despite extensive questioning, particularly on the part of counsel for the family.
- 6.16 At the close of evidence the coroner summed up the evidence over a period of three days, and the transcript of the summing up ran to 280 pages. As part of that summing up, the jury were warned not to hold against the officers their refusal to answer questions. It is worth noting that Mr Justice Jackson, who heard the application for the judicial review of the inquest verdict, was later to comment that:

“The summing up is well structured and is a model of clarity.”

- 6.17 The judge was also complimentary as to the clarity of the legal directions given to the jury by the coroner.
- 6.18 On Day 30 of the inquest, 21 August 2000, the coroner summarised his directions as to the possible verdicts in the following words to counsel:⁵⁶⁶

“I have in the event concluded that I will leave only four conclusions to the jury. They are: unlawful killing on the basis of possible involuntary manslaughter; accidental death; natural causes and an open verdict. It is my belief that these four conclusions are the proper ones indicated by the evidence and realistically reflect the thrust of the evidence as a whole as referred to by the Court of Appeal in the case of *R v Inner South London Coroner Ex Parte Douglas Williams*.

I have considered two other potential sources of unlawful killing, both based on unlawful act manslaughter. The one case based on police conduct, as argued by Mr. Thomas, and on the other case based on conduct by Mr. Jason Paul, which nobody urged me to consider. Nevertheless I felt it my duty to do so. In respect of both of these it is my firm view that the evidence taken at its highest is such that a jury, properly directed, could not reach those conclusions and hence it is my duty not to place such conclusions before the jury.

In respect of self-neglect or neglect, adjectival or free-standing, I am not satisfied that in respect of all the essential ingredients there is evidence upon which a jury, properly directed, could

⁵⁶⁶ Inquest Day 30, p.1

bring in those conclusions, and further and again following the Court of Appeal's ruling in the Douglas Williams case, in exercise of my broader discretion, I do not feel it in the interests of justice to leave any conclusion based on neglect to the jury."

- 6.19 The coroner used the term 'neglect', which is often referred to as a 'lack of care'. The distinction between 'unlawful killing' based upon manslaughter as a result of an unlawful act and the same verdict based upon gross negligence was carefully made. In directing the jury on the possible verdict of 'unlawful killing', the coroner directed them that they could reach such a verdict only if they were satisfied to a criminal standard, that being 'beyond reasonable doubt'. He defined the offence in the following terms:⁵⁶⁷

"Now what is 'Unlawful Killing'?"

In this case it would mean that you are sure that the death of Christopher Alder was as a result of manslaughter, a crime of homicide. It would be as clear-cut and severe as that. The kind of manslaughter involved, and there are different varieties of manslaughter in the criminal law, the kind involved here is something called 'involuntary manslaughter', perhaps more helpfully called 'Manslaughter by gross negligence' and would centre on events in the custody suite.

If you are to make such a finding, you must be satisfied so that you are sure that the act, or omission, of at least one single person, whom on no account must you name, was so grossly negligent as to amount to criminal conduct which caused the death into which we inquire.

Now the separate failures of a number of individual people cannot be added together to justify a gross failure amounting to gross negligence manslaughter, and although you must not publicly declare the identity of any such single person you find you are sure has unlawfully killed Mr. Alder, although you must not publicly declare the identity, his or her identity must be agreed by you all."

- 6.20 At the conclusion of the inquest, the jury retired at 12.50 on Wednesday 23 August. They were sent home overnight and returned to continue their deliberations the following day. At 14.20 on the following day, Thursday 24 August 2000, they delivered their unanimous verdict in the form of the inquisition form, as requested. The conclusions that they reached were:

"1. Name of Deceased: Christopher Ibikunle Alder.

⁵⁶⁷ Inquest Day 32, pp.17-18

2. Injury or disease causing death: Multi factorial events leading to a level of unconsciousness which resulted in upper airways obstruction and positional asphyxia.

3. Time, place and circumstances at or in which injury was sustained: On 1st April 1998 in Hull, between 03.41 and 04.00 whilst in police custody, travelling in a police van from Hull Royal Infirmary and being placed on Queen's Gardens custody suite floor, Christopher Alder met his death.

4. Conclusion of the Jury as to the death: Christopher Alder was killed unlawfully."

- 6.21 The inquest verdict was greeted with jubilation by the family of Mr Alder, who considered it to be a vindication of their position.
- 6.22 There were some unusual postscripts to the verdict, and to the hearing, that continued to occupy those concerned during the following months. The police officers decided very soon after the inquest verdict to pursue a judicial review of the inquest verdict. This was eventually heard in April of 2001.
- 6.23 In late September 2000 a member of the public contacted the police in Humberside to provide information. The general nature of the information given was to suggest that there had been a relationship between one of the female jurors involved in the inquest and a male barrister who appeared before it. The possibility of bias, or appearance of such, caused concern to the Humberside Police. It was also believed that the juror was seen at a rally held by members of the Alder family support group during the period of the inquest.
- 6.24 The police informed Mr Saul, the coroner, who requested that an investigation be carried out into the allegations. Mr Saul suggested that, given the sensitivity of the case and the involvement of officers from Humberside Police, an outside police force be asked to carry out the enquiries. As a result of this, Deputy Chief Constable Clark of Humberside Police contacted South Yorkshire Police and agreed that that force would handle the matter. He wrote to the officer allocated to the task, D/Supt Graham Johnson of South Yorkshire Police, on 11 October 2000 to confirm his terms of reference.⁵⁶⁸
- 6.25 South Yorkshire Police initially interviewed the informant, and then obtained authorisation to check the telephone records of the two people concerned. They subsequently interviewed the juror on two occasions and the barrister once. The records obtained disclosed no contact between the two before 21.56 on 24 August 2000, which was the day the inquest ended.

⁵⁶⁸ Humberside Police letter (11 October 2000) CA0073 pp.74-5 [00730077-8]

- 6.26 The interviews of both parties indicated that the relationship had not begun prior to the end of the hearing and that it had been limited in extent and short-lived. Both denied that it had influenced their actions in relation to the inquest.
- 6.27 On 31 January 2001, DCC Clark forwarded a report, described as interim, by D/Supt Johnson to Mr Saul.⁵⁶⁹ Mr Johnson was able to indicate that there was no clear evidence of the juror attending the rally. The report concluded that there was no evidence of contact prior to the end of the inquest, although it expressed disquiet at the possibility that obvious attraction between the two might have led to the inquest verdict being influenced. The report accepted that the prohibition on questioning of jurors as to their deliberations meant that this could not be taken further.
- 6.28 It is known that the final report from the police was forwarded to the coroner on 22 February 2001. I have not asked to see the report, but it was forwarded to all parties involved in the judicial review hearing as being of potential significance.
- 6.29 The judicial review hearing was argued on 4, 5 and 6 April 2001 before Mr Justice Jackson.⁵⁷⁰ Although technically there were two actions (PS Dunn was separately represented from his colleagues and had instituted a separate action) the issues and grounds advanced were identical. These were summarised by the judge as follows:
1. In relation to question 4 on the inquisition form, the coroner erred in leaving the verdict of unlawful killing to the jury.
 2. The coroner erred in failing to leave lack of care to the jury as a possible verdict.
 3. The coroner's direction to the jury on aggregation was deficient.
 4. The verdict should be quashed by reason of apparent bias on the part of one juror.
- 6.30 Although Mr Justice Jackson granted leave to apply to the applicants, in his judgement he dismissed the application. In relation to the first ground, he ruled that there was evidence before the jury upon which they could find that there was both gross negligence and causation of death, and therefore unlawful killing was a verdict properly open to them.
- 6.31 The second ground, that of failing to leave lack of care as a verdict to the jury, was rejected as to do so would potentially have confused the

⁵⁶⁹ Humberside Police letter and report (31 January 2001) CA0073 [00730062–76]

⁵⁷⁰ Judgement of Jackson J. (9 April 2001) CA005 D102 [00050275–312]

jury and lengthened the summing up. It was a proper exercise of discretion by the coroner not to leave it to them. In any event the applicants had asked the coroner to not leave it at the original hearing, so they could not properly claim now to have been prejudiced by his decision not to do so.

6.32 The judge held that the directions given to the jury on ‘aggregation’ of the acts of individual officers were correct and appropriate. He therefore rejected ground three.

6.33 In relation to the issue of potential bias (the relationship between the barrister and the juror) it was accepted that there had been no contact during the inquest, and the only argument was that of potential bias caused by their attraction to one another. The judge rejected this ground on the basis that:⁵⁷¹

“most of the overtures towards friendship came from [the barrister] rather than [the juror]”,

and there was no reason to doubt her assertion that she had not anticipated his approach, that she did not feel attracted to him during the inquest, and that no such attraction would have influenced her conduct as a juror. The claims for judicial review, therefore, were dismissed.

The trial: pre-inquest

6.34 As is set out in detail elsewhere in this report, the five officers were served with notices on 8 April warning them of potential disciplinary action and were subsequently suspended from duty at the end of that month by Supt Michael Brightmore, the head of the Discipline and Complaints (D&C) Department of Humberside Police. The process to criminal charges from that point forward was a slow one, in that the CPS was not able to consider the issues until after the West Yorkshire Police file was submitted.

6.35 On 9 July 1998 the preliminary report from the investigating officer was received by the PCA. Following additional enquiries made at the request of the PCA, the PCA issued its ‘Interim Statement’ confirming that the investigation was complete.⁵⁷² On 19 August the D&C Department of Humberside Police forwarded the report from West Yorkshire Police to the CPS in York for consideration.⁵⁷³ The decision-taking process was to last a year.

⁵⁷¹ Judgement at paragraph 107(2) CA005 [00050300]

⁵⁷² PCA Interim Statement (13 August 1998) CA076 p.513 [00760515]

⁵⁷³ Humberside Police letter (19 August 1998) CA076 p.510 [00760512]

- 6.36 It is clear that, throughout that period, Humberside Police Force did remain in contact with the officers and provided what information it could regarding the consideration of possible charges. On 2 December 1998, C/Insp. Beckett of Humberside Police D&C Department wrote to all five officers, simply to inform them that no decision had been received from the CPS as to the action they proposed to take.⁵⁷⁴
- 6.37 As is set out in more detail in relation to the post mortem examinations, the CPS had received the evidence amassed by West Yorkshire Police, including the report of the pathologist, Dr John Clark. Over the months following the submission of the investigation report it emerged that the CPS was seeking additional medical opinion to establish whether the actions of the officers could have been the cause, or a cause, of Mr Alder's death.
- 6.38 Dr Clark had requested an analysis of Mr Alder's heart by the consultant pathologist Dr Nathaniel Cary, which was provided in a report of 21 October 1998.⁵⁷⁵ Following a case conference on 18 December 1998 with Treasury counsel, Dr Cary was asked to produce a further report; Mr Elliott notes having been informed of this a few days later by the "IO" (the investigating officer, Supt Holt).⁵⁷⁶ Dr Cary's second opinion was issued on 15 February 1999.⁵⁷⁷
- 6.39 In the meantime, on 13 January 1999, Mr Elliott wrote again to Mr Peter Pike MP, as he did regularly throughout the year, to explain that there was no further news from the CPS.⁵⁷⁸ Also around this time, the CPS commissioned Dr Graham Cook, an expert in accident and emergency medicine, to provide a report, and Mr Elliott wrote to him on 15 February 1999 to provide material.⁵⁷⁹ Dr Cook's report, which was issued on 11 March, included criticisms of the police officers involved.⁵⁸⁰ However, by 4 May, when Mr Elliott wrote again to Mr Peter Pike MP, he was only in a position to tell the MP that the next meeting of the CPS to consider the matter was set for 19 May and that he was hoping for an early decision thereafter.⁵⁸¹
- 6.40 On 10 May 1999 Dr N. Mark Dearden, a consultant anaesthetist, produced another report for the CPS; and the joint meeting of Doctors Cary, Clark, Dearden and Cook took place on 19 May 1998 to identify areas of agreement. This led to a joint report by the doctors being produced on 4 June.⁵⁸² Dr Cary sent a follow-up letter to the CPS on 6

⁵⁷⁴ Humberside Police memo (2 December 1998) CA0076 p.509 [00760511]

⁵⁷⁵ Dr Cary report (21 October 1998) CA001 D62 [00010219–22]

⁵⁷⁶ PCA file note (22 December 1998) CA001 D66 [00010213]

⁵⁷⁷ Dr Cary report (15 February 1999) CA001 D75 [00010198–200]

⁵⁷⁸ PCA letter (13 January 1999) CA001 D72 [00010204]

⁵⁷⁹ PCA letter (15 February 1999) CA001 D74 [00010202]

⁵⁸⁰ Report of Dr Cook (11 March 1999) CA001 D79 [00010182–93]

⁵⁸¹ PCA letter (4 May 1999) CA001 D87 [00010174]

⁵⁸² Joint medical report (4 June 1999) CA001 D89 [00010144]

July 1999 commenting on a report by Dr Peter Cooper, who had been instructed by Mr Alder's family.⁵⁸³ Dr Cary pointed out that Dr Cooper was largely in agreement with the other experts.

- 6.41 The actual decision by the CPS, based upon the evidence then available, was notified to Supt Holt on the morning of 23 July 1999. That decision, passed to Mr Philip Johnston of the PCA by telephone at 10.45, was that there was insufficient evidence to prosecute for manslaughter but that there was sufficient evidence to prosecute for 'misfeasance in a public office'.⁵⁸⁴ This charge is under the common law, and is more regularly referred to as 'misconduct in public office'. It was agreed that Supt Holt would notify the officers and the Police Federation the same day.
- 6.42 The criminal procedure against the officers was commenced by summons, and although the papers available do not disclose the exact date of the issue of the summons, it is clear that they were issued before 6 August 1999, as they are referred to by Insp. Tolan in a letter of that date to Humberside Police.⁵⁸⁵ The first appearance before Hull Magistrates' Court was set for 14 September 1999.⁵⁸⁶
- 6.43 Mr Peter Pike MP was, evidently, telephoned by a journalist seeking a comment the same day, and he wrote to Mr Elliott. Mr Johnston rang him back to explain the position.⁵⁸⁷ A fuller letter was written by Mr Elliott on 26 August 1999 setting out the decision and possible future progress. Mr Elliott stated at the time that the trial was likely to be at least a year away, and that it could be followed by appeals, disciplinary hearings and civil actions. He also told Mr Pike that he had spoken to Ms Alder, who was upset that more serious charges would not be brought against the officers.⁵⁸⁸
- 6.44 Although the criminal process had begun, it was to be interrupted soon after by the decision to proceed with the inquest, regardless of the outstanding criminal matters. Mr Enzor of the CPS was asked specifically about this decision as part of this Review, and the understanding of the CPS is that the officers themselves were anxious to proceed with the inquest first. It is also worth noting that no other parties raised an objection to the inquest taking priority, other than Supt Holt in his letter to the coroner. The criminal process was effectively put on hold, and the files show no activity of note until after the inquest concluded with its verdict of unlawful killing.

⁵⁸³ Dr Cary letter (6 July 1999) CA00106 pp.172-3 [01060174-5]

⁵⁸⁴ PCA file note (23 July 1999) CA001 D91 [00010142]

⁵⁸⁵ West Yorks. Police letter (6 August 1999) CA100 [01000055]

⁵⁸⁶ West Yorks. Police letter (6 August 1999) CA100 [01000054]

⁵⁸⁷ Peter Pike MP letter (23 July 1999) CA001 D92 [00010141]

⁵⁸⁸ PCA letter (26 August 1999) CA001 D95 [00010098-9]

The trial: post-inquest

6.45 On Friday 25 August 2000, the day after the verdict of the coroner's inquest, Mr Peter Pike MP wrote to Sir Alistair Graham, Chairman of the PCA, asking whether the verdict called into question the dealings of the PCA or the information that it had provided.⁵⁸⁹ A full response to the letter was sent on 14 September 2000,⁵⁹⁰ in which Sir Alistair informed Mr Pike that:

“I understand that the CPS are reviewing their original decision on the criminal charges in the light of evidence given at the Inquest, in particular the views expressed by the medical experts involved.”

6.46 Mr Enzor of the CPS confirmed to the IPCC that following the verdict of the inquest in 2000 the CPS undertook a re-review of the case. By this time, the Butler report had been published. That report by HHJ Gerald Butler QC was an “inquiry into Crown Prosecution Service decision-making in relation to deaths in custody and related matters”, which was published in August 1999. The report had considered three cases of deaths in custody (not that of Mr Alder) and resulted in a number of recommendations regarding the approach to be taken when considering possible prosecutions.

6.47 In line with that report's recommendations, the case of Mr Alder was considered in the Casework Directorate of CPS HQ. Because of this Mr Philip Fleming, who had been the reviewing lawyer prior to the inquest, passed the responsibility to Mr Stephen O'Doherty of the CPS, who remained the lawyer in charge until shortly before the trial.

6.48 The review by the CPS took into account the new medical material that had emerged in the run up to the inquest. In addition to that material the CPS commissioned a report by Professor Roger Hall, Professor of Clinical Cardiology at the Hammersmith Hospital in London.⁵⁹¹

6.49 On 6 March 2001 a further meeting of medical experts was held at counsel's chambers at 6 King's Bench Walk, London. At that meeting a note was prepared summarising the collective views and noting dissent, where agreement could not be reached.⁵⁹² The meeting was attended by Dr Clark, Dr Cary, Dr Dearden, Dr Cook, Professor Hall and Professor Crane, together with Mr O'Doherty of the CPS Casework Directorate, James Curtis QC and Nicholas Hilliard of counsel.

⁵⁸⁹ Peter Pike MP letter (25 August 2000) CA0001 D111 [00010101]

⁵⁹⁰ PCA letter (14 September 2000) CA001 D113 [00010098–9]

⁵⁹¹ Professor Hall report (27 February 2001) CA0093 [00930117–23]

⁵⁹² Note of meeting (6 March 2001) CA0099 pp.270–2 [00990271–3]

- 6.50 On Monday 9 April 2001, Mr Justice Jackson gave judgement, rejecting the application for judicial review that had been launched by the officers after the inquest verdict.⁵⁹³
- 6.51 The possibility of adding manslaughter to the indictment was again rejected by the CPS in late April 2001. This was reported in the *Mirror* newspaper on 25 April 2001,⁵⁹⁴ and in the *Independent*, *Daily Express* and *Daily Telegraph* the following day.⁵⁹⁵ In his summary of the major events of the case, Insp. Tolan later made the comment that after consideration of the inquest and the judicial review, the CPS decided that there was no realistic prospect of a conviction for manslaughter, and accordingly it recommenced the proceedings for misconduct in public office.⁵⁹⁶
- 6.52 On 29 June 2001, after an ‘old-style’ committal hearing, at which the evidence was read, the Hull Magistrates’ Court committed the officers for trial.⁵⁹⁷ A ‘plea and directions’ hearing was set for 3 August 2001 at the Hull Crown Court.⁵⁹⁸ At the hearing on that date His Honour Judge Mettyear directed that the trial should take place outside Hull;⁵⁹⁹ the eventual location was to be Teesside Crown Court.
- 6.53 On 4 October 2001 the director of public prosecutions (DPP) wrote to Mr Peter Pike MP, evidently in response to a letter of 28 September 2001.⁶⁰⁰ In that letter the DPP explained that the conflicting medical advice was being reviewed. He also pointed out that the Crown was seeking to have the case listed in Hull, or a nearby court, but that the court had, thus far, deemed that Teesside was the most appropriate venue.
- 6.54 On 12 October 2001 the solicitors for Janet Alder, Harrison Bunday, wrote to inform Mr Peter Pike MP that the firm had secured a report from Professor Jennifer Adgey in relation to the possibility of resuscitation of Mr Alder.⁶⁰¹ Professor Adgey’s first report was produced on 3 August 2001, and a further report was produced on 17 August. The firm had also heard from Dr Janet Porter, the accident and emergency consultant who had volunteered advice concerning his treatment. Dr Porter had originally given evidence at the request of Hempsons, solicitors for the NHS trust concerned, and had, according to Harrison Bunday:

⁵⁹³ Judgement of Jackson J. (9 April 2001) CA0099 pp.314–52 [00990315–53]

⁵⁹⁴ Press report (25 April 2001) CA0001 D127 [00010070]

⁵⁹⁵ Press reports (26 April 2001) CA0001 D128 [00010069]

⁵⁹⁶ West Yorks. Police letter (5 March 2002) CA0065 D76 [00650182–4]

⁵⁹⁷ West Yorks. Police summary (5 March 2002) CA0065 D76 [00650182–4]

⁵⁹⁸ CPS letter (3 July 2001) CA0093 [00930152]

⁵⁹⁹ *Hull Daily Mail* report (4 August 2001) CA58 D44 [00580077]

⁶⁰⁰ CPS letter (4 October 2001) CA0001 D129 [00010068]

⁶⁰¹ Harrison Bunday letter (12 October 2001) CA0001 D130 [00010067]

“then contacted the campaign because she was horrified to read in the press that manslaughter charges were not in progress”.

- 6.55 Both of these experts had been referred to the CPS. Harrison Bunday made clear its hope that this new evidence might lead to the addition of a manslaughter charge to the indictment.
- 6.56 In fact a further joint medical consultation with leading counsel had occurred on 9 October 2001, at which were a number of doctors,⁶⁰² specifically: Professors Adgey, Crane and Hall, Dr Cary, James Curtis QC, Stephen O’Doherty (CPS) and Julia Armitage (CPS). This meeting was called to discuss the report of Professor Adgey dated 17 August 2001, and the written responses of Professor Hall and Dr Porter of September 2001, together with the responses of Professor Crane and Dr Cary.
- 6.57 Also on 9 October 2001, Mr O’Doherty of the CPS wrote to Insp. Tolan indicating that he was anticipating an advice from Mr Curtis QC regarding the possibility of adding to the indictment, and warning Insp. Tolan about the need to have evidence ready in anticipation of an application.⁶⁰³ On 24 October 2001 Mr O’Doherty wrote again to Insp. Tolan, to inform him that following consultation with leading counsel, the CPS was now of the opinion that there **was** sufficient evidence to justify a count of manslaughter, and that preparation would begin on making an application for a ‘voluntary bill of indictment’.⁶⁰⁴ Formal notification was then served at the ‘mention’ of the case on Friday 26 October 2001, at which time the venue and date for the trial were also set. The case was set down for 10 April 2002 at Teesside Crown Court.
- 6.58 On 9 January 2002 Mr O’Doherty wrote to Insp. Tolan and others, to confirm that he had, that day, submitted an application to the Crown Court for a voluntary bill of indictment.⁶⁰⁵ The aim of this application was to add the count of manslaughter to the existing indictment, to try both matters together at the April trial. On 6 February, following consultation with Mr Curtis QC, some amendments were made to the application, removing the judgement of Mr Justice Jackson in the judicial review of the inquest from the list of attached exhibits.⁶⁰⁶
- 6.59 Shortly after this Mr O’Doherty asked to be taken off the case, owing to complaints being made by Ms Alder. Mr Enzor of the Casework Directorate in York therefore took over responsibility from early March 2002.

⁶⁰² Note of meeting (9 October 2001) CA0099 pp.273–80 [00990274–81]

⁶⁰³ CPS letter (9 October 2001) CA0093 [00930134–5]

⁶⁰⁴ CPS letter (24 October 2001) CA0093 [00930099–100]

⁶⁰⁵ CPS letter (9 January 2002) CA0099 p.9 [00990010]

⁶⁰⁶ CPS letter (6 February 2002) CA0099 p.1 [00990002]

CPS relations with the Alder family

- 6.60 While the application and trial were being prepared, on 21 March 2002 Mr Enzor held a meeting with Ms Alder and Mr Ruggie Johnson, an informal adviser who was assisting Ms Alder.⁶⁰⁷ That meeting, which was tape-recorded by Ms Alder, ranged over the many issues that Ms Alder wished to raise in respect of the anticipated trial. The meeting lasted an entire day, and Mr Enzor later told the IPCC that, in the knowledge that he was coming fresh to the case, he was anxious to approach Ms Alder's concerns with a wholly open mind and to try to look at all of them afresh.
- 6.61 With the specific agreement of the DPP, Mr Enzor made it clear that the CPS would fund the attendance at the trial of the immediate Alder family and Mr Johnson. This was an unusual step at the time, and Mr Enzor pointed out the concern within the organisation to allow Ms Alder and the other relatives to be involved, even though the trial was moving to a different city. The commitment made by the CPS eventually cost over £15,000 in family expenses.
- 6.62 The CPS also funded the provision of a barrister, whose task was to represent the interests of the family at the trial. There was considerable discussion over this appointment, and it was made clear to the family that the third counsel would be a full member of the prosecution team and would be subject to the usual duties of counsel. That person would not therefore be 'counsel to the family' but would liaise with them and act as a conduit for their concerns to the prosecuting team.
- 6.63 There was further debate as to who that person should be, as the consensus was that the barrister chosen should have experience of race-related issues. The final choice for the role was Ms Jemma Ivens, whose name was proposed by Harrison Bunday and accepted by the CPS. Mr Enzor was complimentary about the work undertaken by Ms Ivens, whom he described as having played an important role in the prosecution, despite having joined the team at a late stage. He described her as having maintained good relations with Ms Alder initially, and as being able to pass information back and forth between counsel and the family during the trial.
- 6.64 In a note of the conversations between Mr Enzor and the IPCC, agreed by him, it was recorded that:
- "the family regarded her as being **their** counsel, although this was not the case. For example, Mr Johnson at one point demanded that Ms Ivens get on and cross examine witnesses, but these were witnesses being called by the prosecution – the family had misunderstood her role and the limits of what she could do."

⁶⁰⁷ Notes of meeting (21 March 2002) CA002 D28 [00020501–12]

- 6.65 He also pointed out that defence counsel complained at one stage that they had seen Ms Ivens emerge from the same car as Janet Alder. They were told in clear terms that her role was to liaise with the family, and that she was **expected** to spend time with them.
- 6.66 Mr Enzor recalled, however, that relations between the family and Ms Ivens did not remain good to the end. One example of this was that Ms Ivens agreed with the stance taken by Mr Curtis QC, leading counsel for the prosecution, on the 'banana boot' tape and the alleged monkey noises. This was unacceptable to the family.
- 6.67 Mr Enzor felt that the prosecution was rigorously presented and that the defence shared that view. However, the family believed that it was not fought hard enough and so had not achieved the outcome they wished. The family stated that they thought the case had been designed to fail.

Voluntary bill of indictment

- 6.68 A voluntary bill of indictment is a means of creating an indictment upon which a person, or persons, can be tried for a serious matter by the Crown Court. The 'normal' method is that the prospective defendant would be charged or summonsed for an offence and would appear before the Magistrates' Court. This is what happened to all five officers in relation to the charge of misconduct in public office. Once the case reaches the magistrates, if the offence requires Crown Court trial before a judge and jury, or if the law allows for Crown Court trial and the magistrates think it should be so tried, or the defendant wishes it to be so tried, the case will be 'committed' to the Crown Court.
- 6.69 A voluntary bill of indictment is applied for only in circumstances where the ordinary procedure is not appropriate. In this case, the fact that the case was already well advanced, and that further delay would be created by going back to the beginning and charging or summonsing the officers for manslaughter, meant that it was appropriate to make an application to add the count of manslaughter to the indictment, even though the officers had not been the subject of committal proceedings in relation to that charge. A 'Practice Direction'⁶⁰⁸ issued on the subject stated that:

"The preferment of a voluntary bill is an exceptional procedure. Consent should only be granted where good reason to depart from the normal procedure is clearly shown and only where the interests of justice, rather than considerations of administrative convenience, require it."

⁶⁰⁸ Rule 35-3 [2003] 1 W.L.R. 2870, quoted at Archbold 2005 1–227

- 6.70 The actual hearing for the application for a voluntary bill was held over two days on 26 and 27 March 2002, at which stage Mr Justice Evans, who was to be the trial judge, granted the application, and a count of manslaughter was added to the indictment.

The trial hearings

- 6.71 The trial was commenced on 15 April 2002 and continued until 11 June, at which stage the Crown closed its case. Over the course of those weeks, leading up to early June, the court took evidence from a large range of witnesses. A full list of the witnesses who gave evidence is attached at Appendix 28. The most closely examined evidence, as with the inquest, proved to be that of the medical experts. Although fewer experts were called at the trial than at the inquest, there was still extensive evidence on this topic. The doctors who gave evidence at both the inquest and trial were Dr Clark, Dr Cooper, Dr Gray, Dr Cary, Dr Cook, Dr Forrest, Dr Timperley, Dr Dearden, Dr Gosnold, Dr Porter and Professor Crane. Professor James and Doctors Rix, Rice and Lawler, who had been at the inquest, were not called again, but Professors Adgey and Hall gave evidence at the trial for the first time.
- 6.72 Submissions were then made by the various parties for the defence. After the submissions, which were made over the course of a week, Mr Justice Evans gave his ruling on Friday 21 June 2002.⁶⁰⁹ He stated the law to be that the Crown, to prove manslaughter, would need to show that (a) each defendant owed a duty of care to the deceased man; that (b) the defendant breached that duty; that (c) the negligence caused the death; and that (d) the negligence amounted to gross negligence, being so bad as to amount to a criminal act or omission. The defence, for the purpose of the submission, conceded that there was sufficient evidence for a jury to consider on points (a), (b) and (d), but argued that the causation of death was not supported by the evidence.
- 6.73 The judge considered the medical evidence in some detail and posed the question, “Was the evidence taken as whole such that the jury could safely conclude that the actions of any one defendant must have caused or contributed to the death of Mr Alder, more than minimally?”
- 6.74 In his ruling he held that there was no evidence upon which a jury could safely conclude that the conduct of any of the defendants “more than minimally caused his death”. He therefore directed an acquittal on the manslaughter count. He went on to rule that although there would be sufficient evidence to form a case to answer against the officers if negligence were the basis for misconduct in public office, the required level was that recklessness had to be proven, and he found that the evidence presented was insufficient to allow that to be safely left to the jury.

⁶⁰⁹ Judgement of Evans J. (21 June 2002) CA0064 D2 [00640340–68]

- 6.75 Accordingly, on the direction of the judge, all of the officers were acquitted by the jury.
- 6.76 A postscript to the trial of the officers can be found in a judgement of 7 April of 2004, when the Attorney General had exercised his powers to refer an issue arising from the case to the Court of Appeal.⁶¹⁰ The reference requested that the Court of Appeal should clarify the law in respect of the common law offence of misconduct in public office. The questions asked were:
- 1) What are the ingredients of the common law offence of misconduct in a public office?
 - 2) In particular, is it necessary, in proceedings for an offence of misconduct in a public office, for the prosecution to prove 'bad faith' and, if so, what does bad faith mean in this context?
- 6.77 The court gave its ruling, which was designed for the guidance of future courts, and is reported as *Attorney General's Reference No.3 of 2003 [2004] EWCA 3 WLR 451*. Although the ruling did not use the same language as that adopted at the lower court, it did not criticise the judgement of Mr Justice Evans.

The Alder family's complaints

- 6.78 Ms Alder criticised what she regarded as relevant evidence being missing in preparation for the trial. This was in relation to the noises detected on the tape that were believed to be potentially racist. Ms Alder had lobbied the CPS vigorously to have these noises relied on at trial, as she believed that they represented proof of a racist attitude among the police officers. The decision taken not to use the material was one that would have been considered by the barristers involved and by the CPS officials. In light of the sensitive nature of the material, senior prosecuting counsel took a major role in deciding the course of action to adopt.
- 6.79 Mr Enzor subsequently exchanged correspondence with Ms Alder to set out the reasoning behind the decision taken. In a letter of 22 May 2002 Mr Enzor stated that the evidence was only admissible if it went to prove potential racism on the part of PC Barr. The problem faced by the Crown in this instance was not only that they could not say who had made the noises or who had laughed at them but that they could not say why the noises were made: the noises may have been laughter and may as easily have been in relation to the reference to "banana boots" as to any other reason. There was not the necessary evidence

⁶¹⁰ Judgement of Court of Appeal (7 April 2003) CA0065 D100 [00650126-44]

to show that the noises were racially motivated, but there was some evidence to point to them not being. The prosecution team at the trial outlined the situation to the judge and indicated that they could not mount a sufficiently strong argument for the admissibility of that evidence. The judge had described that view as “wholly proper”.

- 6.80 Ms Alder made it clear – then and subsequently – that she did not accept this explanation and was unhappy with the approach taken.
- 6.81 Another aspect of the case that gave rise to disagreement was the decision to call all of the medical experts as part of the prosecution case. In a telephone conversation with Ms Hawkins of the PCA on 13 August 2002, Ms Alder complained about this aspect of the CPS’s handling of the case. Ms Hawkins’ note of the comments made by Ms Alder was:⁶¹¹

“Chris Enzor stabbed her in the back – decide to conflict her evidence. He threw in the element of doubt.”

- 6.82 Given that the Crown’s case relied heavily upon the medical evidence of experts, and that the determination of conflicting opinions was a central element of the trial, Ms Alder was concerned that there appeared to be almost too much evidence before the court.
- 6.83 The approach taken was somewhat unusual, in that the Crown adduced as part of its own case evidence that might be seen as contradicting other evidence upon which it relied. In less complex cases, it would normally be the case that the Crown would decide which evidence it chose to rely upon and to call that evidence, while disclosing to the defence any material in conflict with that.
- 6.84 It is not part of the remit of this Review to perform a critique of the CPS, or of trial counsel, in their handling of the trial. However, the reasoning for the approach taken in the trial was discussed with Mr Enzor of the CPS, who provided an explanation. The reasoning he gave was as follows:
- In applying for a voluntary bill of indictment the CPS was under an obligation to present all of the evidence to the judge, which was done. Had it not been, the CPS would have risked being accused of misleading the judge. Because an application for a voluntary bill of indictment ‘short-circuits’ the usual process, it is essential that the full picture be presented and that the judge not be given a partial view. This having been done, it then follows that one must rely upon all of that evidence and not seek to ‘cherry-pick’ elements that suit one position over another. The CPS was also mindful of the case of *Russell v Jones (Kenneth)* [1995] 3 All E.R. 239, dealing

⁶¹¹ PCA file note (13 August 2002) CA002 D28 [00020500]

with the Crown's obligation to present evidence; the Crown's discretion in such matters is **not** unfettered.

- In any event, the CPS could not say that any one expert was wrong or necessarily mistaken: almost all were expressing only slight variations of views, resulting in a range of opinions. The Crown's position was that there were not extreme contrasts; and it was clear that some experts took the view that the police were responsible, to a criminal standard, while others were less certain but would probably go as far as the civil standard ('more likely than not', for instance). Therefore the Crown was not contradicting its own position but supporting it.
- The majority of the evidence of the experts necessarily relied upon other experts: very few of them saw the body of Mr Alder. The most adamant of the experts (Professor Crane, Professor Adgey, Dr Porter) never examined his body or any part of it and were entirely reliant upon the initial findings of the earlier experts. Therefore the Crown had to include the earlier evidence to lay the basis for the later experts' analysis.
- Finally, the Crown knew that any witness it did not call would have to be disclosed to the defence. Therefore the decision was taken that it would look better to call the experts as Crown witnesses, to be able to demonstrate open-handedness with the jury and to avoid the defence claiming that that it was they who had had to reveal the full story. In effect, the prosecution could claim to present a 'whole' and consistent package.
- Mr Enzor also pointed out that part of the reason for the collapse of the case was that by the end of the trial the evidence given by Professors Crane and Adgey had "crumbled", in that they both conceded that they could not be sure of the ultimate survival of Mr Alder.

6.85 It is worthy of note that Mr Justice Evans, the trial judge, commented on this approach:⁶¹²

"In the present trial the Prosecution has called medical witnesses, for example Dr. Clark and Professor Hall, whose evidence they knew did not support their case on manslaughter to the criminal standard of proof. Their reasoning in doing so was twofold. Namely, firstly, that for them to cherry pick as witnesses for the Prosecution only the medical witnesses who supported their case to the criminal standard of proof would be

⁶¹² Judgement of Evans J, CA064 [00640351]

wrong when they had available highly respectable medical opinions which did not do so. I agree that their calling these witnesses was entirely proper.

Secondly, the Jury, in considering what weight they attached to the medical witnesses who say they are sure of the requisite causal link, would be entitled to consider the fact that other medics, although not going as far as to say they were sure, do say that the causal link is made out on the balance of probabilities.”

- 6.86 Mr Enzor had written to Ms Alder on 28 May 2002⁶¹³ during the course of the trial to explain the approach that was being adopted, and to ensure that she understood why the evidence was being presented in the way that it was. In that letter he explained the CPS approach to Ms Alder in the following terms:

“Calling Expert Witnesses

A decision had to be taken of course, on how best to present the very technical expert evidence in this case. One of the key factors is that the experts tend to agree in large measure about the various elements which made up the cause of Christopher’s tragic death. The disagreements tend to focus around the weight to be attributed to certain possible causes. For example, Professor Hall, whilst more inclined to a cardiac cause, still considered – although not to the criminal standard – that the police officers contributed to Christopher’s death. On the other hand, Professor Adgey felt that a cardiac cause was less likely and was sure to the criminal standard that the officers’ actions/omissions were a cause of death. Each witness was also critical of the conduct of the five police officers being prosecuted here and each provided evidence which is of positive assistance to the Crown.

The prosecuting team noted that the entire body of expert opinion available at the time was considered by the Inquest jury, who still felt able to conclude that Christopher had been unlawfully killed. That was not the only factor, however. You will recollect that the CPS had decided on more than one occasion that there was insufficient evidence for a realistic prospect of conviction. I am satisfied that those decisions were correct on the basis of the evidence then available. It was the report from Professor Adgey and the subsequent conference involving her and others which caused the CPS to change its earlier decisions not to prosecute. That decision was taken on a thorough re-appraisal of all the medical evidence, not just part of it.

⁶¹³ CPS letter of 28 May 2002 provided to IPCC

As you are aware, the prosecution applied to have manslaughter added to the indictment. This was by way of procedure known as a “voluntary bill of indictment”. At the application which you attended there were full legal discussions between counsel and the Judge. The Judge discussed with counsel how the jury were to approach the question of expert evidence given that there were those experts who said they could not be sure to the criminal standard on the one hand, whereas there were a number who were sure to the criminal standard on the other. Part of the exchange between Mr Curtis and the Judge concerned the difficult issue of achieving fairness in the proceedings. Mr Curtis indicated that, in the interests of fairness and justice, the prosecution would seek to put the medical evidence in its entirety before the court. Being fully aware of the prosecution’s proposed course of action, the Judge granted the voluntary bill. I consider that this is a significant endorsement of the approach taken by the prosecution. If the Judge had felt that the prosecution proposal was unworkable he would surely have either made that clear, or refused the application. Mr Curtis specifically argued that if the course which the Crown proposed was self defeating in the Judge’s view, there would be no point in his granting the voluntary bill at that stage. It was only if the Judge was of the view that the proposed evidence, in all its shades of opinion, was capable of satisfying the test of a Case to Answer, that the voluntary bill should be granted. The Judge granted it.

You will, of course, be aware that the prosecution must never seek to obtain a conviction at all costs but must prosecute cases fairly in the interests of justice. That is precisely what we are seeking to do in putting all the medical evidence before the jury, notwithstanding that some experts are more sure than others.

There is another point here also. It is quite right that the expert evidence is complex and we know that there are differing degrees of certainty between the experts. Counsel considered, and I agree wholeheartedly, that it is far better for the prosecution to meet issues like this head on and deal with them ourselves on our terms, rather than allowing the defence to exploit them to the full. It is imperative that the prosecution be seen to adopt a firm but fair and realistic approach if any jury is to have the confidence to convict.

You mention the comments that the Judge made in open court. The Judge has, quite rightly, expressed his concerns for the jury having to find their way through the volume of complex expert evidence in the case. That would be the case whether the evidence was called in the way it has been, or whether the defence were left to call some of the witnesses. This is why he encouraged counsel to provide an agreed synopsis of each

medical expert witness to assist the jury. The Judge was not saying that the case was being prosecuted in an unreasonable way and it was clear that his remarks were not critical of the prosecution case. His concern was to assist the jury.”

- 6.87 Ms Alder was reported to have argued for the approach taken by the CPS in an interview that she gave to *Private Eye* in May 2001.⁶¹⁴

“Christopher’s sister Janet said she believed the CPS was putting itself in the place of a judge and jury by not allowing conflicting medical evidence to go before a criminal court. ‘The Inquest jury was allowed to hear all the evidence and make up its own mind – I cannot see why a criminal court jury cannot be allowed to do the same thing,’ she told the Eye.”

- 6.88 Ms Alder sent an e-mail to myself at the outset of the Review.⁶¹⁵ In that she said:

“I believe what happened to Christopher was criminal and the CPS should have prosecuted this case in the way they would prosecute any other involving conflicting medical evidence, as the where [sic] the very same people that went out of their way to collate negative evidence as said by JUSTICE Jackson at the judicial review of the Coroners decision to leave MANSLAUGHTER, only one medical expert was needed, the defence would have had no experts to call after the halfway stage.”

- 6.89 It would appear that Ms Alder is basing this view upon a comment made by Mr Justice Jackson in the judgement rejecting judicial review of the inquest verdict.⁶¹⁶ The comment is at paragraph 71 of the judgement,⁶¹⁷ where he said that the evidence of Professor Crane alone would have been a sufficient basis to leave the issue of causation to the jury during the inquest. This was to rebut an argument on behalf of the officers that one expert in conflict with the others should not have been sufficient evidence for the jury to rely upon. The judge did not criticise the decision to call the various experts.
- 6.90 It is evident from reading all of the available correspondence between Ms Alder and the CPS that relations between them deteriorated during the trial and that the CPS’s explanations of its actions were simply not acceptable to her. Although Ms Alder’s letters to the CPS have not been provided to the Review, it is evident that she made a series of allegations and accusations against the personnel involved in the trial. These included assertions that prosecuting counsel were trying to

⁶¹⁴ *Private Eye* magazine 4 May 2001 CA58 D44 [00580082]

⁶¹⁵ J Alder e-mail to N Hardwick (9 November 2004) CA005 D200 [00050040–1]

⁶¹⁶ Judgement of Jackson J. (9 April 2001) CA005 D102 [00050275–312]

⁶¹⁷ Judgement of Jackson J. (9 April 2001) CA005 D102 para. 71 [00050291]

secure an acquittal for the defendants and that the prosecution was being run in a “racist way”. In letters of 16 April and 28 May 2002 Mr Enzor firmly rejected these allegations.

- 6.91 In a further letter of 28 May Mr Enzor addressed a series of complaints raised by Ms Alder and concluded as follows:

“I do not accept your view that the case is being presented in a racist way. It is being presented properly in accordance with the heavy duties imposed on the CPS and counsel to prosecute cases fairly and in the interests of justice, and with the greatest attention and sympathy for your concerns that the circumstances allow.”

- 6.92 The family of Mr Alder were clearly unhappy at the divergence in verdicts between the inquest and the trial. This view is very understandable, as the directions given to the inquest jury and the standards used in the Crown Court are very close indeed. The standard of proof for the verdict returned is the same as that applied in the Crown Court at trial.

- 6.93 At the inquest the coroner directed the jury that they could not return a verdict of unlawful killing, which was their eventual verdict, unless they were satisfied to a criminal standard that the actions of the officers contributed more than minimally to the death of Mr Alder. The jury, one must assume, found that they were satisfied to the requisite standard that this had been proved. The direction given to the jury by the coroner was that they would have to be satisfied that they would in effect be finding that manslaughter had occurred.

- 6.94 The medical evidence that was summarised for the inquest jury has been set out in Chapter 5. As has been explained, the coroner concluded his explanation of the evidence on this point⁶¹⁸ by saying:

“I suggest you ask yourselves this question, members of the jury, as you wrestle with this difficult concept of causation: If the experts cannot be sure that his condition was survivable come what may when he arrived at the custody suite, can you in turn be sure, as a jury, that any hastening of the death you may find by omitting to place him in the recovery position and check his airway etcetera, caused his death more than minimally, trivially or negligibly?”

His death may have been hastened by his position but can you say that caused his death more than minimally if, because we do not know the cause of his unconsciousness, we cannot rule out as a reasonable possibility that he might have died shortly anyway?”

⁶¹⁸ Inquest Day 32, p.29

- 6.95 In this regard the coroner was, very properly, pointing out the conflict of evidence that also arose at the trial. The possibility of an ‘unlawful killing’ verdict was left to them, and the inquest jury took the view that there was enough evidence to find that at least one of the officers caused Mr Alder’s death. It should be remembered also that Mr Justice Jackson, in the judicial review of the inquest, made no criticism of the decision to leave that option to the jury.
- 6.96 However, at the Crown Court, Mr Justice Evans, having heard the evidence, decided that there was **not** sufficient evidence to leave the case to the jury on a count of manslaughter. This was on the basis that there was not sufficient clear evidence that any contribution to his death was more than minimal. Some evidence used at the inquest was not before the trial, but mostly because it was repetitious or no longer in issue. The additional medical evidence called at trial was that of Professors Adgey and Hall, who were on opposite sides of the divide as to causation. There was in fact less medical evidence, in terms of number of doctors called, at the trial than at the inquest.
- 6.97 The reasons for the difference in verdict are ultimately impossible to identify, given that we cannot know the inquest jury’s deliberations. The same divide existed at the inquest stage as was observed at trial, although at trial it was perhaps a little starker and was argued out more fully by leading counsel for both sides. It should also be remembered that the case of *Sinclair* to which the judge made reference was not referred to in the inquest. If it had been, it is possible that the option of unlawful killing would not have been left.

Complaint against CPS lawyer

- 6.98 One complaint that was raised with the IPCC by Jane Deighton, a solicitor representing Ms Alder, was that the case had been handled by a CPS staff official who had exhibited racist behaviour at one stage. This arose from a complaint made by Ms Alder concerning information that she was given on Stephen O’Doherty of the CPS, who had handled the prosecution during the period immediately after the inquest. Ms Alder had written to the CPS and received a response from the director of public prosecutions (DPP). In that letter the DPP, David Calvert-Smith QC, said the following:⁶¹⁹

“A member of CPS staff alleged in 1996 that she had been racially and sexually discriminated against. These allegations did not involve Mr O’Doherty at all. The matter was eventually sorted out and the member of staff withdrew her allegations in May 1997. Subsequently, Mr O’Doherty took a management decision to move that member of staff to another CPS office.

⁶¹⁹ CPS letter (8 April 2002) CA002 D114 [00020023–4]

She complained to another Employment Tribunal and in 1998 the Tribunal upheld her complaint and decided that Mr O'Doherty had victimised her, because of her original allegations. As the Tribunal made clear, a complaint of victimisation does not require proof of any racial prejudice or discrimination and they made no such finding against Mr O'Doherty.

Following the Inquest into your brother's death the case had to be transferred to the Casework Directorate in Headquarters, to be handled by a very senior lawyer. Mr O'Doherty was asked to assume responsibility because he was well suited to do so. The case would not have been allocated to him otherwise. I have had no cause for concern over his handling of the case throughout. The recent reallocation of the case was made at his request."

- 6.99 On 27 February 2003 the Attorney General, Lord Goldsmith, wrote to Mr Peter Pike MP, forwarding a copy of the letter. In his letter the Attorney General makes reference to a "press-release" from Ms Alder (I do not have a copy of this). He refers to sections of this being "seriously misleading" in relation to Mr O'Doherty.

The disciplinary process

- 6.100 The decision to serve notices upon the five officers regarding potential disciplinary action was one that gave rise to some controversy, and this matter is addressed separately in this Report, in the section covering the investigation by West Yorkshire Police in Chapter 4.

- 6.101 On 8 April 1998, in the afternoon, Insp. Tolan of West Yorkshire Police served notices upon four of the five officers under the Police (Discipline) Regulations 1985 Regulation 7 (PC Barr was served with a similar notice the following day).⁶²⁰ Each notice stated that:

"Superintendent Holt has been appointed to investigate a matter concerning you from which it appears that you may have committed an offence against the Discipline Code",

and each stated that

"Initial enquiries reveal that you may have neglected your duty in relation to the care and treatment of Mr Alder whilst he was in your custody."

- 6.102 'Regulation 7 notices' were served upon any officer when it first became apparent that he or she might be subject to disciplinary proceedings. They were designed merely as an initial warning of

⁶²⁰ Regulation 7 notices CA0076 pp.223-7 [00760262-6]

possible disciplinary action and did not commit the disciplining force to proceed with a hearing; they did, however, permit the officer to prepare any defence and avoid the risk of potential defence evidence being lost. Since the time of these incidents the title of such notices has changed, to reflect the new regulations; they are now known as Regulation 9 notices.

- 6.103 Home Office guidance to chief officers issued in September 1991 stated (Paragraph 4.16) that service of the notice should be as soon as practicable, giving:

“formal notice in writing...of the nature of the complaint and inviting him to make a statement”.

Para 4.16a of the same guidance permitted the subsequent service of an amended Regulation 7 notice when the necessary information is to hand.

- 6.104 Approximately three weeks later, on 1 May 1998, Supt Michael Brightmore, the head of the D&C Department of Humberside Police, made a statement. In that he recorded the fact that at 19.30 on 30 April 1998 he had formally suspended the five officers.⁶²¹ The notices of suspension had been signed by ACC Gordon Clark, after a meeting that day between him and Supt Brightmore.
- 6.105 Mr Clark (by then DCC) was later to confirm to Mr Peter Pike MP in a letter of 30 July 2002 that the official suspension of the officers was lifted after the verdicts in the criminal trial.⁶²² The consideration of disciplinary hearings against the five officers was necessarily deferred until the completion of the criminal trial against them. Given the decision to hold the inquest first, and the further delay before the trial, the issue of disciplinary proceedings did not come into play until the trial verdicts were delivered. The eventual disciplinary hearing did not take place until 2003, over five years after the death of Mr Alder.

PCA misconduct review

- 6.106 After the completion of the Crown Court trial, the issue of disciplinary hearings fell to be considered. The PCA, having supervised the original investigation, was at this stage required to hold a misconduct review. This required them to assess whether it was appropriate that disciplinary charges should be laid against the officers. In the event of a conviction for a criminal offence, disciplinary charges would follow automatically; the acquittal of criminal charges did not, however, rule out disciplinary measures. The behaviour covered by criminal charges

⁶²¹ Supt Brightmore statement (1 May 1998) CA0076 [00760604]

⁶²² DCC Clark letter (30 July 2002) CA002 D36 [00020491]

may not have reached the standard of proof required by a court, but may still amount to a breach of the police disciplinary code.

- 6.107 The procedure for police discipline has changed on a number of occasions over the last ten years. PCA's supervision of police discipline cases was altered by the Police Act 1996. Those provisions were changed again by the Police Reform Act 2002, which established the IPCC. A summary of the changes in the discipline system between 1995 and 2005 is set out at Appendix 29. It is important to note that although the Police Act 1996 pre-dated the death of Mr Alder, the provisions were not brought into effect until 1999. The previous rules had therefore been applicable at the time of his death and were applied in the discipline hearing that followed.
- 6.108 Important changes that were introduced by the Police Reform Act 2002 and by the Serious Organised Crime and Police Act 2005, which amends the 2002 Act, mean that if a similar case were to arise now, the case would be automatically referred to the IPCC. The IPCC would determine its own involvement in the investigation and could, if appropriate, present the case before the tribunal.
- 6.109 On 26 June 2002, Ms Sally Hawkins of the PCA telephoned the firm of Harrison Bunday, which was acting for Ms Alder, to inform them that she was the member of the authority dealing with the misconduct review of the case.⁶²³
- 6.110 Ms Hawkins explained, in interview with the IPCC, that she had taken over responsibility for the case of Mr Alder because she was a "misconduct review member" of the PCA. It was standard practice that one member of the authority would supervise the initial investigation (in this case through to trial) and another would carry out the misconduct review. She had therefore taken up the responsibility with effect from the end of the trial in mid-2002.
- 6.111 The role of the PCA at this stage was to reassess the available evidence and to issue a "provisional decision" as to whether disciplinary proceedings should be pursued against the police officers.
- 6.112 Ms Hawkins met with Chief Superintendent Andrew Everett of Humberside Police and Mr Stephen Hodgson, the head of the force's Legal Services Department, on 2 July 2002 to discuss the scope for a disciplinary hearing.⁶²⁴ There was a subsequent exchange of correspondence, including e-mails, telephone conversations and letters, between C/Supt Everett, the head of the Humberside Police Professional Standards Unit, and Ms Hawkins. Ms Hawkins also spoke

⁶²³ File note (26 June 2002) CA002 D1 [00020568]

⁶²⁴ Minutes of meeting (2 July 2002) CA002 D9 [00020545–8]

by telephone with Mr Enzor of the CPS and met with him on 6 August to compare their understandings of the situation.⁶²⁵

- 6.113 By this stage, after the trial, a number of press reports emerged concerning the section of the tape that contained the alleged racist noises. Mr Enzor pointed out at that time that the family had not heard the tape, but he felt that they were entitled to.
- 6.114 On 13 August 2002 Ms Hawkins spoke to Janet Alder regarding the misconduct review. The record of that conversation is in an e-mail sent the same day to Ruth Bunday, solicitor for Ms Alder.⁶²⁶ Ms Alder evidently made it clear that she would not cooperate with the misconduct review, and she expressed the view that “disciplinary action is irrelevant”.
- 6.115 Although Ms Hawkins was requesting that Ms Bunday liaise to see if Ms Alder would change her views, it is also clear from the e-mail that Ms Alder did not wish to be contacted directly by the PCA.
- 6.116 Notwithstanding this, Ms Alder rang the PCA herself on 4 September to enquire about the progress of the misconduct review. Ms Alder, on that occasion, made a series of allegations against the police and the PCA to the effect that her brother had been deliberately assaulted, that evidence had been destroyed to cover up the crime, and that “the PCA colluded in attempts to avoid manslaughter charges”.⁶²⁷
- 6.117 Meanwhile Humberside Police was considering the issue of disciplinary hearings. Mr Hodgson took advice from counsel and passed on the advice given to DCC Clark⁶²⁸ on 22 August. Formal written advice from that barrister, Ms Bernadette Baxter, followed,⁶²⁹ confirming Mr Hodgson’s summary.

6.118

31 lines redacted
Legal and Professional Privilege

⁶²⁵ PCA minute of meeting (6 August 2002) CA002 D61 [00020317–21]

⁶²⁶ Sally Hawkins e-mail (13 August 2002) and reply CA002 D34 [00020494]

⁶²⁷ PCA file note (5 September 2002) CA002 D38 [00020489]

⁶²⁸ Humberside Police advice (22 August 2002) CA0064 D27 [00640233–6]

⁶²⁹ Counsel’s advice (23 August 2002) CA0064 D28 [00640221–31]

6.119

***11 lines redacted
Legal and Professional Privilege***

6.120 The quotation from Mr Justice Evans regarding the concession from the officers is as follows:

“In order to prove manslaughter the Prosecution must prove, in relation to each defendant, firstly, that the defendant whose case they are considering owed a duty of care to Christopher Alder. Secondly, that under the ordinary principles of negligence the defendant breached that duty. Thirdly, that the negligence caused death and, fourthly, that the negligence amounted to gross negligence in that it was so bad as to amount to a criminal act or omission. The Defence concede that there is evidence for

a Jury to consider in respect of elements A, B and D, but submit that there is no evidence upon which a Jury, properly directed, could be sure that the necessary causative link with death exists.”

- 6.121 The case on manslaughter was, ultimately, removed from the jury because the causative link was not proven.

3 Lines Redacted
Legal and Professional Privilege

Humberside Police memorandum

- 6.122 Having received the advice of counsel and the legal department, DCC Clark produced a memorandum for the PCA concerning misconduct.⁶³⁰ The appropriate regulations were the Police (Discipline) Regulations 1985 made under the Police and Criminal Evidence Act 1984 (PACE). The memorandum was produced, and should have been identified as being produced, under section 90 of PACE. In fact, the sections of PACE that dealt with police discipline (Part IX as amended by the Police and Magistrates’ Courts Act 1994) were re-enacted in the Police Act 1996, which was a consolidation act. The new act came into force in 1999, but the case of Mr Alder had commenced and so remained under the old legislation.
- 6.123 Both Humberside Police and the PCA referred, on occasions, to the section numbers under the new Police Act, but counsel advising the PCA clarified the position in a later advice.⁶³¹ Therefore this memorandum was stated to be produced in accordance with Section 75 of the Police Act 1996, whereas the correct section should have been Section 90. No problems arise as a result of this, since the ultimate disciplinary hearing was held under the correct heading.
- 6.124 The reasoning employed by DCC Clark was that, as there was no proven causative link between the actions of the officers and the death of Mr Alder, the fact of the death should be disregarded in considering the issue of the ‘extent of breach’. He went on to say that:

- “e) For an act or omission to amount to a disciplinary neglect, it is not a necessary requirement to establish a wilful neglect of duty. However, in my view to proceed to a charge of neglect there should be a ‘conscious’ act or omission. Or, put simply, an officer who is aware they could have done more and chooses not to is very different from an officer who could have done more but does not.

⁶³⁰ Humberside Police memo (30 September 2002) CA0064 D30 [00640173]

⁶³¹ See reference to advice of Michael Bromley-Martin, *infra*.

- f) Therefore, in summary, I consider that the officers were in breach of their duty of care owed to Mr Alder. That breach amounts to a neglect of their duty. However, the extent of their neglect does not amount to a neglect deserving of a discipline charge against them. The fact that there was a neglect of a strict duty of care in this case does require remedial action by way of training and guidance.”

- 6.125 DCC Clark also dismissed the issue of racism, on the basis of the evidence given to him of the analysis by Dr French.
- 6.126 In respect of PS Dunn, DCC Clark stated that he was not recommending a disciplinary tribunal, on the basis that the officer had been suspended for four years and had been through a coroner’s inquest and trial. DCC Clark gave as a separate reason the fact that PS Dunn had stood trial, that the evidence under consideration was essentially the same, and that he had been acquitted of the charges. He also stated that the pursuit of disciplinary charges might be an abuse of process and was not in any event in the public interest. Finally, he stated that there was “no irrefutable evidence” that any neglect of duty by the sergeant contributed to the death of Mr Alder. He recommended that PS Dunn be admonished by the Chief Constable and attend a custody officers’ training course, that PC Barr attend a custodians’ training centre, and that all five officers be given ‘duty of care’ advice by an assistant chief constable.
- 6.127 The memorandum prepared by DCC Clark is as significant for what it omits as for what it includes. It works from the assumption that there was no activity meriting criticism prior to the arrival of the officers at the police station. It accepts at face value, and summarises very briefly, the version of events propounded by the officers, even when evidence from a number of persons was contradictory. It also fails to examine the inherent contradictions within the officers’ versions of events as to their state of mind and their beliefs. No mention is made of the fact that the man in their custody was half naked and doubly incontinent.
- 6.128 The rationale in determining whether disciplinary hearings should be brought, as employed by DCC Clark, is highly questionable: the earlier acquittal and the mere facts of trial and inquest were not of themselves reasons for not holding a disciplinary hearing; the assertion that the officers’ actions did not contribute towards the death (expressly disregarded in deciding whether neglect did occur) cannot be justified as a reason not to pursue charges once neglect has been established.
- 6.129

**17 lines and footnote redacted
Legal and Professional Privilege**

- 6.130 After the delivery of this memorandum, there followed an exchange of correspondence with the PCA. On 2 October 2002 Ms Hawkins wrote to DCC Clark acknowledging receipt and requesting that he employ a specified forensic medical examiner (FME) to prepare a report on the extent of neglect shown by each officer.⁶³² She also requested details of the information that had been provided to Richard Alder in the early stages of the enquiry that had led to his claim that he had been given two stories.
- 6.131 DCC Clark agreed to the latter request but refused to comply with the request for an FME's involvement.⁶³³ C/Supt Everett did write back to Ms Hawkins on 14 October 2002 setting out the result of research undertaken into what was said to Mr Richard Alder in the early days of the investigation.⁶³⁴
- 6.132 Ms Hawkins' formal response to the memorandum came in a letter dated 30 October 2002.⁶³⁵ This letter was a scathing critique of the memorandum, pointing out the omissions and inconsistencies in the document. Ms Hawkins defined the differences in attitude between Humberside Police and the PCA as follows:

“We are agreed that all of the officers present in the custody suite owed a duty of care to Mr Alder and that they were in breach of that duty. However, you have said that for this to be a disciplinary neglect, there would need to be a conscious act or omission. You say that the fact that the officers could have done more but did not, is not the same as choosing not to. Your assessment of the officers' actions is therefore based on an analysis of whether there is any evidence that they were aware that they should have behaved differently.

⁶³² PCA letter (2 October 2002) CA0064 D31 [00640172]

⁶³³ Humberside Police letter (4 October 2002) CA0064 D32 [00640171]

⁶³⁴ Humberside Police letter (14 October 2002) CA0064 D35 [00640165–6]

⁶³⁵ PCA letter (30 October 2002) CA0064 D41 [00640151–7]

I take a different approach. I start with the standard of care that the public can reasonably expect from police officers. I go on to ask if this standard is within the competence of the officers. If officers fail to meet this reasonable standard, and this is not through lack of competence, then this is a disciplinary neglect.”

6.133 She went on to outline the reasons for her view of the evidence, and said that:

“I have watched the video recording of events in the custody suite with great care, and each time I am struck by the lack of ordinary humanity with which the officers respond, or fail to respond, to Christopher Alder lying inert on the floor. They show no interest in him or his welfare; they assure themselves he is faking when they have no evidence of this; they focus entirely on ‘processing’ him. They needed no special expertise to attempt to rouse him or to focus on his welfare or to at least attempt to place him in the recovery position.”

6.134 In each case she recommended formally (stated to be under Section 76 of the Police Act; in fact under Section 93 of PACE) that the officers should face a disciplinary hearing. She observed:

“I do not accept that the public interest has been fully served by the criminal trial. The public can be satisfied that any evidence of a crime has been tested in court, however, the public should also be satisfied that the officers’ actions, whilst not criminal, have been judged against the high standards that should be expected of public servants.”

6.135 The letter ended by asking whether DCC Clark could:

“outline for me the lessons that the Force has learned from the tragic death of Christopher Alder. Have there been any significant changes in practice, policy or training?”

6.136 DCC Clark wrote again to the PCA on 11 November 2002,⁶³⁶ taking issue at length with the analysis of Ms Hawkins. He maintained his position that he did not regard disciplinary proceedings as appropriate. He rejected her recommendations and declined to follow them.

6.137 As a result, Ms Hawkins of the PCA wrote to counsel, Mr Michael Bromley-Martin, the following day,⁶³⁷ seeking an advice as to whether it would be appropriate:

⁶³⁶ Humberside Police letter (11 November 2002) CA0064 D43 [00640142–8]

⁶³⁷ PCA letter (12 November 2002) CA002 D61 [00020362–3]

“to charge the officers in the absence of evidence that they were consciously neglecting their duty towards Mr Alder?”

- 6.138 Mr Bromley-Martin provided an advice dated 11 December 2002, in which he confirmed that there was no requirement in determining whether there had been neglect of duty that ‘wilfulness’ be demonstrated.⁶³⁸ He rejected the contention that pursuit of disciplinary charges would amount to an abuse of process, or that the public interest had been fully served by the criminal trial.
- 6.139 Mr Bromley-Martin pointed out that the decision to direct charges under Section 93(3) of PACE lay with the PCA. It was a matter for the PCA’s discretion, although the reasons put forward by DCC Clark for not pursuing such a course of action were not valid.

PCA’s direction to Humberside Police

- 6.140 As a result of this advice, and having considered the matter, the PCA decided to direct Humberside Police to pursue disciplinary proceedings. Formal notice of the direction was sent by the PCA under cover of a letter of 17 December 2002 from the Chairman of the PCA, Sir Alistair Graham, to DCC Clark.⁶³⁹ By a letter dated 18 December, DCC Clark acknowledged the direction.⁶⁴⁰
- 6.141 At the same time as the issue of disciplinary hearings was being considered, there was also discussion of the issue of the possible racial abuse in the form of the possible “monkey noises”. DCC Clark wrote to Ms Hawkins prior to Dr French’s report being available,⁶⁴¹ indicating that he had reviewed the tape and stating clearly his view that the noises were not aimed at Mr Alder but were made in response to PC Barr’s complaint about the forensic over-suit. He said:

“There is no doubt in my mind that the reference to ‘banana boots’ is a reference to the yellow overshoes which form part of the disposable clothing kit and was said by PC Barr because he felt he would look ridiculous going home in the disposable clothing. The term ‘banana boots’ is a reasonable and understandable description of the yellow overshoes. To suggest that it had any racist connotations is totally without foundation.

The comment and speculation about ‘monkey noises’ is also without foundation. The sound on the tape is readily identifiable as Matron Winkley laughing. The fact that her laughter is verging

⁶³⁸ Counsel’s advice (11 December 2002) CA002 D65 [00020289–98]

⁶³⁹ Fax including letter (17 December 2002) CA002 D65 [00020284–7]

⁶⁴⁰ Humberside Police letter (18 December 2002) CA002 D69 [00020274–5]

⁶⁴¹ Humberside Police memo (30 September 2002) CA002 D47 [00020443–62]

on hysterical is perhaps a reflection of the stressful situation she had experienced.”

6.142 He went on to conclude:

“I do not believe it is appropriate to delay the submission of this memorandum because in my view there is no evidence whatsoever of racist attitudes or behaviour on the part of the police staff.

Nevertheless it is regrettable that more regard was not given to the fact that Mr Alder was still lying dead and naked on the custody suite floor. The situation demanded greater sensitivity and respect.”

6.143 Ms Hawkins of the PCA responded to the issue in her letter of 30 October 2002,⁶⁴² in which she said:

“Ancillary matters

There has been an allegation that officers were using racist language when they referred to banana boots or boats. I agree that the officers were clearly talking about clothing and that in this context the reference is to the yellow paper over-shoes known as banana boots. I accept that Matron Winkley can be heard laughing and that there is then a further sound which could be someone making monkey noises, although you have had expert opinion that this too is more likely to be laughter.

I agree with your conclusion that this audio evidence does not demonstrate a racist attitude on the part of the officers. However, I agree with you that the officers should have shown more respect for Mr Alder’s body which was still lying on the floor of the custody suite.

I recommend that the officers should receive advice in this matter, especially the supervising officer who had a responsibility to ensure that everyone present behaved with appropriate respect.”

6.144 Following the receipt of the formal statement from Dr French, C/Supt Everett forwarded the document to Ms Hawkins on 29 November.⁶⁴³

6.145 In direct telephone conversations with Ms Alder, the issue of the noises arose on a number of occasions. On 13 August 2002 Ms Hawkins recorded that Ms Alder had said:⁶⁴⁴

⁶⁴² PCA letter (30 October 2002) CA0064 D41 [00640151–7]

⁶⁴³ Humberside Police letter (29 November 2002) CA0064 D51 [00640098]

⁶⁴⁴ PCA file note (13 August 2002) CA002 D62 [00020356]

“It’s evidence of racism that we didn’t find monkey noises.”

- 6.146 On 6 November Ms Alder called Ms Hawkins twice and raised the issue.⁶⁴⁵ Ms Alder was, evidently, adamant that the discussion must have been about “banana boats”, although it is unlikely that she had heard the tape, as Ms Hawkins was still discussing with her the possibility of listening to it. Ms Alder also expressed doubts that the yellow overshoes were in use by Humberside Police.
- 6.147 I have set out, in my account of the events on the night on which Mr Alder died, a description of the yellow overshoes used by Humberside Police for forensic purposes.
- 6.148 In her provisional decision letter of 24 December 2002, Ms Hawkins indicated that the PCA had directed that there be disciplinary proceedings.⁶⁴⁶ She then went on to deal with the issue of the noises and laughter. She considered the evidence and quoted from the report of Dr French. She then went on to say:

“The forensic evidence is therefore not conclusive regarding the sound that could be monkey noises. However, even if it is accepted that these are monkey noises, this does not provide evidence that the officers were being racist since, in this context, any monkey noises would most probably have resulted from the reference to the banana boots.

Whilst this audio evidence does not provide firm evidence of a racist attitude on the part of the officers, I do believe that the officers should have shown more respect for Mr Alder’s body which was still lying on the floor of the custody suite.

This matter has not been subject to a formal complaint and therefore the officers have not been served with notices and interviewed about what they said and how they behaved.

My provisional conclusion

In the absence of a formal complaint and evidence from the officers concerned, I have considered the forensic evidence that is available. Any decision to issue notices to the officers and interview them would need to be reasonable and proportionate.

I am therefore minded to deal with this matter informally and I propose that all the officers identified should receive advice about their conduct, especially the supervising officer who had a responsibility to ensure that everyone present behaved professionally and with due respect.”

⁶⁴⁵ PCA file note (6 November 2002) CA002 D62 [00020360]

⁶⁴⁶ PCA letter (24 December 2002) CA0064 D60 [00640058–63]

6.149 In her letter to Janet Alder of 6 May 2003, forming the follow-up to the provisional decision of the previous December, Ms Hawkins dealt with the issue of the noises.⁶⁴⁷ In the intervening period, although Ms Alder had been given opportunities to view the tapes, she had not done so. The letter said:

“Comments and laughter after Mr Alder’s death

I wrote to you separately about this matter in my provisional decision letter. I received a letter from your solicitor in which she explains that you decided not to listen to this part of the tapes and have therefore not commented on my decision.

More recently, on 11 March 2003, you telephoned me to say that you remain of the view that the officers’ behaviour is evidence of racism. I understood you to say that the family had not been afforded an opportunity to listen to the tapes, but you explained that you meant that you had not been given an opportunity to bring in an independent expert to listen to the tapes.

In my letter dated 24 December 2002 I gave my reasons for my Provisional Decision, and this included the evidence of an independent expert. Since you have not provided any fresh evidence, I am confirming my decision that the officers should receive advice regarding their failure to behave appropriately and professionally in the presence of Mr Alder’s body.”

Refusal of legal representation

6.150 At the time that the PCA directed Humberside Police to hold a disciplinary hearing, it also recommended that Mr Bromley-Martin be employed to prosecute the matter. This recommendation was, however, rejected by DCC Clark, who informed the PCA that he had decided that none of the officers would be afforded legal representation and that the case would be presented by C/Supt Everett, the head of the Professional Standards Unit at Humberside Police.

6.151 Ms Hawkins sought further advice from Mr Bromley-Martin regarding the decision of DCC Clark to not provide legal assistance to the officers.⁶⁴⁸ As Ms Hawkins recognised in her letter, the decision to deny representation:

“means that the only sanctions available to the tribunal will be a fine, a reprimand, a caution, or no action at all”.

⁶⁴⁷ PCA letter (6 May 2003) CA003 D7 [00030102–21]

⁶⁴⁸ PCA letter (30 December 2002) CA002 D76 [00020268]

The decision made by DCC Clark, which might at first sight have appeared to be restricting the officers in the presentation of their defence, had the effect of restricting the tribunal in its ability to punish them for any infringements that were found to have occurred. Ms Hawkins sought advice as to whether that decision would be amenable to judicial review.

6.152 In an advice of 15 January 2003, Mr Bromley-Martin dealt with this matter.⁶⁴⁹ He stated that:

“The effect of the Deputy Chief Constable’s decision and the above provisions is to limit the powers of punishment, in respect of any of the five officers who may be found guilty of disciplinary offences, to those of reduction in pay, fine, reprimand or caution. Another effect is, the officers not having been given the opportunity to be legally represented, that the case against them may not be presented by counsel or solicitor. The Deputy Chief Constable has indicated that his head of professional standards will therefore present the case.

The decision by the Deputy Chief Constable is an unfortunate one. His views of the case and whether these officers should face disciplinary proceedings, or are even guilty of neglect of duty, are well documented. The appearance that is given is that, despite the fact that a direction to bring charges has had to be made by the Authority, the decision as to available punishment and the decision as to who will make the presentation of the case has or will be undertaken by the very party who opposed the bringing of charges in the first place. From a public interest point of view, this situation is, at the very least, unattractive.”

6.153 The advice from Mr Bromley-Martin was, however, that judicial review would not be a realistic option and was highly unlikely to succeed.

6.154 In the meantime, Humberside Police had notified the officers on 18 December that they would be the subject of disciplinary hearings,⁶⁵⁰ and issued a press release on 20 December 2002.⁶⁵¹ Official notices to the officers were dated 30 December 2002 and sent from C/Supt Everett to each of the five men.⁶⁵²

6.155 Humberside Police then had to give consideration to the nature of the charges to be pursued. Draft charges were prepared by Ms Hawkins of the PCA, dated 7 January 2003, but Humberside Police retained discretion as to the actual wording of the charges to be put.⁶⁵³ In an

⁶⁴⁹ Counsel’s advice (15 January 2003) CA002 D92 [000200145–51]

⁶⁵⁰ Humberside Police fax (18 December 2002) CA0064 D54 [00640081]

⁶⁵¹ Press release (20 December 2002) CA0064 D57 [00640068]

⁶⁵² Internal memos (30 December 2002) CA0064 D61 [00640053–7]

⁶⁵³ Draft charges (7 January 2003) CA0064 D62 [00640050–2]

internal report of 13 January 2003 Mr Hodgson of the Legal Department set out his proposals to C/Supt Everett.⁶⁵⁴ The next day this report was discussed between Mr Hodgson and C/Supt Everett, and with the agreement of the former it was e-mailed to Ms Hawkins at the PCA for her views.⁶⁵⁵ Ms Hawkins agreed that this was a privileged document and was not to be disclosed.

- 6.156 Having received the document by e-mail, Ms Hawkins raised one query as to whether the failure to physically cover Mr Alder when he was lying naked on the floor of the custody suite should form the basis of a separate charge.⁶⁵⁶
- 6.157 In a telephone conversation of the following day, 15 January, Ms Hawkins, after consulting with Mr Bynoe of her office, agreed the charges as proposed by Mr Hodgson. C/Supt Everett spoke again with Ms Hawkins on 20 January 2003 to inform her that the charges against the officers had been settled.⁶⁵⁷ The same day he informed PS Stuart Richardson of the Police Federation, who was involved in representing the officers.⁶⁵⁸ On 21 January C/Supt Everett drafted notices for the five officers confirming the nature of the charges against them.⁶⁵⁹ These stated that each officer would be charged under the 'old' regulations as follows:

"Neglect of Duty

Contrary to Code 4(a) Schedule 1 Police (Discipline) Regulations 1985.

That on the 1 April 1998 at Queen's Gardens Police Station, Hull, being a member of Humberside Police, without good and sufficient cause, you neglected to carry out with due promptitude and diligence your duty towards Christopher Ibikunle ALDER, a man for whose welfare you had responsibility in that [being an officer involved in the arrest and transportation of Christopher Ibikunle ALDER to] Queen's Gardens Police Station, you failed to take any or sufficient steps to ascertain whether or not his apparent unconsciousness was genuine or to direct others to do so, or otherwise to safeguard his medical wellbeing."

- 6.158 The words between the brackets were those used for PCs Dawson and Blakey; in the case of A/PS Ellerington the charge omitted the words "arrest and"; in the case of PS Dunn it read:

⁶⁵⁴ Humberside Police memo (13 January 2003) CA0002 D90 [00020153–62]

⁶⁵⁵ File note (14/15 January 2003) CA0064 D67 [00640038]

⁶⁵⁶ E-mails (14 January 2003) CA0064 D66 [00640039–40]

⁶⁵⁷ File note (20 January 2003) CA0064 D69 [00640036]

⁶⁵⁸ File note (20 January 2003) CA0064 D70. [00640035]

⁶⁵⁹ Notices of charges CA0076 pp.193–7 [00760194–8]

“being the Custody Officer at the time of Christopher Ibikunle Alder’s arrival in the Custody Suite at...”,

and for PC Barr:

“as the Warder within the Custody Suite at...”

6.159 On the same day, 21 January, C/Supt Everett served a report on Mr Hodgson setting out the facts upon which he proposed to rely and a number of supporting documents that related to the charges.⁶⁶⁰ Ms Hawkins was informed of the fact of the charges by e-mail from C/Supt Everett forwarded to her by Mr Tipple.⁶⁶¹ C/Supt Everett met with Ms Hawkins of the PCA on 27 January, and on the following day he served notices on the five officers dealing with the statements relied upon and documents in support of the case against them.

Decision to apply security measures

6.160 As with many aspects of the case, there was considerable press interest in the decision to pursue charges and the limitation of the punishment. Articles appeared in, among other newspapers, the *Times*,⁶⁶² the *Independent*⁶⁶³ and the *Guardian*⁶⁶⁴ on Friday 21 February 2003. The *Hull Daily Mail* had reported the matter on that day,⁶⁶⁵ and it had appeared the previous day on the BBC internet service⁶⁶⁶ and in the *Daily Mirror*.⁶⁶⁷

6.161 On 24 February 2003 another, larger article appeared in the *Daily Mirror* regarding the disciplinary hearing on the five officers, accompanied by photographs of the officers.⁶⁶⁸ Following that article, which reported the decision to deny the officers legal assistance and thereby limit the available penalties, anonymous death threats aimed at the officers were sent to the PCA, which were subsequently passed to Humberside Police.⁶⁶⁹ Those threats made reference to the *Daily Mirror* photographs.

6.162 From that point forward, it would appear that the security of the officers, and of those involved in the case, became a concern within Humberside Police. This led to the decision not to publicise either the

⁶⁶⁰ Internal report (21 January 2003) CA0076 pp.198–235 [00760199–236]

⁶⁶¹ E-mail (21 January 2003) CA0064 D77 [00640019]

⁶⁶² Press clipping (21 February 2003) CA0002 D103 [00020042]

⁶⁶³ Press clipping (21 February 2003) CA0002 D103 [00020041]

⁶⁶⁴ Press clipping (21 February 2003) CA0002 D107 [00020037]

⁶⁶⁵ Press clipping (21 February 2003) CA0002 D104 [00020040]

⁶⁶⁶ Press clipping (20 February 2003) CA0002 D105 [00020039]

⁶⁶⁷ Press clipping (20 February 2003) CA0002 D106 [00020038]

⁶⁶⁸ Press clipping (24 February 2003) CA0002 D108. [00020035]

⁶⁶⁹ PCA fax (26 February 2003) CA0002 D109. [00020036]

time or the location of the disciplinary hearings. On 14 March 2003 these matters were discussed at a Humberside Police staff meeting,⁶⁷⁰ and alternative venues were considered in case of a breach of security. The minutes of the meeting also said:

“On balance, because of security implications the location and date of the hearing will remain confidential. The PCA have indicated they will co-operate with this request.”

6.163 At a subsequent meeting of 7 April 2003 it was agreed that:⁶⁷¹

“the date and location of the tribunal would remain confidential”,

and that the PCA agreed with this (the minutes describe this meeting as 7 March, but the covering e-mail makes it clear that this was a typographical error). The issue of threats made against the officers was raised as an agenda item, and forensic analysis of the threatening documents was discussed.

6.164 DCC Clark retired from service with Humberside Police at the end of 2002 and was succeeded by DCC Steven Love, formerly of Thames Valley Police. In a presentation made to the local Police Authority by DCC Love,⁶⁷² he also informed them that the forthcoming disciplinary hearings would be kept secure, because of:

“death threats against officers and those involved in the decision making to date”.

The question of confidentiality was touched upon again briefly in the staff meeting of 7 May.⁶⁷³

6.165 In the meantime the arrangements for the disciplinary hearings continued. Having been contacted by PS Richardson of the Police Federation, C/Supt Everett passed on the news to Ms Hawkins that the officers would be disputing the charges. This letter was sent on 24 February 2003,⁶⁷⁴ and on the same day C/Supt Everett wrote back to PS Richardson to discuss arrangements for the hearing.⁶⁷⁵ At that stage it was believed that the hearing would take place on 22 and 23 May, and a preliminary hearing was planned for 21 May.

⁶⁷⁰ Minutes of meeting (14 March 2003) CA0065 D5 [00650368]

⁶⁷¹ Minutes of meeting (7 March 2003) CA0065 D15 [00650387–8]

⁶⁷² Police Authority presentation (15 April 2003) CA0065 D13 [00650355–7]

⁶⁷³ Minutes of meeting (7 May 2003) CA0065 D19 [00650380–1]

⁶⁷⁴ Humberside Police letter (24 February 2003) CA0064 D73 [00640027]

⁶⁷⁵ Humberside Police letter (24 February 2003) CA0064 D74 [0064026]

Chairing the tribunal

6.166 Because the events that led to the disciplinary process occurred in 1998, they came under the ‘old’ rules. What this meant was that the Police and Criminal Evidence Act 1984 had established the PCA, and had made provisions for police discipline under Part IX of that Act. The detailed rules were set out in the Police (Discipline) Regulations 1985. The Police Act of 1996 was passed in order to implement changes in this regime, and it created new regulations which were known as the Police (Conduct) Regulations 1999. These came into force on 1 April 1999 but had not been in force at the time of Mr Alder’s death; hence the reference to the ‘old’ legislation.

6.167 That legislation did include provision for the PCA to insist that the tribunal for such disciplinary matters should consist of the presiding police officer and two members of the PCA. The changes wrought by the Police Act included the abolition of this provision, in part because there was perceived to be a conflict of interest in the PCA promoting the bringing of charges and in its sitting on the panel to adjudicate such charges. In any event, although in my view this power was still technically available to the PCA, because the old rules applied, its use was clearly either not considered or was considered and rejected in this case. The upshot of this was an acceptance that a single officer would sit as the presiding officer – effectively a single judge.

6.168 It is clear that in the early stages of the planning for the disciplinary hearing, it was envisaged that DCC Love would be the presiding officer. However, on 17 March 2003, DCC Love informed C/Supt Everett that he had been reviewing notes of an earlier meeting that he had attended with DCC Clark, during the period of transfer of responsibilities. DCC Love had realised that although he did not recall the details of the Alder case, the notes made it clear that he had, at one stage, known rather more. The notes also indicated a view expressed at the earlier meeting (which was unattributed) that:⁶⁷⁶

“the officers had suffered enough”.

6.169 DCC Love having disclosed this matter, C/Supt Everett, in consultation with the Legal Department of Humberside Police, decided that another presiding officer would have to be found. He informed Ms Hawkins of the PCA and PS Richardson of the Police Federation of this by letters the following day.⁶⁷⁷

6.170 By coincidence PC Barr, one of the accused officers, had written to C/Supt Everett requesting that an officer from another force be used to

⁶⁷⁶ File note (17 March 2003) CA0065 D43 [00650292]

⁶⁷⁷ Humberside Police letters (18 March 2003) CA0065 D45 & D46 [00650287–9]

chair the disciplinary hearing.⁶⁷⁸ PC Dawson had written to the Chief Constable in similar terms on 12 March 2003.⁶⁷⁹ C/Supt Everett was able to respond and to inform them that matters were in hand to appoint an external officer to deal with the hearing.⁶⁸⁰

6.171 Initially arrangements were made for the hearing to be before DCC Meredydd Hughes of South Yorkshire Police, and a formal invitation to him was sent on 20 March 2003 by Mr Westwood, who was by now the Chief Constable of Humberside Police.⁶⁸¹ DCC Hughes agreed to act, by letter of 25 March 2003.⁶⁸² PS Richardson of the Police Federation was notified by letter of 28 March and informed that the hearing dates had been put back to 19–24 June.⁶⁸³ Notices to that effect were served upon the Police Federation on 2 April 2003,⁶⁸⁴ and Ms Hawkins was notified by post.⁶⁸⁵ Individual letters were sent to the officers on 4 April 2003.⁶⁸⁶

6.172

**14 lines and 2 footnotes redacted
Legal and Professional Privilege**

6.173 On the afternoon of 20 May, C/Supt Everett discussed the matter with Ms Barton by telephone and informed the Police Federation of the problem. At 07.30 the following morning he met and spoke with DCC Love.⁶⁸⁷ A meeting between Chief Constable Westwood of Humberside Police, DCC Love and C/Supt Everett was held at 09.00 to discuss the implications of the advice received. At that meeting Chief Constable Westwood decided that the earlier involvement of DCC Love in discussions of the case should not be a block to his hearing the case

⁶⁷⁸ PC Barr letter (17 March 2003) CA0065 D47 [01440005]

⁶⁷⁹ PC Dawson letter (12 March 2003) CA0065 D1 [01440006]

⁶⁸⁰ Humberside Police letter (18/20 March 2003) CA0065 D48–9 [01440003–4]

⁶⁸¹ Humberside Police letter (20 March 2003) CA0076 p.160 [00760161]

⁶⁸² South Yorkshire Police letter (25 March 2003) CA0076 p.159 [00760160]

⁶⁸³ Humberside Police letter (28 March 2003) CA0065 D51 [00650279]

⁶⁸⁴ Humberside police memos (2 April 2003) CA0076 pp.154–6 [00760155]

⁶⁸⁵ Humberside Police letter (28 March 2003) CA003 D3 [00030144]

⁶⁸⁶ Humberside Police letters (4 April 2003) CA0076 149–53 [01440007–11]

⁶⁸⁷ File note (20/21 May 2003) CA0065 D30 [00650312]

and that DCC Love should therefore be the tribunal. DCC Love agreed to this.⁶⁸⁸ DCC Hughes was informed of this change of arrangements by C/Supt Everett and thanked for offering his assistance.⁶⁸⁹

6.174

***3 lines and 1 footnote redacted
Legal and Professional Privilege***

Following a meeting between C/Supt Everett and the Chief Constable, the decision to pass the case to DCC Love was reversed, and Chief Constable Westwood agreed to find another chief constable. By 15.00 arrangements had been made to have the charges heard by Chief Constable Sean Price of Cleveland Police. A note of confirmation was sent to Chief Constable Price, indicating that the hearing would be held on the 19, 20, 23 and 24 June 2003, at Scunthorpe Police Station.⁶⁹⁰

Attendance at the tribunal

6.175 The issue of the attendance of Ms Alder at the tribunal is considered separately in this Report in Chapter 8.

6.176 C/Supt Everett had sought agreement from the Police Federation representatives that Ms Hawkins of the PCA be allowed to attend the hearing in her professional capacity,⁶⁹¹ following her request,⁶⁹² which C/Supt Everett supported. The consent of the federation having been obtained, he wrote again to Ms Hawkins to inform her of this.⁶⁹³

6.177 A letter from Whittles solicitors, instructed on behalf of the Police Federation, was sent to C/Supt Everett on 1 April 2003.⁶⁹⁴ The letter acknowledged that legal representation was not being permitted, but sought C/Supt Everett's agreement to legal representatives attending for the purposes of a legal argument only.

6.178 The response from C/Supt Everett was that he did not agree to any legal representation but was prepared to have both sides submit written legal submissions (prepared by solicitors or counsel if wished) that could be handed to the tribunal in advance.⁶⁹⁵ From separate correspondence it becomes clear, however, that Ms Georgina Kent of counsel was engaged by Humberside Police to provide independent legal advice to the presiding officer. This appears to have been

⁶⁸⁸ File note (21 May 2003) CA0065 D28 [00650313]

⁶⁸⁹ Humberside Police letter (27 May 2003) CA0065 D40 [00650296]

⁶⁹⁰ Humberside Police letter (29 May 2003) CA0065 D43 [00650293]

⁶⁹¹ Humberside Police letter (18 March 2003) CA0065 D44 [00650290-1]

⁶⁹² PCA letter (12 March 2003) CA0065 D4 [00650370]

⁶⁹³ Humberside Police letter (3 April 2003) CA003 D4 [00030143]

⁶⁹⁴ Whittles letter (1 April 2003) CA0065 D11 [00650360]

⁶⁹⁵ Humberside Police letter (4 April 2003) CA0065 D12 [00650358-9]

necessary, as submissions for dismissal were set down for the first day of hearing.⁶⁹⁶

- 6.179 The Whittles solicitors wrote again on 9 May 2003 seeking details of the venue and time for the hearing, and indicating that they would attend even if they could not sit in the hearing itself.⁶⁹⁷ They did not agree with written submissions being put to the tribunal in advance. C/Supt Everett spoke to the solicitors on 12 May, and by letter of the same day he confirmed the details of the venue and arrangements made for them, while confirming that counsel and solicitor would not be permitted to sit in the hearing.⁶⁹⁸
- 6.180 A final exchange of correspondence occurred prior to the hearing, when Whittles wrote to C/Supt Everett expressing concern that the “Chief Constable” might delay issuing his judgement following the hearing.⁶⁹⁹ Mr Hodgson replied on behalf of Humberside Police, stating that no indication had been given that the judgement would be delayed. The letter also pointed out that Chief Constable Price would not need to make a recommendation to the Chief Constable of Humberside, but would make the findings himself and, if appropriate, determine punishment.⁷⁰⁰

The disciplinary hearing

- 6.181 The disciplinary hearing was convened at Scunthorpe Police Station on Thursday 19 June 2003. It sat that day, the following day and again on Monday 23 and Tuesday 24 June. The first day of the hearing was concerned with submissions made on behalf of the officers that the pursuit of the disciplinary hearing was an abuse of process. I have established, in interview with Chief Constable Price, that by agreement with the parties he was given access to legal advice (counsel, Ms Kent) for this argument. The agreement was that once the legal argument was concluded, the factual issues would be decided by him, without further legal assistance. This approach was taken in order to comply with Regulation 18 (4), which states that:

“Where the case against the accused is presented by counsel or a solicitor, the officer conducting the hearing may be assisted at the hearing by counsel or a solicitor.”

- 6.182 Police disciplinary hearings are heard in a manner similar to a criminal trial: the ‘presenting officer’ acts as prosecuting counsel and calls evidence. The officers concerned may cross-examine any live

⁶⁹⁶ Humberside Police letter (18 June 2003) CA0076 [00760084]

⁶⁹⁷ Whittles letter (9 May 2003) CA0065 D16 [00650385]

⁶⁹⁸ Humberside Police letter (12 May 2003) CA0065 D17 [00650383–4]

⁶⁹⁹ Whittles letter (11 June 2003) CA0076 p.135 [00760136]

⁷⁰⁰ Humberside Police letter (12 June 2003) CA0076 p.136 [00760137]

witnesses called. This they may do themselves or by a federation representative or a 'friend'. At this time, the standard of proof required for a finding of guilt was "beyond reasonable doubt".

- 6.183 I have been provided with the "presenting side's opening remarks", which is the prepared statement of C/Supt Everett setting out the case against the five officers.⁷⁰¹ I understand from Chief Constable Price that this was read out at the hearing, and written statements were then presented on behalf of the presenting side.
- 6.184 At the close of the evidence against the officers, their representative (PS Savage) made a submission of no case to answer. This was also presented in written form, and I have been provided with a copy of it.⁷⁰² Had this submission failed, the officers would have been given the opportunity to give or call evidence in their defence. As matters unfolded, the presiding officer, Chief Constable Price, ruled that there was no case to answer.
- 6.185 The form of the presiding officer's judgement, as presented to the Review, was a typed document that appeared to be a verbatim transcript of his judgement. The original tape of the judgement has not been located. This document proved somewhat difficult to work from, as it did not appear to have been proofread, and a number of minor errors in names and references appear on the face of it. It was also clear that no attempt had been made to impose any punctuation upon it, as it read as one continuous paragraph of approximately seven pages.⁷⁰³ Accordingly, it is acknowledged that errors in the judgement may in some cases be merely mistakes in transcription that were not corrected at the time. In interview with Chief Constable Price, it became clear that he had never seen a copy of the transcript.
- 6.186 For the purposes of the Review, this document was broken down into sections, and the paragraphs numbered, although the words have been left unaltered. It is attached as Appendix 30.
- 6.187 Presiding officers are not usually legally qualified, and therefore one might expect them to avoid pronouncements upon legal matters. In this case, however, the submissions at the close of the presenting officer's case were based upon legal authorities, and the presiding officer purported to base his decision upon legal precedent, without having legal assistance in respect of it.
- 6.188 Counsel, Ms Kent, who was engaged to assist Chief Constable Price on the first two days of the hearing, was not asked to attend or to assist on Monday 23 or Tuesday 24 June, when the later submissions were made and the judgement was given.

⁷⁰¹ Presenting side's opening remarks CA0079 [00790004–32]

⁷⁰² Officers' defence submission CA0003 D20 [00030042–56]

⁷⁰³ Presiding officer's judgement (24 June 2003) [00650220–7]

6.189 In discussions with the IPCC C/Supt Everett confirmed that legal advice was available to the tribunal only for an initial submission to strike out the hearing on the grounds of abuse of process.⁷⁰⁴ He went on to say that no legal advice was sought in respect of the submission:

“The Federation presented their half-time submission, which they had obviously prepared in advance with legal help. No-one else had that advantage when considering what they put forward. I did not consider asking for an adjournment to take legal advice on their submission, and just reiterated to Sean Price that my case was as I had already stated it. He was able to deal adequately on his own.”

6.190 In giving his judgement the presiding officer made the following comments at the outset:

“2. ...I intend to use for my authority decided cases within the wider criminal and legal context and I’m obliged for the access made to me to a current copy of Archbalds for this purpose. *R v. BROOM 2002* is the most recent case which gives this power in to Judges and builds upon the earlier and often quoted GALBRAITH case. The principle is that a submission of no case to answer should be allowed where there is no evidence upon which, if the evidence adduced were accepted, a reasonable jury, properly directed, could convict. In my role I suppose I act more as a Magistrate as I have to be, as Presiding Officer, a Judge of both the facts and the law. In essence, therefore, I have to decide if there is sufficient evidence to prove the charge without hearing any further, i.e. even without the defence case, does the prosecution prove its charge sufficiently to require an answer.”

6.191 The book to which he refers, “Archbold”, deals with the approach to be adopted in considering submissions of no case to answer. It quotes the leading case on the subject, which is that quoted by Chief Constable Price as “GALBRAITH”. The full title of this case is *R. v. Galbraith [1981] 73 Cr.App.R. 124, CA*. In that case the Lord Chief Justice dealt with the correct approach to adopt in cases where a submission of no case to answer was made following the close of the prosecution case in a Crown Court trial. His judgement included the following paragraph, which remains the law on this topic:

“How then should the judge approach a submission of ‘no case’? (1) If there is no evidence that the crime alleged has been committed by the defendant, there is no difficulty. The judge will of course stop the case. (2) The difficulty arises where there is some evidence but it is of a tenuous character, for

⁷⁰⁴ C/Supt Everett interview (21 March 2005) p.6 Q.34 [01370008]

example because of inherent weakness or vagueness or because it is inconsistent with other evidence. (a) Where the judge comes to the conclusion that the prosecution evidence, taken at its highest, is such that a jury properly directed could not properly convict upon it, it is his duty, upon a submission being made, to stop the case. (b) Where however the prosecution evidence is such that its strength or weakness depends upon the view to be taken of a witness's reliability, or other matters which are generally speaking within the province of the jury and where upon one possible view of the facts there is evidence upon which a jury could properly come to the conclusion that the defendant is guilty, then the judge should allow the matter to be tried by the jury...

There will of course, as always in this branch of the law, be borderline cases. They can safely be left to the discretion of the judge."

- 6.192 The case referred to as "*R v. BROOM 2002*" is probably in fact *R. v. Brown (Davina) [2002] 1 Cr.App.R. 5, CA* in which, as the more recent 2005 edition of Archbold comments:⁷⁰⁵

"it was confirmed that if, at any time after the conclusion of the prosecution case, the judge is satisfied that no jury, if properly directed, could convict, he has the power to withdraw the case from the jury, but that this is a power to be sparingly exercised".

- 6.193 The book also comments upon the role of a magistrate in a similar situation as follows (2005 edition, paragraph 4-296):

"D. Magistrates' Courts

In their summary jurisdiction magistrates are judges both of facts and law. It is therefore submitted that even where at the close of the prosecution case, or later, there is some evidence which, if accepted, would entitle a reasonable tribunal to convict, they nevertheless have the same right as a jury to acquit if they do not accept the evidence, whether because it is conflicting, or has been contradicted or for any other reason."

- 6.194 It is important to note that the case of Galbraith and the other authorities quoted in this context speak about the evidence disclosing a "case to answer". The question that should be posed by a tribunal after the submission of no case to answer is whether, taking account of the standard of proof to be applied, there is sufficient evidence for a properly directed tribunal to find the charge proved. This is not the same as the question of whether the case has been proved beyond reasonable doubt. The distinction between the two may appear slight,

⁷⁰⁵ Archbold 2005 para. 4-292

but it is a distinction that is very familiar to all lawyers dealing in criminal law.

6.195 Unfortunately, the presiding officer did not seem to appreciate either this distinction or the full import of the cases that he was referring to. Although Chief Constable Price quoted the authorities involved, he treated the decision to be made as a **factual** one. The determination was, however, a **legal** question. This is best illustrated by reference to an ordinary criminal trial before the Crown Court. The jury determine all factual issues, while the judge determines all matters of law: it is the judge who rules on whether there is a case to answer, in the absence of the jury. As a result of this misunderstanding, Chief Constable Price applied the wrong standard in making his decision, which is demonstrated when he went on in paragraph 4 to add that:

“the Presenting Officer at this stage must be able to demonstrate that he has shown neglect beyond reasonable doubt for each of the officers”.

6.196 The presiding officer proceeded, throughout the judgement, to apply the ‘beyond reasonable doubt’ test to each element of the prosecution’s approach. He found, in each case, that they had not reached that standard.

6.197 C/Supt Everett accepted, in interview with the IPCC, that his response to the submission had simply been to tell the presiding officer that his case was as he had stated it.

6.198 In any case in which the tribunal rules that there is a case to answer, the presentation of defence evidence may result in the case being ‘answered’ and the prosecution evidence being contradicted. The defence evidence may, in some instances, actually serve to strengthen the prosecution case, particularly if it is subjected to effective cross-examination. The determination of guilt against the appropriate standard of proof (being in this case and in all criminal cases ‘beyond reasonable doubt’) then takes place in the context of all of the evidence. It is not appropriate to try to make that decision at the close of the prosecution case, on the assumption that the defence case can only improve its own position and weaken that of the prosecution.

6.199 In considering whether there was a case to answer, one need only look at the pronouncements of previous courts that had considered the various cases against the officers. The inquest jury had been directed, correctly, as to the law and had returned a verdict (beyond reasonable doubt) that the actions of the officers constituted gross negligence, as a basis for unlawful killing.

6.200 The Divisional Court that carried out the judicial review of the inquest verdict specifically considered submissions based upon the case of *R. v. Galbraith*. It concluded that there was a proper case for the jury to

answer. In that hearing Mr Justice Jackson quoted the summary of the coroner when he considered possible breaches of duty.⁷⁰⁶ He identified the placing of Mr Alder face down as being a potentially negligent act and identified a series of omissions as being other areas of potential negligence:

“...they include not putting him into the recovery position, not checking his airway, not checking his pulse, not seeking to rouse him, not speaking to him for that purpose, not realising from his breathing noises that he was in danger and not giving aid and not telephoning the ambulance until too late. You may find other possible areas of negligent omissions.”

6.201 Mr Justice Jackson then went on to list eight arguments raised by the counsel for the officers, Mr Ferm, as to why those were not potential breaches, but dealt with them,⁷⁰⁷ saying:

“other factors existed which militated towards a finding of gross negligence. First, and most obviously, the video film is a telling piece of evidence. It shows the police officers standing in the foreground discussing what charges may be brought against Mr Alder. No attention is paid to Mr Alder himself who is lying prone and unconscious upon the floor. The need to put Mr Alder in the recovery position, to check his airways and so forth, may be regarded as basic matters of first aid with which any police officer should be familiar.”

6.202 He went on to observe that:

“the passage from the summing up which sets out possible breaches of duty (quoted earlier in Part 5 of this judgment) is not criticised as it stands. The claimants accept, as they must, that it was open to the jury to find proved each of the breaches of duty enumerated by the Coroner.”

6.203 In essence the judge was saying not only that it was clear that there were breaches of duty, but that counsel for the officers did not argue and could not argue otherwise; the issue at inquest was, given that there were clearly matters that could be categorised as breaches of duty, did those breaches amount to gross negligence?

6.204 Similarly, at the trial, Mr Justice Evans dealt with the behaviour of the officers. It should be noted that Mr Justice Evans made it clear that he had not read the judgement of Mr Justice Jackson from the judicial review of the inquest. In his judgement he set out the factors that had to be considered for manslaughter:

⁷⁰⁶ Inquest Day 32, pp.21–2

⁷⁰⁷ Judgement of Jackson J. (9 April 2001) CA005 [00050286]

“In order to prove manslaughter the Prosecution must prove, in relation to each defendant, firstly, that the defendant whose case they are considering owed a duty of care to Christopher Alder. Secondly, that under the ordinary principles of negligence the defendant breached that duty. Thirdly, that the negligence caused death and, fourthly, that the negligence amounted to gross negligence in that it was so bad as to amount to a criminal act or omission.

The Defence concede that there is evidence for a Jury to consider in respect of elements A, B and D, but submit that there is no evidence upon which a Jury, properly directed could be sure that the necessary causative link with death exists.”

6.205 Therefore at the trial, for the purposes of submissions, the defence on behalf of the five officers **conceded** that there was evidence for the jury to consider (‘a case to answer’) in respect of there being a duty of care, in respect of that duty of care being breached and in respect of that breach potentially amounting to gross negligence. Such an important concession could not have been made except on instructions from the officers. It does not amount to agreement that the duty or breach was proven; it is, however, an agreement that there is evidence of such duty and breach.

6.206 The issue for the trial judge was, given the concession that there was evidence capable of supporting that position, if that evidence were accepted was it capable of proving manslaughter? As is known, it proved not to be, which led to the end of the trial; this was not an issue that needed to be proven for the purposes of the disciplinary hearing. The breaches of police duty, and the duty of care discussed in the context of manslaughter, were based upon the same acts and omissions by the same officers as were being considered by the tribunal.

6.207 The fact that evidence supporting breaches of duty was identified by the coroner and was confirmed as being correctly identified by a High Court judge does not seem to have been argued before the presiding officer. Similarly, the fact that the very officers before the tribunal had actually conceded that there was a case to answer on the same evidence of breach of duty before a second High Court judge does not seem to have been considered. The acquittal of the officers on charges of manslaughter was irrelevant to the consideration of the tribunal, as that decision was taken purely on the lack of evidence of causation.

6.208

***6 lines and 1 footnote redacted
Legal and Professional Privilege***

6.209 Although it could not be said that the findings of two earlier High Court hearings bound the tribunal as any form of precedent, it is difficult to see how the presiding officer could ignore those decisions in making a decision on effectively the same issue, one purported to be based upon case law. The concessions made on these points in those earlier hearings would have provided a strong basis for a lawyer to argue that there was a case to answer on the disciplinary hearing.

6.210 In discussion with Chief Constable Price, it was pointed out to him that his ruling at the close of the presenting side's case was made under a misapprehension. To his credit, Chief Constable Price conceded that he now recognised it as such. He expressed frustration at the lack of legal representation and at the fact that he had not received legal advice after the first two days of the hearing. He made it clear that he had been anxious to have advice but that, despite an approach he had made to Humberside Police, the force was not prepared to reverse its decision to deny legal representation to the officers. For this reason, the view taken was that legal advice was also not available to the tribunal.

6.211 Ms Hawkins of the PCA had been present at the hearing, and in interview with my staff she indicated that she was surprised by the outcome. She answered:⁷⁰⁸

A. "I thought it was a shame that it was Andy presenting it because I felt this isn't what Andy's job is and you know I would have liked to have had a lawyer who would have made better use of the evidence that we had...and I was deeply disappointed that it didn't go beyond half way...Um and I don't understand that – truly I don't understand that outcome.

Q. Have you had an opportunity to view the finding by Sean Price?

A. Yes – yes I still didn't understand it after I had read that."

6.212 She went on to say that the tribunal hearing was the only one that she had attended, and she stated:⁷⁰⁹

"I felt very tense about this whole thing and facing these officers who thought they never should have been brought there and I was responsible for bringing them there – so all I can recall about it is that I felt that the evidence could have been presented differently and more forcefully than it was presented...So I don't recall exactly the content of the evidence and I had no need to take notes because again it had finished for me and all I can recall is that it didn't feel as powerful as I thought it could be."

⁷⁰⁸ Sally Hawkins interview (15 March 2005) CA0121 Tape 2 p.18 [01210055]

⁷⁰⁹ Sally Hawkins interview (15 March 2005) CA0121 Tape 2 p.20 [01210057]

6.213 Ms Hawkins, in interview with my staff, reflected upon her impressions of the process, and she observed that:⁷¹⁰

“The thing that has most come out of this for me is that the gap between how police officers can view – you know you can look at a set of circumstances and police officers will look at that and say well that looks fine to me and a member of the public will look at it and will say that that doesn’t look fine to me and it’s that gap in understanding and that what most struck me about the whole process was that as the Senior Officers in Humberside were looking at this – they didn’t look at it from a public interest point of view at all – they only looked at it from – well if I was that PC I you know – I wouldn’t have roused him because I’m used to dealing with drunks – you know it’s that kind of approach that didn’t feel itself accountable to the public somehow.”

Post-hearing correspondence

6.214 On 24 September 2003 DCC Love sent a letter to Harrison Bunday, inviting Janet Alder to meet with the Humberside Police “to discuss all that has occurred over the last five years”.⁷¹¹

6.215 DCC Love referred to an earlier letter of 3 July 2003 in similar terms (no copy of which appears in the files available to us). Harrison Bunday acknowledged the letter on 30 September⁷¹² and wrote more fully on 10 October.⁷¹³ At that stage they said:

“Our client is of the view that it would not be appropriate in all the circumstances to have a meeting, particularly at this point in time when civil proceedings are ongoing and there may be further Public Review of the events concurring [sic] her brother’s death. However thank you very much for making the offer. At some future time it might indeed be possible to take it up.”

6.216 Subsequently a letter was sent to DCC Love from the solicitors Deighton Guedalla on 3 December 2003:⁷¹⁴

“Your correspondence with Janet Alder has been referred to us. As you know, we are the solicitors representing Janet Alder in relation to the Humberside Police. Perhaps you could tell us why it was that you did not seek to contact us first.

⁷¹⁰ Sally Hawkins interview (15 March 2005) CA0121 Tape 2 p.27 [01210064]

⁷¹¹ Humberside Police letter (24 September 2003) CA0065 D93 [00650154]

⁷¹² Harrison Bunday letter (30 September 2003) CA0065 D94 [00650153]

⁷¹³ Harrison Bunday letter (10 October 2003) CA0065 D95 [00650152]

⁷¹⁴ Deighton Guedalla letter (3 December 2003) CA0065 D97 [00650150]

We have considered your letter with our client. So that we can make an informed decision as to your offer, we would be grateful if you could let us know what it is you would seek to achieve from a meeting, what issues you would wish to discuss and what information you would wish to give to our client.”

6.217 Both Harrison Bunday and Deighton Guedalla were acting for Ms Alder at that time. As far as I am able to ascertain, no meeting between Ms Alder and Humberside Police ever took place.

CHAPTER 7: WAS RACISM A FACTOR IN THE DEATH OR HANDLING OF THE CASE OF CHRISTOPHER ALDER?

Introduction

- 7.1 From the earliest stages of the Review, I have been conscious of the need to consider the possibility that racism may have played a part in the events leading up to and surrounding the death of Christopher Alder. The lessons that were learnt from the Lord Macpherson report into the death of Stephen Lawrence were only to emerge after the death of Mr Alder, although Mr Lawrence died nearly five years earlier. Nevertheless, I think it is helpful to view the events in Hull in 1998 in the light of knowledge and understanding that later events have developed, but great care has to be taken in applying this to judgements about individuals.

The Stephen Lawrence Inquiry

- 7.2 The interviews of the five officers, in May 1998, all took place before the Stephen Lawrence Inquiry and therefore the guidance provided by that report would not have been available to the West Yorkshire police officers. Since the Stephen Lawrence Inquiry there has been the opportunity for greater awareness among the wider policing community regarding unconscious racism and the need to take a proactive stance to tackle racist behaviour and attitudes. Of course, even now, much remains to be done.
- 7.3 I am struck by parallels between the some of the problems identified by the Stephen Lawrence report and the present case. The original Kent Police investigation into the handling of the Stephen Lawrence case resulted in Metropolitan Police Service (MPS) officers being questioned. The report recorded (paragraphs 6.2–6.3) that:

“Each of 17 officers interviewed by Kent was baldly asked whether his or her ‘judgement and subsequent actions were based on the fact that Stephen was black’. In some cases Mrs Lawrence’s condemnatory words about the lack of first aid were quoted to the officers. Each officer roundly denied racism or racist conduct. Each officer plainly and genuinely believed that he or she had acted without overt racist bias or discrimination. The answers given were thus predictable.

In this inquiry we have not heard evidence of overt racism or discrimination, unless it can be said that the use of inappropriate

expressions such as ‘coloured’ or ‘negro’ fall into that category. The use of such words, which are now well known to be offensive, displays at least insensitivity and lack of training. A number of officers used such terms, and some did not even during their evidence seem to understand that the terms were offensive and should not be used.”

7.4 The same approach of a ‘closed’ question was used in this case, and each received the predictable reply. Similarly, there was no identifiable evidence of overt racism on the part of the officers.

7.5 Lord Macpherson describes at paragraph 6.17 how unwitting racism can develop:

“Unwitting racism can arise because of lack of understanding, ignorance or mistaken beliefs. It can arise from well intentioned but patronising words or actions. It can arise from unfamiliarity with the behaviour or cultural traditions of people or families from minority ethnic communities. It can arise from racist stereotyping of black people as potential criminals or troublemakers. Often this arises out of uncritical self-understanding born out of an inflexible police ethos of the ‘traditional’ way of doing things. Furthermore, such attitudes can thrive in a tightly knit community, so that there can be a collective failure to detect and to outlaw this breed of racism. The police canteen can too easily be its breeding ground.”

7.6 Lord Macpherson goes on to define racism in general terms and ‘institutional racism’ as follows:

“‘Racism’ in general terms consists of conduct or words or practices which advantage or disadvantage people because of their colour, culture or ethnic origin. In its more subtle form it is as damaging as in its overt form.” [6.4]

“‘Institutional Racism’ consists of the collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantage minority ethnic people.” [6.34]⁷¹⁵

This definition provides a standard against which the treatment of Mr Alder can be considered. I use Lord Macpherson’s discussion of these issues to consider the actions of the officers who were in contact with Mr Alder on that night. It was not within my terms of reference to

⁷¹⁵ www.archive.official-documents.co.uk/document/cm42/4262/4262.htm

consider to what extent these behaviours were typical of the force as a whole either then or now.

Police Complaints Authority guidelines for investigating allegations of racially discriminatory behaviour

- 7.7 In July 2003, the Police Complaints Authority (PCA) published its *Guidelines for Investigating Allegations of Racially Discriminatory Behaviour*. These set out much more sophisticated guidance for dealing with this kind of allegation than existed previously.
- 7.8 The PCA guidelines use assistance from the case of *King v. Great Britain-China Centre of 1991*,⁷¹⁶ which suggested the criteria against which the existence of racist attitudes could be assessed and in which guidelines for such cases were set out. These were:
- difference in treatment;
 - difference in race;
 - detriment for the complainant; and
 - no explanation for these differences being available.
- 7.9 This formula (known as Dx3+E) provides a further test against which the treatment of Mr Alder can be measured.

Language used

- 7.10 The population of the city of Kingston upon Hull includes a far smaller percentage of visible minority ethnic people than is to be found in many other UK cities of similar size. The police officers involved in the events surrounding Christopher Alder's death would have had little impetus to think through and develop their own attitudes to race or to have their own assumptions and prejudices challenged.
- 7.11 The language used by the arresting officers to describe Mr Alder was the first indicator of this: PC Blakey and Acting Police Sergeant (A/PS) Ellerington both described him as "coloured", and Police Sergeant (PS) Dunn described him as being "of negroid appearance".
- 7.12 The language and descriptive phrases used were inappropriate and unacceptable, even if, as I accept, they were not used to be deliberately insulting about Mr Alder.
- 7.13 There is no incidence of overtly racist language in the custody suite, and no reference to the racial origin of Mr Alder over the radio before he is brought into the custody suite. Having had a full forensic analysis of the discussion at 05.45 on the CCTV audio track, I am now satisfied

⁷¹⁶ *King v. Great Britain-China Centre* [1991] IRLR 513 CA

that the language used did not include the overtly racist phrases that have subsequently been alleged and was not intended to be insulting to Mr Alder.

- 7.14 I believe that monkey noises were made in the custody suite by Sgt Dunn before midnight on 31 March 1998, and that similar noises were made following PC Barr's complaint about wearing a blue forensic suit. I am strongly of the view that a custody sergeant on duty should have appreciated, even in 1998, that making monkey noises as a form of joke had the potential to be offensive and was likely to be perceived as racist and offensive whether or not it was intended to be insulting to any individual. The fact that he was mocking a drunken detainee and the noises were repeated as Mr Alder's body lay on the custody suite floor adds to the impression of insensitivity and callousness. I find it difficult to believe that police officers did not know the connotations of these sounds. Similarly, the use of expressions such as "banana boots" are inappropriate and risk offending individuals – as has been illustrated only too clearly in this case.

Assessment

- 7.15 It appears to me that there are a number of aspects of the behaviour of the officers that suggest that unwitting racism, as described by Lord Macpherson, may have influenced the way in which Mr Alder was treated. Addressed singly, all of these matters might have a reasonable explanation; taken together, in my view they amount to a pattern of "processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping", which further stacked the odds against Mr Alder that evening. This pattern included:
- The assumption at both the Waterfront Club and later at the hospital that Mr Alder was suffering from the effects of amphetamines, steroids or alcohol and the way in which this view persisted despite evidence to the contrary, while the effects of the head injury were not given sufficient weight.
 - The willingness to believe that he was unhurt despite having been severely struck.
 - The willingness to attribute his problems to a "bad attitude" on his part, rather than to any physical injury.
 - The suggestion in the police station that Mr Alder was "mentally disabled".
 - The reluctance to touch or rouse him once at the police station.

- The language used and referred to above: “coloured” and “of negroid appearance”.
- The monkey imitations, the reference to a hood with slits and banana boots, which referred to the forensic overclothing, none of which were directed at Mr Alder yet all of which show an alarming insensitivity.
- The rapid change in perception of Mr Alder from victim of crime to potential threat – I understand how his behaviour contributed to this but I am concerned at how easily it seemed to have occurred.

7.16 These factors, I believe, reflect a set of stereotypical assumptions and attitudes based on Mr Alder’s colour, and these assumptions and stereotypes are likely to have influenced the care – or lack of it – with which Mr Alder was treated. The adverse assumptions made are typical of those made about minority ethnic people, and the use of inappropriate language bears this out.

7.17 I have not, of course, had the opportunity to question the officers concerned directly about these matters. In these circumstances, I can do no more than draw the conclusions that seem most likely to me on the evidence I have available. Such conclusions cannot be said to be reached ‘beyond reasonable doubt’, but rather on the ‘balance of probability’.

7.18 I conclude that the treatment of Mr Alder did indeed reflect the definition of “unwitting racism” described by Lord Macpherson. There is evidence of the “lack of understanding, ignorance or mistaken beliefs and well intentioned but patronising words or action” that Lord Macpherson describes. I believe we can see in the treatment of Mr Alder “processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantage minority ethnic people”, and I believe this did lead to a failure by these officers to “provide an appropriate and professional service” to Mr Alder because of his “colour, culture or ethnic origin”.

7.19 Applying the test set out in the PCA guidelines, I believe there was “difference in race”, “detriment” for Mr Alder and “no explanation for these differences being available”. I cannot say for certain that a white prisoner with similar injuries would have been treated differently and better. Indeed, it has been suggested that the treatment of Mr Alder was typical of what might be found in many custody suites. This is a disturbing conclusion and not one supported by the police investigators who have viewed the CCTV footage and have advised me. On balance, I think the treatment of Mr Alder was not typical. There was “difference” in his treatment.

The investigation

- 7.20 The possibility that the actions of the officers might have been racially motivated was considered by Mr Elliott of the PCA at an early stage, and he took informal advice from two experienced police officers. Neither officer was asked to commit their thoughts to writing but both were asked independently of each other to view the extract of video of Christopher Alder at the police station. Both officers were asked to advise on policing generally and how detainees were treated. Mr Elliott interpreted their advice by concluding that the behaviour of the officers was poor, but was likely to have been as poor for a white detainee as it was for this particular black detainee.
- 7.21 While taking this advice into account, I bear in mind that the officers who provided the advice saw only the video of the custody suite and could not necessarily place it in context. I consider the behaviour and language of the officers taken as a whole to be relevant.
- 7.22 I regard the single question concerning his race, asked of each police officer, as being of little use in determining the truth about the attitudes of the individual officer. At the same time, it seems reasonable to conclude that each officer probably felt that they were telling the truth when answering it, and that they believed themselves to be without any prejudice to Mr Alder.
- 7.23 Ideally, these are all matters that we would wish to have questioned the officers about, but this has not been possible. In my view, the behaviour of the officers revealed a clear need for greater training on the part of custody officers and constables.
- 7.24 The PCA and Humberside Police recognised in their assessments that the attitudes of the officers were unacceptable. I have gone further in my own conclusions. However, ultimately events overtook the proposed “advice” that would have been given to the officers concerned.
- 7.25 I have also considered to what extent the dealings of the police and other agencies with the family of Mr Alder were influenced by racism in any way. This was alleged by Ms Alder of both the PCA and the Crown Prosecution Service (CPS). As I have described, there were clearly difficulties in the relationship between Ms Alder and the police, the PCA and the CPS. However, I have not found any evidence to support her allegations of racism.
- 7.26 I have also noted that in the civil hearing in January 2006 to consider Mr Paul’s arrest and subsequent detention, Mr Recorder Ekins ruled that there was no evidence to suggest that Mr Paul had been denied bail because he was black as had been alleged.

Subsequent progress

- 7.27 I am grateful for the assistance extended to this Review by Mr Adil Khan of Humberside Police, who now acts as the Community Race Relations Officer for Humberside Police. Mr Khan was able to point to education now provided to officers as to appropriate use of language, together with religious awareness. I understand that there has also been human rights awareness training.
- 7.28 More recently the Humberside Police Race Equality Scheme for 2005–08 has been launched. Although this is still in its early stages, I hope that this bodes well for the future development of racial awareness in the force.
- 7.29 I am aware of other studies and reports that have been conducted into the issue of race relations in Hull. It is not part of my role in this report to form any conclusions or to pass comment upon the state of racial awareness in the city or in the Humberside Police. Racism is a problem encountered throughout the UK, and is being recognised and addressed by police forces countrywide. Although the evidence considered in the course of this review points to possible unwitting racism in the treatment of Mr Alder, I recognise that this of itself does not point to institutional racism on the part of the force.
- 7.30 It is not my intention, nor within the terms of reference of this Review, to cover ground that has already been thoroughly covered by the Lord Macpherson report. However, the causes for concern arising from the events surrounding the death of Mr Alder and other matters identified in the course of this review suggest that, even after the passage of several years, that report still deserves consideration and has many lessons that are still to be learnt.

CHAPTER 8: CONTACT WITH THE FAMILY OF CHRISTOPHER ALDER

Introduction

- 8.1 This chapter addresses the contacts between the various authorities and the family of Christopher Alder. This largely falls under the heading of 'family liaison', although it extends somewhat wider than that. Mr Alder's two siblings who became involved in the investigation into his death were Richard Alder and Janet Alder. The Police Complaints Authority (PCA) was also contacted once by a cousin of his named Tracy. Finally there was contact with Mr Alder's two sons, Leon and Kelvin Wilson, made through their mother, Nicola O'Brien.
- 8.2 I do not deal in this section with the substantive criticisms or allegations that the family made regarding the death or the handling of Mr Alder's case, but rather with the complaints regarding the way that they were treated and the response of the police to family requests. This is relevant in so far as it reflects the handling of a relative of a deceased person, and therefore falls within the terms of reference of this Review.
- 8.3 I deal below with each family member in turn, but it would be useful first to consider the pattern of family liaison into which these contacts fall.

Family liaison

- 8.4 From the early hours of the investigations into the death of Mr Alder, Humberside Police decided to appoint officers to deal with family liaison. Such officers are designated 'family liaison officers' (FLOs), and specialist training is available for the role. The role was shared between two officers in the early stages of the investigation: Detective Constable (DC) Fountain and Police Constable (PC) Beatrice Ogunleye-Smith (mostly referred to as PC Smith). I have seen no details of DC Fountain's qualifications, but PC Smith, while not being qualified as an FLO, was qualified as a 'victim liaison officer' (VLO) to deal with victims of assaults. Both of these officers liaised with Richard Alder, and PC Smith endeavoured to do so with Ms Alder, with less success.
- 8.5 The role of an FLO is to be the first and main point of contact with the victim of a crime, and/or the family of a victim, while the matter is being investigated. This role will often continue through to trial or even beyond. This will involve explaining the criminal investigation and court processes. It may also involve being a conduit for information from the victim or family back to the police as part of the investigation. The role

will vary widely from case to case, and will involve a degree of sensitivity to the needs and vulnerabilities of the people involved.

- 8.6 West Yorkshire Police did not appoint a separate FLO, and Superintendent (Supt) Holt noted that Humberside Police had appointed an FLO. He recorded the contact between that FLO and Richard Alder. He apparently asked that Mr Alder be informed of the PCA involvement.⁷¹⁷ Supt Holt did not have any direct contact with any family member before 27 April 1998.
- 8.7 Mr Elliott of the PCA did become involved in family liaison, and, as set out below, he made contact with each of the family members at some stage. It would appear that he was the sole point of contact for Ms Alder for a period. When asked about this by the IPCC, in preparing this report, he did not believe that he had allowed himself to become the FLO. He did, however, make clear that he had seen family liaison mismanaged by police officers in the past, and was anxious that errors made in other cases should not be repeated here. Supt Holt did not raise any objection to Mr Elliott becoming involved in the family liaison role.
- 8.8 In notes provided to the IPCC, subsequent to his interview, Mr Elliott explained that he had agreed with Supt Holt that the antipathy expressed by Ms Alder to the police meant there was “little to be gained” from arranging any other police FLO to contact Ms Alder.⁷¹⁸
- 8.9 When interviewed by the IPCC, Mr Elliott was asked about his immediate concerns at the outset of the investigation. One of the aspects he mentioned was that of contact with family members:

“That would have been a particular issue, I think, for me because that sort of thing had gone very badly wrong in the past and it was part of the transitional thinking, if you like, for the PCA to try and address that, what was often a very serious gap. So that would have been part of my agenda, to say, well, what are we going to do about that, and what would my role be in that. That’s part of what I’m referring to when I say that at the time at the PCA that was not necessarily what people normally did, it was seen as quite a controversial thing to do, talk to families. It was certainly not approved of particularly. I think I was the first member of the Authority to, as a routine, go to post mortems and then talk to family members about it.”

⁷¹⁷ West Yorkshire policy log (3 April 1998) CA001 D11 [00010371]

⁷¹⁸ Jim Elliott notes following interview (27 May 2005) p.5

Richard Alder

8.10 Richard Alder was the first family member to be in contact with the police. In an internal memo, dated 27 September 2002, Police Sergeant (PS) Ruty of Humberside Police outlined the history of the early contact.⁷¹⁹ This memo, based on the HOLMES records, indicated that Richard Alder contacted the police at 00.15 on 2 April to enquire whether it was his brother who had died. As a result of this, PC Smith, who became the FLO, visited him at home during the morning of 2 April to confirm that it had been Christopher who had died. The memo says that Richard Alder identified the body of his brother Christopher:

“prior to the post mortem which was conducted that afternoon”.

8.11 In fact the memo is incorrect in parts, and incomplete. Following the death of Mr Alder in the early hours of 1 April, the first post mortem examination took place on the afternoon of 1 April between 17.00 and 19.45. This timing is established by various documents, including the report of the post mortem examination itself.⁷²⁰ Richard Alder made a statement dated 3 April 1998 confirming that he had identified the body of his brother on the previous afternoon, 2 April, at 16.30 hours.⁷²¹ PC Smith made a separate statement confirming that the identification was made at that time.⁷²² Richard Alder’s identification was therefore approximately 24 hours after the post mortem examination.

8.12 Richard Alder also made a statement, dated 20 July 2000, which is given the heading of ‘Kingston upon Hull Coroner’s Court’.⁷²³ In that statement he says that he had heard that a black man had died in police custody following a fight at the Waterfront Club. Knowing that his brother went to that club, he had contacted the police on 3 April, and was eventually put through to an officer at Queen’s Gardens police station (given the date quoted in his other statement, and supporting evidence for this, it would appear that Mr Alder must be mistaken as to the date by one day).

8.13 He recalled that the officer to whom he spoke at the time, whom he named as PC Campbell, was rude and offensive to him. However, the officer had told him that a message would be left in the incident room that he had called. The record taken from HOLMES shows that this was done.⁷²⁴ PC Campbell, who entered the HOLMES message, has not made any identified statement.

⁷¹⁹ Internal report (27 September 2002) CA0002 doc. 46 [00020479]

⁷²⁰ Post mortem report of Dr Clark CA0028 [00280051–66]

⁷²¹ Richard Alder statement (3 April 1998) CA007 p.190 [00070191]

⁷²² PC Smith statement (5 April 1998) CA007 p.189 [00070190]

⁷²³ Richard Alder statement (20 July 2000) CA0082 [00820030–3]

⁷²⁴ HOLMES account, Message 18

- 8.14 Richard Alder described seeing PC Smith and another officer the next day, prior to the identification of the body. He recalled making a telephone call to the police station from a telephone box; the police asked him to wait there, and they came to him and drove him home before taking him to Sheffield for the identification. He was to indicate, in the statement made in July 2000 for the coroner,⁷²⁵ that he was suspicious because the description of aggressive behaviour did not fit with his knowledge of Christopher, and he refused to believe that the stitches to his brother's skull were just the result of the post mortem examination.
- 8.15 The post mortem photographs, which were made available to the IPCC, show the normal cuts that are made during such an examination. After the examination is complete, the body is returned, as far as possible, to its normal condition, and cuts made are sewn up.
- 8.16 DC Fountain's notes of the call from Richard Alder are in accordance with Mr Alder's recollection, save that the call was received on the morning of 2 April. DC Fountain confirmed that he and PC Smith went to meet Richard, drove him home and spent some time with him, explaining the facts as they knew them at the time.⁷²⁶
- 8.17 Mr Alder's description of events was that a second visit by the officers came about two days later, and that they gave him a different version of events as to how his brother died. He recalled Supt Holt visiting "on or about the 21st of April" and providing a third version of events, to the effect that his brother:

"had been brought into the custody room, laid on the floor and then fell asleep. They then realised that he was dead."

- 8.18 This was followed by a visit from Mr Elliott the next day. He claimed that Mr Elliott told him that the police were lying and that this upset him and made him suspicious.
- 8.19 Mr Elliott of the PCA recalled in a memorandum of 2003 that he first saw Richard Alder on 2 April, possibly prior to the identification of the body.⁷²⁷ He met with Mr Alder on subsequent occasions, to keep him informed of the progression of events. In particular, they spoke prior to the suspension of the officers in late April. Mr Elliott's visit of 2 April to speak with Mr Alder was not mentioned when Mr Alder made his statement in 2000. Mr Elliott described it in the following terms:

"I did not say to Richard Alder that the police had lied to him. What I did say was that it was not unusual for people to be told things that might appear to be conflicting because a full

⁷²⁵ Richard Alder statement (20 July 2000) CA0082 [00820031]

⁷²⁶ DC Fountain notes CA0068 [00680086-116]

⁷²⁷ Jim Elliott memo CA0002 doc.88 [00020138-44]

investigation had not yet been conducted, and, until it had, we could not be certain of what happened. Similarly, some of the things he had been told had been conveyed by word of mouth through more than one person, and inevitably things would become distorted...somewhere along the line he formed the view that I had told him he had been lied to.”

8.20 In interview with the IPCC, as part of the current review, Mr Elliott made clear that from the outset he regarded liaison with the family of the deceased as a major element of his responsibility, and that his decision to travel to Hull as soon as he practicably could was motivated in large part by this requirement. He was anxious to avoid the confusion caused by partial and incomplete renditions of the facts. He recognised that misunderstanding and suspicion were common factors in the experience of relatives of the deceased following deaths in custody.

8.21 Although two years after the event Richard Alder had described the meeting as being on 21 April, both Supt Holt and PC Smith made notes at the time recording it as being on 27 April. Supt Holt stated in an e-mail to Sally Hawkins, dated 15 January 2003, that:

“I have a Pocketbook record of what I told Richard at his home address on 27 April 1998. The initial record from Humberside was that he had collapsed in the Custody area. I told Richard that he was apparently unconscious from the time he was taken from the Police van. The confusion is down to terminology and reinforces the need to make sure that mixed messages are not given. We are all aware that two people can describe the same incident in different ways.”⁷²⁸

8.22 PC Smith also recorded in her pocket notebook that she had accompanied Supt Holt to see Richard Alder on 27 April and introduced them. She recalls Mr Alder being hostile and disbelieving of Supt Holt.⁷²⁹

8.23 Four years later, in 2002, C/Supt Everett of Humberside Police wrote to the PCA in response to a request for information. (That letter,⁷³⁰ written on 14 October 2002, set out the response of Humberside Police to complaints made by Richard Alder in the statement for the coroner written in July 2000.⁷³¹) His letter indicated that DC Fountain had accompanied PC Smith in meeting Richard Alder. C/Supt Everett said that Stephen Hodgson of Humberside Police had obtained statements from both officers. It has subsequently become clear that, while both officers were spoken to, this was on an informal basis and no written

⁷²⁸ Supt Holt e-mail (15 January 2003) CA0002 doc.95 [00020131-3]

⁷²⁹ PC Smith notes CA0068 [00680149]

⁷³⁰ Humberside Police letter (14 October 2002) CA0064 D3 [00640165-6]

⁷³¹ Richard Alder statement (20 July 2000) CA0082 [00820030-3]

statements were produced. According to the letter, both officers were adamant that, contrary to the description of Richard Alder, neither of them had told him that Christopher walked into the custody suite, as both knew this was not the case.

8.24 The letter continued:

“PC Smith says, for a time, she had almost daily contact with Richard in her capacity as family liaison officer. She says he was ‘extremely concerned’ that the police were hiding something. She says that she did not, nor can she recall any other officer in her presence, tell Richard that Christopher had been standing at the custody desk or sitting in a chair before he collapsed.”

8.25 C/Supt Everett stated that PC Smith recalled being with Supt Holt “on 21 April” when he met Richard Alder (contrary to PC Smith’s own notes that stipulate 27 April), and Supt Holt giving his understanding of what had happened, to which Richard Alder commented that this was yet another version of events. While the description of events may be correct, C/Supt Everett seems to have misinterpreted what PC Smith said about the date.

8.26 Unfortunately, while Mr Elliott had attempted to avoid confusion and misleading impressions, Richard Alder interpreted the explanations offered by the police as being attempts to hide matters from him. The available evidence from the early stages of the investigation would tend to suggest that Mr Elliott was the most senior person to speak to Richard Alder, although Mr Alder had forgotten the earliest contact of 2 April, possibly due to the emotional impact of that day, which he described as being severe. Other than that, Richard Alder spoke only with PC Smith, until such time as Supt Holt met with him.

8.27 PC Smith would necessarily have received information concerning the investigation at one remove, and could not be expected to have the overview of the case that Supt Holt would have had. It is worthy of note, however, that PC Smith appears to have been assiduous and diligent in her duties and spent a considerable amount of time with Richard Alder and his girlfriend in the days following his contact with the investigating authorities. The notebook of Detective Inspector (DI) Brookes makes clear that PC Smith was withdrawn from this duty on 30 April and that he instructed her to have no further contact with the family, as that would be left to West Yorkshire Police.⁷³²

8.28 Supt Holt, in the policy log prepared by West Yorkshire Police, stated that:

⁷³² DI Brookes notes (30 April 1998) CA0068 D108 [00680224]

“The I.O. liaised with the Humberside appointed Family Liaison Officer and requested he [Mr Alder] be informed of the Police Complaints Authority involvement and that direct contact would be made in the near future...The I.O. is of the opinion that in the very early stages of the enquiry next of kin should be allowed to come to terms with their grief before they are appraised of the nature and scope of the Police Complaints Authority enquiry.”⁷³³

- 8.29 It would appear that Supt Holt envisaged the “early stages” as being the first three weeks of the investigation, as there is no indication that he met with Mr Alder before 27 April. It is unfortunate that it was not recognised that coming “to terms with their grief” for family members would be made much easier by knowing the facts surrounding the death of their loved one. If it were appropriate for the family to meet with the investigating officer, it might be thought appropriate to do this at an early stage.
- 8.30 It is worthy of note that, following the unhappy meeting of 27 April, there was a further meeting on 20 May 1998 between Supt Holt, Mr Elliott and Mr Alder, at the offices of solicitors Stamp Jackson and Procter, to discuss progress.⁷³⁴ The same solicitors continued to represent Mr Alder throughout subsequent events, despite breaking their connection with Ms Alder at a later stage.
- 8.31 On 9 December 1998, Alan Johnson MP, the Member of Parliament for Hull West and Hessle, wrote to the Chief Constable of Humberside, Mr D Leonard, saying that he had been approached by Christopher Alder’s parents and asking for a briefing on the case.⁷³⁵ As Mr Alder’s father died in 1981 and his mother emigrated to Nigeria in the 1970s, Mr Johnson was probably mistaken. He may well, however, have been approached by Richard Alder as a constituent, and misinterpreted the relationship between his constituent and the deceased.
- 8.32 The response to the letter was written by David Westwood, who was at that time the Deputy Chief Constable (DCC). DCC Westwood stated that he was dealing with the response because the Chief Constable was ultimately responsible for disciplinary issues and could not correspond in respect of the investigation of such issues.
- 8.33 Unfortunately, DCC Westwood then stated that:

“Christopher was arrested outside the Waterfront Nightclub in Hull following a disturbance during the early hours of 1 April 1998.”

⁷³³ Policy log (2 April 1998) CA0085 PL10 [00850006]

⁷³⁴ PCA file note (20 May 1998) CA1 D158 [00010020]

⁷³⁵ Letter and response both in CA0076 [00760499–501]

- 8.34 Given that the DCC should have had access to the interim report of Supt Holt dated 30 June 1998, and the summaries of evidence prepared by Detective Sergeant Ralphs on both the Jason Ramm and Jason Paul investigations, it is surprising that his letter should have contained such a fundamental error of fact.
- 8.35 DCC Westwood then went on to state that from the point at which Supt Holt was appointed:
- “to conduct an investigation into Christopher’s death...neither I nor any other member of this force has taken any part in that enquiry”.
- 8.36 This statement is also fundamentally incorrect, in that a full investigation into Mr Alder’s death had been run as a murder inquiry by Humberside police officers, and Supt Holt relied heavily on the work done by those officers.
- 8.37 While DCC Westwood was, no doubt, keeping himself separate from any investigation, he also appears to have failed to acquaint himself with the true nature of the large inquiry on which he was purporting to comment. It is scarcely surprising, in light of this, that the Alder family should lack confidence in the information provided to them by Humberside Police.

Janet Alder

- 8.38 Extensive correspondence took place between Janet Alder and the various official bodies involved in the investigation of her brother’s death, in the course of which she raised a number of criticisms. The complaints made by Ms Alder fall into three main categories: the treatment of her brother at the hands of the police; the investigation into the death of her brother (this covers both police forces, the Crown Prosecution Service (CPS), the PCA and other official bodies; and, thirdly, the treatment of herself and other family members by those bodies.
- 8.39 In identifying when particular events occurred, there is occasional confusion as to dates or to days of the week. I attach a calendar for April 1998 at Appendix 1 of this report for assistance.
- 8.40 Ms Alder was not seen by any police officers until Friday 17 April 1998. There is no evidence to suggest that Christopher Alder had any details of his sister’s address or whereabouts on his person, nor that any details were found at his flat. Richard Alder told the police that he believed she lived in Newcastle, which proved to be incorrect. Ms Alder

was traced by PC Smith, via the Contributions Agency (DSS), to an address in Burnley, Lancashire.⁷³⁶

- 8.41 Having identified the likely address of Ms Alder, Humberside Police sent faxed details of the death of Mr Alder to the Lancashire Constabulary at Burnley, who directed PC James North to call at her address. PC North stated that he had passed on the full details provided to him when he called at her home at 23.00 on 17 April 1998.⁷³⁷ He described Ms Alder's reaction as "very hostile and she was extremely upset". He also commented that she expressed surprise that they had managed to find her.
- 8.42 The fax sent by PC Smith to Burnley police station on Friday 17 April⁷³⁸ had said that she was involved in the "investigation of the murder of Christopher Alder", which was still the official view of Humberside Police at that time. Unfortunately, the fax, which was sent at 10.55 on that day, was not acted on for approximately 12 hours, by which time PC Smith had gone off duty for the weekend. The wording of the fax was also ambiguous, in that it said that Mr Alder had been arrested and "died on arrival at police station". This was interpreted by PC North, or whoever passed on the information to him, as meaning that Mr Alder died in police transport. PC North told Ms Alder this.
- 8.43 From telephone records, Ms Alder rang Humberside Police at 01.50 on Saturday 18 April and was unable to reach PC Smith, whose name and number she had been given by PC North.⁷³⁹ A statement by Humberside police officer PC Richard Scott, who was staffing the divisional advice desk at Queen's Gardens police station, recalled that he had received a call prior to 02.00 on an evening around that time (he could not specify the date).⁷⁴⁰ The caller had asked for PC Smith regarding the death of a relative. PC Scott had asked the switchboard to transfer the call to the "death in custody" incident room in D Division (covering the City of Hull). He realised almost immediately that the request was made with the caller still on the line and the line open. The caller, Ms Alder, had said:

"What do you mean, 'Death in custody'?"

- 8.44 In his statement, PC Scott, who recalled the incident when asked about it by PC Smith, apologised for any upset or embarrassment caused by his lack of familiarity with the system. It is unclear whether any apology was offered to Ms Alder that evening.

⁷³⁶ PC Smith notes (20 April 1998) CA0068 D103 [00680134]

⁷³⁷ Statement of PC James North (24 April 1998) CA0095 p.237 [00950230-40]

⁷³⁸ PC Smith fax (17 April 1998) CA0067 D65 [00670277]

⁷³⁹ Log of call from Janet Alder CA0067 D58 [00670267]

⁷⁴⁰ Statement of PC Scott (25 April 1998) CA0095 p.275 [00950276]

- 8.45 The written record of the call, as recorded on the Humberside Police computer, indicates that Ms Alder was very distressed and asking for confirmation as to which brother had died, although she did acknowledge that she had been told it was Christopher.⁷⁴¹ The record shows that PS Kelly was to call her back, although there is no statement available from PS Kelly regarding this. In a letter written by Ms Alder and passed to her MP, she did say that she had spoken to a PS Kelly, who gave her the first description of her brother's death.⁷⁴²
- 8.46 When Ms Alder gave evidence before the inquest, two years later, she said that she had been told that he died in police custody by the original officer who came to her house. She told the coroner that she had called Burnley police station and had been told to contact Humberside Police. She clearly took the view that the information given over the phone then (the officer was not named) was inadequate. She had seen a representative from the PCA who came up from London and subsequently visited Hull.
- 8.47 The representative from the PCA who visited her was Mr Elliott, who describes having seen Ms Alder about three weeks after the death of her brother. She was first contacted by Lancashire Police late in the evening of Friday 17 April; she describes having seen the PCA representative before she went to Hull. Other records show her being in Hull on Tuesday 21 April, and she was to describe going to Hull on the Tuesday and staying until Friday. However, Mr Elliott's later note of his initial meeting with her stated that he saw her after she had already been to visit Humberside Police. He said that:

“She had already visited Humberside Police and this had been a difficult and unpleasant experience for her.”⁷⁴³

- 8.48 Mr Elliott described her earliest responses in a subsequent file note for the PCA:

“It was clear from the start that Janet Alder believed that the conduct of Humberside Police towards her brother was motivated by racism. This was stated when I visited her at home in Burnley. Her opening position was that the officers had engineered the confrontation at the Waterfront Club in order to get Christopher Alder to the Police Station where they could murder him. In her opinion this was because he was black. She was also intensely suspicious of me and saw the PCA and me as part of a conspiracy to cover things up.”⁷⁴⁴

⁷⁴¹ Log of call from Janet Alder CA0067 D58 [00670267]

⁷⁴² Janet Alder letter CA001 D32 [00010272]

⁷⁴³ Jim Elliott letter (30 March 2004) CA0060 [00600023]

⁷⁴⁴ PCA file note (undated) CA002 D88 [00020166]

- 8.49 Mr Elliott confirmed this to the IPCC in interview,⁷⁴⁵ and acknowledged that dealing with Ms Alder's opening position was difficult. This initial view was to influence all subsequent interaction between Ms Alder and the police and authorities.

Meetings with Humberside Police

- 8.50 The first written record of Ms Alder's experience in Hull was in an undated letter sent to her MP, Mr Peter Pike, and forwarded to the PCA by Mr Pike on 26 June 1998. In that, she dealt with the explanations given to her by Humberside Police. She related the first explanation that was given by PS Kelly on the telephone (she did not specify the date). He had said to her that:

“Christopher had been involved in a fight outside of a nightclub he had been taken to hospital and refused treatment he then told me he had been arrested by the police from the hospital, they didn't have chance to get him to the Custody Suite and at this point he collapsed and died.”

- 8.51 PS Kelly had told Ms Alder that he was reading the details from a card, as he was not personally present at the events. Ms Alder then described having travelled to Hull and attending a police station on Tuesday 19 April. In fact, the Tuesday of the week following her notification was 21 April. It seems from other evidence I have seen that the visit did take place on Tuesday 21 April.
- 8.52 DI Brookes was, according to his notes, the person who met with Ms Alder at Queen's Gardens police station in Hull on Tuesday 21 April 1998.⁷⁴⁶ She had come to the front desk in the foyer of the building and asked to speak to the officer in charge. DI Brookes met with her, and at her request he gave her an account of the events leading to the death of her brother, as known to him at the time. Ms Alder told the inquest in 2000 that this version was:

“Your brother was taken into custody and he was sat next to a policeman and he collapsed.”

- 8.53 This description is very similar to the second version described by Richard Alder in his statement of 20 July 2000.⁷⁴⁷ It also reflects the inaccurate summary given to West Yorkshire Police when they first attended Hull, as described by Inspector (Insp.) Tolan. By the time Ms Alder was spoken to by Humberside Police, this misunderstanding should have been sorted out, but the description from Ms Alder suggests it had not been. DI Brookes' notes do not give details as to

⁷⁴⁵ Jim Elliott interview Tape 2 p.5 [01100036]

⁷⁴⁶ DI Brookes notes CA0068 D108 [00680217–20]

⁷⁴⁷ Richard Alder statement (20 July 2000) CA0082 [00820030–3]

how he described the events, and there is no indication that any other person was present.

8.54 Ms Alder also described this meeting in an undated letter written to her MP, Mr Peter Pike, which he forwarded to the PCA under cover of a letter dated 26 June 1998.⁷⁴⁸ In that letter Ms Alder stated that on the Tuesday she had met with DI Brookes in Hull. She went on to outline the details given to her. The explanation that Ms Alder described DI Brookes as giving her appears to be largely correct, although she stated that DI Brookes told her that her brother “assaulted a hospital worker”.

8.55 She went on to say that DI Brookes told her initially that Mr Alder had arrived at the police station at 03.46, which was accurate, but later, having “called the incident room to check on the times”, told her it was 03.05, which was incorrect. She does not describe his explanation as to the state of her brother on arrival at the station.

8.56 In March 1999, she characterised this interview in an address to the National Civil Rights Movement⁷⁴⁹ in the following terms:

“The first policeman...said to me ‘your brother went to a nightclub, had a fight and due to the fight he died in police custody’.”

8.57 Ms Alder has mentioned on a number of occasions that the first officer she met at Humberside Police had been chewing gum when he told her about her brother’s death. This has never been raised as a formal complaint with Humberside Police, and DI Brookes’ notes do not record Ms Alder complaining about it at the time, although it has been stated to a number of other parties. It first arose in her letter of June 1998 to Mr Peter Pike MP when she said that “Detective Brookes” had been chewing gum while telling her about her brother.

8.58 The issue was subsequently mentioned in 1999 to the National Civil Rights Movement, in an article in the *Independent on Sunday*⁷⁵⁰ immediately before the inquest, and as part of her inquest evidence⁷⁵¹ (although attributed to “Detective Davidson” [sic] on that occasion). It was also raised in an interview with the *Socialist Worker* on 24 April 2004.⁷⁵² On some occasions she stated that the officer sat back with his hands behind his head, although this aspect was not mentioned in the initial description of the event. The raising of this issue on several occasions suggests that this was something that made a lasting impression on Ms Alder.

⁷⁴⁸ Peter Pike MP letter and attachment CA0001 docs 31 & 32 [00010271–80]

⁷⁴⁹ NCRM website: www.ncrm.org.uk/campaigns/alder.html

⁷⁵⁰ *Independent on Sunday* article (2 July 2000) CA58 D22 [00580124]

⁷⁵¹ Inquest Day 1, p.29

⁷⁵² *Socialist Worker* article (24 April 2004) CA004 D25 [000400226]

8.59 DI Brookes was asked about this matter when spoken to by the IPCC:

Q. She suggests that you were chewing gum, and she found this offensive. Were you?

A. I might have been, or perhaps eating a sweet. It was not intended to be offensive.

8.60 Ms Alder was also to complain about her first meeting with the senior officer on the Humberside Police investigation, Supt Bates. This complaint also arose in her June letter to Mr Peter Pike MP. In that letter she said that she had met him on the Friday of the week she spent in Hull, which would have been 24 April. She described her meeting as follows:

“On entering the office I then informed Detective Bates that there were various outside organisations willing to support my family on this and I had heard so many different stories, at this point Det. Bates became very intimidating by rolling his chair over to me and informing me ‘we don’t deal with outside organisations, we deal with the family’. I at this point reminded him I was family and there were questions that I wanted answers to. He then said to me if you are going to be like that you can leave now. At this point I felt there was no need for me to get into an argument with him as I was at no fault so I decided to leave. On leaving the office Sergeant [sic] Ken Bates then told me he would deal with my brother Richard as he could talk to him. At this point I informed Sgt Bates that he would find Richard would not talk to him anymore and any communication from then on would go through our solicitor. Sgt Bates then told me ‘we don’t deal with solicitors’ and then in the next breath asked me who my solicitors were. I walked out without saying anymore.”

8.61 The notes of PC Beatrice Smith, who was present at the meeting, reflected the heated exchanges in the meeting, but with a different emphasis:

“As soon as we entered the room she stated that she wanted some answers re questions that she had. The 1st question was about some conflicting statements in the press. Supt Bates explained to Alder that the police has no control over the press & that whatever was printed wd have been as a result of the press investigation. Alder then began to write & she then said I have some questions here which I’d like to be answered on behalf of the orgs that I represent. Supt Bates then stated that, he will speak to her as the sister but not as a representative of an org. Alder then stood up & said I will be speaking to you via

my Solicitor. When asked the name of the solicitor she refused to ans.”⁷⁵³

- 8.62 Detective Supt Bates was asked about this issue in interview with the IPCC.⁷⁵⁴ He expressed some strong views on Ms Alder:

“I remember Janet was very difficult...She did not want a black police officer as a VLO for whatever reason. Right from the start Janet was aggressive, abusive. She kept throwing the race card in right from the off. And yet, she had had nothing to do with Christopher. Suddenly Janet was on a platform. She saw, I am quite certain, she saw Christopher as a vehicle she could use to further her own political views, anti-police views. And she did and has.”

- 8.63 Supt Bates also recalled something of the meeting with Ms Alder. He agreed that Ms Alder had wanted him to provide information to an organisation:

“She wanted, she definitely wanted me to, she, (a) she distrusted, it was quite obvious she distrusted the police generally, she wanted all information, she didn’t want Beatrice involved, she didn’t like Beatrice. She didn’t like Beatrice and she didn’t like the fact that Beatrice was black, that was, that was very evident, and she wanted this organisation, and I cannot remember for the life of me what the organisation was, although I will have made a note in my pocket book of it, she wanted all communication between the police and her to go through this organisation, and I cannot remember for the life of me what it’s called, I wish I could. But she certainly, it was an organisation that she was involved in and had friends in and had lawyers in, and she wanted all information to go through this organisation so that they could look after her interests.”⁷⁵⁵

- 8.64 In her letter to Mr Peter Pike MP, Ms Alder claimed that when she left the police station she was followed by police officers. Her letter alleged that an officer stood outside a shop into which she had gone and took notes. Mr Pike was to mention this to the PCA in a letter of 3 March 1999:

“She feels her phone calls and mail are being interrupted – I am sure that this is not correct but is a result of the pressure she feels under. Her other brother was arrested – unjustifiably in her view – and was charged with affray.”⁷⁵⁶

⁷⁵³ PC Smith notes (24 April 1998) CA068 [00680143–4]

⁷⁵⁴ Supt Bates interview Tape 2 p.5 [01320032]

⁷⁵⁵ Supt Bates interview Tape 4 p.13 [01320089]

⁷⁵⁶ Peter Pike MP letter (3 March 1999) CA001 D77 [00010196]

- 8.65 That letter includes her claims that her mail was being interrupted and her telephone tapped. Supt Bates was asked about these allegations and dismissed them as being wholly untrue.
- 8.66 Ms Alder's relations with the police appear to have gone downhill very rapidly after these initial meetings with them. Mr Elliott made a file note dated 23 April relating to his first contact with Ms Alder,⁷⁵⁷ and saying she "has involved Inquest", which may well refer to the organisation of that name. It is not clear whether this is the same organisation that Ms Alder mentioned to Supt Bates. Mr Elliott also notes that:

"the IO will be meeting the family on Monday evening".

The following Monday would have been 27 April, when it is known that Supt Holt did have a meeting with Richard Alder.

- 8.67 Ms Alder contacted her local MP, Mr Peter Pike, and his initial letter points to her having called him in the week following her notification of the death, and having seen him in person on Saturday 25 April. He wrote the first of many letters to Humberside Police on 29 April, addressed to the then Chief Constable, Mr Leonard.⁷⁵⁸ In that letter he states that

"She is deeply distressed and concerned at the position regarding her brother. She now believes he was murdered."

- 8.68 The PCA files show a letter prepared by Mr Elliott (dated only "May 1998"; Mr Peter Pike MP acknowledged their "letter of 19 May") in response to Mr Pike's letter, explaining the efforts made by Mr Elliott to keep the family informed and offering to discuss the matter further with Mr Pike.⁷⁵⁹
- 8.69 In a letter to Mr Elliott of the PCA dated 3 March 1999,⁷⁶⁰ Mr Pike, writing on behalf of Ms Alder, indicated to Mr Elliott that:

"she complains strongly that she is being harassed by the Hull Police. She was offered a 'black' liaison officer but feels this was an unnecessary move – she feels quite strongly that this move was inappropriate."

- 8.70 Mr Elliott responded by a letter of 8 March, and pointed out that he was aware of these issues raised by Ms Alder. Ms Alder had, of course, made clear to PC Smith at an early stage that she did not wish to avail herself of the services of an FLO, and was unhappy that Humberside Police had appointed a black officer to that role. PC Smith respected

⁷⁵⁷ PCA file note (23 April 1998) CA001 D159 [00010019]

⁷⁵⁸ Peter Pike MP letter (29 April 1998) CA001 D17 [00010356]

⁷⁵⁹ PCA letter (May 1998) CA001 D18 [00010355]

⁷⁶⁰ Peter Pike MP letter (3 March 1999) CA001 D77 [00010196]

the decision of Ms Alder, and, indeed, following the decision of West Yorkshire Police to take over the role of family liaison, PC Smith had no further dealings with the family after 30 April 1998. Although almost a year had passed, the appointment of PC Smith clearly still rankled with Ms Alder.

8.71 Supt Bates was asked about the issue of a black FLO:

A. I remember Janet was very difficult. At least Beatrice had established some form of liaison with her, however difficult. Beatrice was not wanted by Janet right from the off. [Janet] was abusive about her, although I did not pass that on to Beatrice because I did not want to damage the relationship that Beatrice and Janet may -----

Q. She was abusive to you about Beatrice?

A. In my office at the police station Janet actually called Beatrice a “coconut”. Now that is offensive. I know what it means: brown on the outside, white on the inside. I did not pass that on to Beatrice, but I was angry with Janet and told her that it was well out of order to describe her as that. She did not want a black police officer as a VLO for whatever reason.⁷⁶¹

Use of a photograph without permission

8.72 On 23 July 2002, Ms Alder’s solicitors complained to the PCA that a picture of their client had been used on the cover of the *PCA Annual Review*.⁷⁶² The PCA wrote to explain that the photograph had been purchased from the *Hull Daily Mail*, and that the wish of the publicity department of the PCA had been to:

“focus the minds of the readers on the death of Mr Alder”.⁷⁶³

The PCA apologised for doing so without her consent.

8.73 The issue was raised in an internal memo, following a telephone call with Ms Alder, by Ms Sally Hawkins. Ms Hawkins was the PCA member responsible for the misconduct review, who took over the handling of the case from Mr Elliott. She indicated to a colleague that Ms Alder was reluctant to accept the PCA explanation, as she believed that the photograph, showing her walking into Teesside Crown Court for the criminal trial, had been taken by the police.⁷⁶⁴ It appears that the issue was allowed to drop, and was not pursued further.

⁷⁶¹ Supt Bates interview Tape 2 p.5 [01320032]

⁷⁶² Harrison Bunday letter (23 July 2002) CA002 D31 [00020497]

⁷⁶³ PCA letter (7 August 2002) CA002 D32 [00020496]

⁷⁶⁴ Sally Hawkins e-mail (13 August 2002) CA002 D33 [00020495]

Formal complaints/attendance at the disciplinary hearing

8.74 As set out in Chapter 6 above, the trial of the officers was followed by a disciplinary hearing in 2003. An issue arose in the lead up to the police disciplinary hearings as to whether any family representative, and specifically Ms Alder, was entitled to be present during the hearing. The disagreement and dispute that arose over this matter can only be understood by considering the correspondence between the parties that preceded the hearing, and by seeking to determine whether or not Ms Alder was a formal complainant against the officers.

8.75 The regulations covering the hearing specified that they should be in private, although the officer conducting the hearing could permit the attendance of officials from the PCA, legal representatives or other police officers, if the accused officers did not object. The regulations also allowed the presiding officer discretion to permit a complainant to attend, “where the charge is in respect of a complaints matter”.

8.76 Available records show that Ms Hawkins spoke by telephone to Ms Ruth Bunday of Messrs Harrison Bunday & Co., the solicitors acting for Ms Alder, on 23 July 2002. In that conversation, Ms Hawkins told Ms Bunday that Ms Alder was not, at that stage, a formal complainant in the eyes of the PCA.⁷⁶⁵ Harrison Bunday wrote to the Chief Constable of Humberside on the following day, 24 July 2002, approximately one month after the Crown court trial came to an end.⁷⁶⁶ In that letter they said:

“We write to make formal complaint on behalf of our client Janet Alder in connection with the actions and in-action perpetrated towards her brother Christopher Alder on the 1st April 1999 [sic] on the part of all those officers involved in his care, and particularly officers Dunn, Barr, Dawson, Blakey and Etherington [sic]. Our client includes within this complaint any behaviour/conversation/noises apparent from the custody suite video referable to that morning, both before, during, and after Christopher Alder’s death on the custody floor.”

8.77 A copy of the same letter was sent to the PCA, for the attention of Ms Hawkins, together with a covering letter addressing the role of the PCA.⁷⁶⁷ That letter went on to state that:

“our client wishes to formally complain about the failure of the PCA investigation into Christopher Alder’s death by Chief Superintendent Holt...”

⁷⁶⁵ Sally Hawkins file note (23 July 2002) CA002 D20 [00020524]

⁷⁶⁶ Harrison Bunday letter (24 July 2002) CA0076 p.146 [00760147]

⁷⁶⁷ Harrison Bunday letter (23 July 2002) CA002 D24 [00020520]

- 8.78 The letter then listed a series of areas of complaint. The letter concluded by saying that:

“As you will know, we are of the view that only a full Public Inquiry into this case will suffice...We do not believe that these complaints can be hived off and investigated individually by separate organisations, but believe that the case must be looked at as a whole...”

- 8.79 Ms Hawkins, for the PCA, wrote back to Harrison Bunday on 30 July 2002, pointing out that it was open to Harrison Bunday to complain about the supervisory role exercised by the PCA, in which case the letter would be handed to the complaints manager.⁷⁶⁸ She also pointed out that any complaint against West Yorkshire Police should be sent directly to them. Ms Hawkins asked for clarification as to what Harrison Bunday wished to be done with the letter.

- 8.80 On 31 July 2002, C/Supt Everett of the Professional Standards Branch of Humberside Police wrote to Harrison Bunday, saying that:

“it would be helpful if you could be more specific regarding the matters of complaint your client wishes to raise”.⁷⁶⁹

- 8.81 He went on to point out that the DCC was preparing a memorandum for the PCA dealing with the inquest and trial, including concerns raised about noises heard subsequent to the death of Mr Alder.

- 8.82 On 6 August 2002, Harrison Bunday responded to both of these requests for clarification. In a letter to the PCA they said that, as they wanted a public inquiry:

“We therefore do not wish you to deal with our letter as a formal complaint through your complaints manager, nor do we intend to make complaint to the West Yorkshire Police about the conduct of the investigation.”⁷⁷⁰

- 8.83 On the same day, the firm wrote to Humberside Police saying that:

“It would appear to us that the Deputy Chief Constable’s memorandum will cover many of the concerns of our client. She and we are of the view that only a public inquiry will suffice to consider all aspects of the events which led to and post-dated the death of Christopher Alder in a coherent and open manner. We therefore have nothing further to raise at this stage.”⁷⁷¹

⁷⁶⁸ PCA letter (30 July 2002) CA002 D25 [00020519]

⁷⁶⁹ Humberside Police letter (31 July 2002) CA0076 p.145 [00760146]

⁷⁷⁰ Harrison Bunday letter (6 August 2002) CA002 D26 [00020518]

⁷⁷¹ Harrison Bunday letter (6 August 2002) CA0076 p.144 [00760145]

8.84 While this exchange of correspondence was not wholly clear, the impression given to Humberside Police was that Harrison Bunday, and/or Ms Alder, had reversed their position, having announced that they were making a formal complaint and then withdrawing it in their next letter. The PCA was left with a similar impression. There was no further correspondence on the issue for several months, during which time the PCA engaged in exchanges with Humberside Police, obliging the force to hold disciplinary proceedings. Ms Hawkins of the PCA also wrote to Ms Alder, via her solicitors, on 6 May 2003, stating that :

“you have chosen not to make a formal complaint regarding the death of your brother in police custody”.

8.85 An important development that Harrison Bunday would not have been aware of was that, in February 2003, Humberside Police had received death threats directed at the five officers and at those involved in handling the case (dealt with in Chapter 6 above). There is no suggestion that the family of Mr Alder would have known of these, nor that Humberside Police thought that the family was responsible for them in any way. Nonetheless, it is clear that security for the disciplinary hearing became a greater concern for the police, and that no details of the time and place of the hearings were released to the public or to the family from that point on.

8.86 Following the decision to hold a disciplinary hearing, a letter was sent, on 14 May 2003, by Harrison Bunday to the Chief Constable of Humberside regarding the anticipated hearing.⁷⁷² The letter requested details of the tribunal and the case manager so that “arrangements” could be made in relation to Ms Alder. The response of 19 May from Mr Hodgson of Humberside Police Corporate Services Branch stated:

“It is not exactly clear what you mean by arrangements. If it is the case that your client will seek to be present at the Hearing, then I have to say that I do not believe that your client has any locus such that she could insist on being present. I say this because she is not a complainant.”⁷⁷³

8.87 By a letter of 20 May 2003, Harrison Bunday responded to Mr Hodgson and said:

“Janet Alder is indeed a complainant in these proceedings as far as the PCA is concerned – the complaint was made on 24 July 2002 and confirmed by letter to Sally Hawkins of the Police Complaints Authority and we have certainly been given to

⁷⁷² Harrison Bunday letter (14 May 2003) CA0065 D77 [00650181]

⁷⁷³ Humberside Police letter (19 May 2003) CA0076 p.142 [00760143]

understand by the PCA that our client would have the right to be present, no doubt with a friend, at the disciplinary hearing.”⁷⁷⁴

8.88 While this exchange was going on, C/Supt Everett had also raised the same issue – the attendance of Ms Alder at the proposed hearing – with Mr Hodgson in a memorandum of 21 May.⁷⁷⁵ C/Supt Everett passed on the correspondence that he had seen from Harrison Bunday, and expressed the view that the letters did not disclose a complaint, but that even if they did, the entitlement to attend under Regulation 22 only arose when the charge was “in respect of a complaints matter”. As the charges arose from a police investigation, he contended, the later complaint was irrelevant to the hearing and gave rise to no entitlement to Ms Alder to attend.

8.89 Although Regulation 18 of the Police Discipline Regulations 1985, which governed this hearing, stipulated that the hearing should be in private, Regulation 22 did permit the “complainant” to be present with the consent of the presiding officer. Regulation 18(5) also made clear that:

“In this Regulation a reference to the complainant is a reference to the originator of the complaint notwithstanding that it was transmitted to the chief officer of the police force by some other person or by the Authority or some other body.”

8.90 It is worth noting that these rules have since been superseded by the Police Reform Act of 2002, which created the IPCC. The rules on attendance at disciplinary hearings were amended to allow interested parties to attend such hearings, with friends⁷⁷⁶. Thus the requirement that one be a “complainant” has been abolished, and any interested party may be permitted to attend, with the support of a ‘friend’ (in the sense of someone to speak on their behalf) if necessary. The new Act did not apply to this hearing, however.

8.91 On 22 May 2003, Harrison Bunday wrote to Mrs Janice Connor of the Professional Standards Branch of Humberside Police, asking what arrangements could be made for Ms Alder to attend the disciplinary hearing.⁷⁷⁷ Mr Hodgson wrote back on behalf of Humberside Police on 2 June,⁷⁷⁸ indicating that he had spoken to Ms Hawkins, and that the PCA did not regard Ms Alder as a complainant. He also reminded Harrison Bunday of their earlier correspondence, and said that because they had declined to raise “specific matters of substance”, no complaint had been registered. He went on to say that if the tribunal

⁷⁷⁴ Harrison Bunday letter (20 May 2003) CA0076 p.141 [00760142]

⁷⁷⁵ Humberside Police memo (21 May 2003) CA0065 D34 [00650301]

⁷⁷⁶ Police Reform Act 20002 section 21(3) and (12). Also reg. 13 of Police (Complaints and Misconduct) Regulations 2004.

⁷⁷⁷ Harrison Bunday letter (22 May 2003) CA0076 p.139 [00760140]

⁷⁷⁸ PCA letter (2 June 2003) CA0076 p.138 [00760139]

and the officers agreed, she might be permitted to attend, but not as a complainant. It is not entirely clear on what basis he believed that this would be allowed.

- 8.92 Harrison Bunday's response to this was by letter of 11 June to Mr Hodgson, copied to Mrs Connor.⁷⁷⁹ That letter insisted that the earlier letter of 24 July 2002 had been a formal complaint, and had not been withdrawn. The letter then cited correspondence with the PCA in which further concerns had been raised about the handling of the investigation:

"We would scarcely have engaged in all this correspondence on our client's behalf if she was in fact turning her back upon the proposed disciplinary proceedings involving the five officers.

We therefore do not understand at all the first line of Sally Hawkins letter of 6 May 2003 stating that Ms Alder had chosen not to make a formal complaint, because this comment is inconsistent with all our correspondence, and we can only assume that a chance remark made by Ms Alder personally over the telephone may have been misinterpreted by Ms Hawkins. Once again, had a stage been reached when either the PCA or yourselves chose to take a view that Ms Alder was no longer a complainant, we should have been formally notified with a chance to respond.

We therefore contend that Ms Alder is a complainant and has a statutory right to be present at the disciplinary proceedings."

- 8.93 The letter went on to say that seeking the consent of the officers to the presence of Ms Alder:

"would be entirely inappropriate, demeaning to our client and only add insult to injury".

- 8.94 The letter of 6 May 2003 had been a very long and detailed letter from Ms Hawkins of the PCA to Ms Alder, c/o Harrison Bunday. The letter, which was also copied to solicitors Deighton Guedalla, ran to 20 pages. The opening paragraph of that letter began in unequivocal terms:

"Dear Miss Alder,

You have been very clear with me that you have chosen not to make a formal complaint regarding the death of your brother in police custody."

⁷⁷⁹ Harrison Bunday letter (11 June 2003) CA0076 p.133 [00760134]

- 8.95 Harrison Bunday did not respond to this letter until 11 June, the same date as the letter to Mr Hodgson.⁷⁸⁰ In the letter to the PCA they said that:

“We were very surprised at the first sentence of your letter, giving your opinion that Ms Alder had chosen not to make a formal complaint, when all the correspondence between us had suggested the contrary. We enclose for your information a copy of a letter that we have today sent to Mr Hodgson on this subject.”

- 8.96 The letter then noted the issues raised by the PCA in the earlier letter without adding any details as to the complaint, or against which body it was being made.
- 8.97 Mr Hodgson wrote again to Harrison Bunday on 12 June 2003, declining to change the stance of Humberside Police.⁷⁸¹ The letter also pointed out that the wording of Regulation 22 of the Police (Discipline) Regulations 1985 allowed a right of attendance to a complainant only if the charges to be determined arose “in respect of the complaints matter”.
- 8.98 Mr Hodgson applied the argument first put forward by C/Supt Everett, that the charges arose from the investigation carried out by West Yorkshire Police, and not from any complaint raised by the family of Mr Alder. Both the original letter from Harrison Bunday and the Humberside Police response were copied to the PCA.⁷⁸²
- 8.99 Harrison Bunday wrote on 13 June 2003, repeating the request for Ms Alder to be present, and asking that the request be placed before the chair of the tribunal.⁷⁸³ The letter also reiterated requests for detailed reasons as to why legal representation had been denied to the officers. Mr Hodgson responded by letter on 18 June 2003, saying that the issue of attendance lay with the discipline authority, not with the chair of the tribunal, and that even if the chairman retained residual discretion to admit a person, such admission would be entirely dependent on the consent of the officers.⁷⁸⁴ He stated that, as Harrison Bunday did not wish the officers to be consulted, the matter could not be taken further.
- 8.100 The final letter in the sequence was that of Harrison Bunday dated 7 July 2003, subsequent to the disciplinary hearing and complaining of

⁷⁸⁰ Harrison Bunday letter (11 June 2003) CA003 D9 [00030096]

⁷⁸¹ Humberside Police letter (12 June 2003) CA003 D17 [00030085–6]

⁷⁸² Humberside Police letter (12 June 2003) CA003 D18 [00030084]

⁷⁸³ Harrison Bunday letter (13 June 2003) CA0065 D82 [00650174]

⁷⁸⁴ Humberside Police letter (18 June 2003) CA0065 D83 [00650173]

the failure to notify them of the actual date of the hearing.⁷⁸⁵ They said of this that:

“We consider this failure of communication to be inexcusable.”

8.101 Mr Peter Pike MP had written to DCC Gordon Clark (by then retired) on 23 June, enquiring when the disciplinary process would be completed,⁷⁸⁶ and he received a letter from DCC Love, by fax on 1 July, informing him of the outcome.⁷⁸⁷ A letter complaining in similar terms to those used by Harrison Bunday was sent by Mr Pike to DCC Love on 14 July 2003.⁷⁸⁸

8.102 The PCA did not become involved in the argument over attendance at the hearing, as this was purely a matter between Humberside Police and the family of Mr Alder. It is evident that they did not have any control over the matter, and would not have been in a position to dictate who was permitted access to the hearing.

8.103 Having read the correspondence from Harrison Bunday, I agree that it does appear at times unclear, firstly as to whether a complaint is being made and maintained, and secondly as to what that complaint was. Ms Hawkins of the PCA, in interview with my staff, indicated that she understood that Humberside Police did not want Ms Alder to be present at the hearing because:

“I know that, for Humberside, they felt that her behaviour – she couldn’t be relied on to allow the process to continue.”⁷⁸⁹

8.104 Ms Hawkins was also asked about her efforts to establish whether a formal complaint had been made. She said that:

“you will have seen that I was trying to get her to make a formal complaint in order that she could be present, um, and she never would, and so I to some extent thought, well, you know, this is how you could have, and you chose not to, so I wasn’t going to press further.”

8.105 Whether or not a complaint had been made, however, C/Supt Everett of Humberside Police took the view that the proceedings were not initiated by a complaint, and therefore the right for a member of the family to attend would not have arisen.⁷⁹⁰

⁷⁸⁵ Harrison Bunday letter (7 July 2003) CA0065 D84 [00650172]

⁷⁸⁶ Peter Pike MP letter (23 June 2003) CA0066 D6 [00660041]

⁷⁸⁷ Humberside Police letter (1 July 2003) CA0066 D7 [00660040]

⁷⁸⁸ Peter Pike MP letter (14 July 2003) CA0065 D35 [00650300]

⁷⁸⁹ Sally Hawkins interview (15 March 2005) CA0121 Tape 1 p.3 [01210035]

⁷⁹⁰ C/Supt Everett interview (21 March 2005) p.3 Q.14 [01370005]

Release of the videotape for viewing

- 8.106 The tape of the custody suite on the night of the death of Mr Alder was a central piece of evidence in both the inquest and the trial that followed. It has also been shown to a series of experts for their comments, and featured, in a rough format, in the 2004 BBC documentary, *Death on Camera*. It goes without saying that the videotape itself is a sensitive and emotive document, which understandably rouses passions on all sides. Humberside Police has taken the view that the video is their property, and that they have copyright over it. In legal terms, this position is unchallenged. Humberside Police has complied with all requests to disclose the video for the purposes of court hearings.
- 8.107 Following the completion of the trial of the officers in 2002, and the commencement of the misconduct review by the PCA, there was a series of exchanges between the PCA, Ms Alder and her representatives regarding possible release of the tape. It had not been suggested that Humberside Police would give the tape to Ms Alder, as they appear to be concerned about the effect this might have on the officers. However, there was recognition that Ms Alder was entitled to at least have access to it.
- 8.108 Correspondence regarding such access appears to have started when Ms Alder rang the PCA on 2 October 2002. Ms Sally Hawkins indicated that she was sympathetic to the request and said that she would get back to her. Ms Hawkins later e-mailed Ruth Bunday, the solicitor, to discuss the matter.⁷⁹¹ In that e-mail she indicated that a provisional decision on discipline would be issued by the PCA, and Ms Alder would be invited to comment on it. For that purpose, Ms Hawkins felt it appropriate that she should have access to the tape.
- 8.109 On 11 December 2002, Ms Hawkins told C/Supt Everett that she wanted to arrange for Ms Alder to view the tape, and that she suggested doing this in Ruth Bunday's office to avoid the risk of covert copying of the tape taking place.⁷⁹²
- 8.110 Access to the tape was discussed between the PCA and Ms Bunday in an exchange of e-mails on 16 December 2002.⁷⁹³ In those, Ms Hawkins suggested to Ms Bunday that the PCA should ask Humberside Police to let Ms Alder see the tape. The tone of the e-mails was amicable and seems to reflect a mood of cooperation.
- 8.111 In her letter of 24 December 2002, Ms Hawkins provided her provisional decision (PD) regarding the disciplinary process.⁷⁹⁴ In that

⁷⁹¹ PCA e-mail (2 October 2002) CA002 D 50 [00020440]

⁷⁹² PCA e-mail (11 December 2002) CA002 D63 [00020355]

⁷⁹³ PCA e-mails (16 December 2002) CA002 D80 [00020246–7]

⁷⁹⁴ PCA letter (24 December 2002) CA0064 D60 [00640058–63]

letter Ms Alder was invited to comment in writing by 30 January, and arrangements were mentioned for her to view the tape. On the same day, Ms Hawkins e-mailed the PD to Harrison Bunday and added details of her plan to allow Ms Alder to view the tape at the offices of Harrison Bunday.⁷⁹⁵ Ms Hawkins discussed arrangements further with C/Supt Everett on 30 December, as it was he who was due to deliver the tape.⁷⁹⁶

- 8.112 Before arrangements were eventually finalised, Mr Peter Pike MP wrote to the PCA on 2 January 2003 saying that Ms Alder had visited him on 31 December to show him the letter received from the PCA.⁷⁹⁷ He commented that:

“Janet does not accept the position at all but I assume she will respond via her solicitor on an official basis.”

- 8.113 On 6 January 2003, Harrison Bunday wrote direct to C/Supt Everett to finalise arrangements for delivery of the tape to their offices on 15 January. The plan at that stage was that the tape would be left with the solicitors to allow Ms Alder to view it.⁷⁹⁸ The outcome emerges from a telephone note of 17 January, the day following the proposed viewing, in which Ms Bunday informed C/Supt Everett that Ms Alder had not been able to attend her office the previous day.⁷⁹⁹ There was a conversation regarding the possibility of alternative arrangements, but no final arrangement was made; I have not seen any evidence to suggest that a further date was ever agreed. There is no correspondence from Harrison Bunday to request such a date.
- 8.114 Since this Review began, Ms Alder has informed my staff that she does now have access to a copy of the tape. It is my understanding that this may have been supplied to Liberty, which is representing her in an action that she hopes to bring before the European Court of Human Rights.

Nicola O'Brien and Leon and Kelvin Wilson

- 8.115 Ms Nicola Wilson was the girlfriend of Mr Alder between approximately 1981 and 1985. During that time the couple had two sons, named Leon and Kelvin. Ms Wilson is now Mrs O'Brien (although referred to as Mrs “O'Brian” by her friend Nicola Killen,⁸⁰⁰ I have taken the spelling used by Mr Elliott as being correct).

⁷⁹⁵ PCA e-mail (24 December 2002) CA002 D84 [00020214]

⁷⁹⁶ Humberside Police note (30 December 2002) CA0064 D64 [00640044]

⁷⁹⁷ Peter Pike MP letter (2 January 2003) CA002 D85 [00020213]

⁷⁹⁸ Harrison Bunday letter (6 January 2003) CA0064 D65 [00640042]

⁷⁹⁹ PCA file note (17 January 2003) CA0064 D68 [00640037]

⁸⁰⁰ Nicola Killen statement (29 April 1998) CA0080 p.768 [00800689]

- 8.116 The police managed to trace the family, who still live in the Andover area, and first contact with Mrs O'Brien was made by DC Mainland of Humberside Police, who visited them at their home. DC Mainland recorded his conversations with Mrs O'Brien in a HOLMES entry of 14 April 1998.⁸⁰¹ Mrs O'Brien gave the officer a history of the relationship between herself and Mr Alder. She told him that the relationship had continued until about 1988, and had been a very troubled one. Mr Alder had not had contact with his former girlfriend or his sons for several years before his death.
- 8.117 On 20 April 1998, PC Smith, the FLO, first spoke with Mrs O'Brien, who requested that PC Smith visit her in Andover to meet with her sons.⁸⁰² PC Smith made the necessary arrangements and travelled to Andover on 29 April to meet Mrs O'Brien.⁸⁰³ She met Mrs O'Brien on the evening of 29 April and the morning of 30 April before returning to Hull. Mrs O'Brien talked in some detail about her relationship with Mr Alder, and PC Smith noted this. She was also in a position to answer some of the questions from Leon and Kelvin, who were at that time in their mid-teens. Mrs O'Brien was evidently grateful for the visit and said that her sons appreciated it.
- 8.118 On 12 May 1998, Mr Elliott of the PCA went to see them.⁸⁰⁴ He recorded that he explained the role of the PCA, and agreed to inform both Janet and Richard Alder that the two sons of Mr Alder would wish to attend the funeral (he later passed on this information via the solicitors). Mr Elliott later expanded on the meeting in a note to Ms Hawkins regarding his handling of the case.⁸⁰⁵ He stated that:
- “I was briefly introduced to Leon and Kelvin Wilson but they were not present for most of the meeting. Mrs O'Brien stated that she did not want the two boys to be involved in this matter...
- At no stage did I feel it was appropriate that I spoke directly to the two boys as they were minors at that point in time and it was clear Mrs O'Brien did not wish them to be directly involved if at all possible.”
- 8.119 On 19 August 1998, Mr Elliott wrote to Mrs O'Brien again to inform her that the PCA inquiry was concluded.⁸⁰⁶
- 8.120 Mr Enzor of the CPS indicated that, during the course of the trial, the CPS had funded the travel expenses of the family, including the sons of Mr Alder. The option of attending the trial every day was therefore

⁸⁰¹ DC Mainland HOLMES report R3

⁸⁰² PC Smith notes (20 April 1998) CA0068 D103 [00680134]

⁸⁰³ PC Smith notes (29–30 April 1998) CA0068 D103 [00680153–8]

⁸⁰⁴ PCA file note (8 June 1998) CA001 D155 [00010024]

⁸⁰⁵ PCA note CA0060 [00600027–8]

⁸⁰⁶ PCA letter (19 August 1998) CA001 D45 [00010257]

extended to the boys; in fact they attended on only a couple of occasions.

- 8.121 The civil actions commenced on behalf of the family are specifically in the names of Leon and Kelvin Wilson, who are now both adults. No civil action has been issued on behalf of Mrs O'Brien. During the course of the Review, Mrs O'Brien was invited to discuss any concerns that she might have with the IPCC. She has chosen not to do so.

Tracy Alder

- 8.122 On 30 December 1998, Tracy Alder wrote to Mr Elliott at the PCA regarding the death of her cousin Christopher. She expressed concern that the delay was causing distress to her family and that little appeared to have been done. She requested details of the PCA involvement.⁸⁰⁷
- 8.123 Mr Elliott wrote back on 4 January, the same day that her letter arrived.⁸⁰⁸ He offered to discuss the matter by telephone and provided contact numbers for her to call him. There is no record of her having been in contact again, and Mr Elliott confirmed that he had heard no more from her.
- 8.124 Ms Tracy Alder was listed as one of the family members to whom the open letter from the 'Justice for Christopher Alder Campaign' was addressed (as a carbon copy) on 13 November 2000.

⁸⁰⁷ Tracy Alder letter (30 December 1998) CA001 D69 [00010207]

⁸⁰⁸ PCA letter (4 January 1999) CA001 D70 [00010206]

CHAPTER 9: ASSESSMENTS AND CONCLUSIONS

Introduction

9.1 I have divided my assessments and conclusions to reflect the different parties who have played roles in the events surrounding the death of Mr Alder. I deal firstly with the five officers who are at the centre of the case. I go on to address the role of Humberside Police as investigators, West Yorkshire Police, Lancashire Constabulary, the Police Complaints Authority (PCA) and the Crown Prosecution Service (CPS), and the role of Humberside Police in relation to the discipline hearings. I also consider, as a separate heading, the issue of liaison with the Alder family, which fell between the Humberside and West Yorkshire forces.

Assessment of Humberside Police: the five officers

9.2 Invitations were extended to the five officers to participate in this Review on several occasions, up to and including the last weeks of the preparation of this report. Despite the extensive opportunities I have given them to do so, they have refused to provide any information; thus assessments of their actions need to be based on the information available from existing documents. Although assertions have sometimes been made that the officers have not given any account of their actions, it should be remembered that statements were given and interviews held with all five officers. I do not criticise their exercising the right not to incriminate themselves at the inquest, as this was no more than the exercise of a legal entitlement available to every person. Similarly, the fact that they were not called on to give evidence at trial or the disciplinary hearing reflects the fact that both hearings ended before the defence stage arose.

9.3 However, I believe that as public servants they had a clear public duty to cooperate with my Review. In not doing so, they have prolonged the anguish of the Alder family. Their reluctance to cooperate is in marked contrast to that of the NHS staff, PCA members and other police officers and staff – some of whom also faced potential criticism. It is a deeply disappointing failure.

9.4 The behaviour of the officers does call for criticism. They have decided not to provide information to this Review, and so I base my judgements on the material I have available. They have no cause for complaint in my doing so.

9.5 I am keenly aware that the five officers have been treated as a group in terms of their behaviour throughout the investigation and been viewed

as a team. I have aimed, however, to view each officer separately and to assess the actions of each as an individual as well as a member of a group.

At the Waterfront Club

- 9.6 The behaviour of PCs Dawson and Blakey before arriving at the hospital and in their early dealings with Mr Alder is, in my view, relevant and should have been considered by the investigations that took place into Mr Alder's death. The approach taken to Mr Alder at that stage was indicative of their attitudes and reveals assumptions on the part of the officers that were to play a large part in their later actions.
- 9.7 It is unfortunate that, on arrival at the scene of the initial incident outside the Waterfront Club, neither officer made any effort even to speak to Mr Alder. I accept that he was dealt with relatively quickly by the ambulance crew and was removed from the scene within a couple of minutes. There is no evidence, however, that the officers even spoke to the ambulance crew regarding his condition. The only person from among the crowd who is mentioned as offering information was Jurgen Jarvis. In the brief exchange he had with PC Blakey, the two men do not appear to have seen eye to eye, and the officer did not seem to regard Mr Jarvis as a reliable witness.
- 9.8 What concerns me is that the two officers leapt to conclusions about Mr Alder from the outset and expressed them over the radio when they described him as being "well in drink". As they had not spoken to him or to the medical staff in attendance, and they do not record having been given information by anyone else, there was no obvious basis for that conclusion. The later evidence from the hospital and, sadly, from the post mortem examination made it clear that the assumptions made at the club and later at the hospital concerning drink and amphetamine use were largely incorrect.
- 9.9 Whatever the reason for the erratic behaviour of Mr Alder, both officers began making adverse assumptions from their earliest contact with him. Each of these assumptions was to the effect that his state and behaviour were voluntary or self-induced. The later radio message from the hospital, expressing the view that he was being troublesome, and that this might be the reason that he was hit, implicitly suggests that he may have deserved the blow that he received. Although Mr Alder was nominally a victim at this stage, the possibility that his behaviour might be related to a severe blow to the head was not even being entertained by the two officers.
- 9.10 It is clear to me from the CCTV footage that the officers were present when staff from the Waterfront Club washed the blood from the cobblestones. I agree with the view expressed by Supt Bates in interview that such events happen outside nightclubs throughout the

country, on a nightly basis, and that this does not form the basis for a valid criticism. Having seen Mr Alder walk, albeit aided and unsteady, to the ambulance, the officers were not to know at that stage that the events of the night would turn out to be as serious as they became. Preservation of the scene was not called for at that point.

- 9.11 What is unfortunate, however, is that when questioned about the washing away of the blood PC Blakey could have told the truth and said 'we did not think we needed to preserve the scene'. Instead he misrepresented what had happened and claimed that they had wished to preserve it but had been too late. I believe PC Blakey knowingly gave an inaccurate account of this matter.
- 9.12 The treatment of Mr Alder by the staff of the Waterfront Club was, in my view, exemplary. As soon as the incident outside the club came to their attention they telephoned for an ambulance and police, and followed up the call soon after to ensure the message had got through. Staff members attended to him immediately and provided a blanket, while placing him in the recovery position and keeping other people away from him. They were encouraging and concerned for his well-being.
- 9.13 Similarly, it should be noted that Mr Jarvis showed concern and care for Mr Alder. He deserves credit for this, which possibly he did not receive at the time.
- 9.14 It is a sad reflection on Humberside Police at that time that the treatment provided to Mr Alder at the roadside by door staff of a nightclub was markedly better and more considerate than that which he received when left on the floor of the custody suite at Queen's Gardens police station later in the night.

At the hospital

- 9.15 On their arrival at the hospital it is clear that PC Blakey recognised Mr Alder for the first time. The evidence that they were at the same school is not surprising; Hull is not a large city, and Mr Alder, being one of a very small minority of black residents, would have been more memorable if, as seems likely, he was part of the only black family at the school. I have seen no evidence – and Richard Alder has not suggested – that there was any form of animosity between PC Blakey and any member of the Alder family who went to the school. Ms Alder was at the same school and has made no suggestion that there was any history of problems involving PC Blakey as a child.
- 9.16 The reference to the comment at the hospital emerged from the statement of the hospital security guard Mr Rodgers, and as PC Blakey was clearly heard mentioning names of the family in the custody suite, it is unfortunate that the matter was not the subject of questioning in

the West Yorkshire Police interview. It is also unfortunate that PC Blakey did not raise it himself in his statement or interview, to avoid misunderstanding. The fact that it has never been addressed has given rise to suspicion and speculation; nonetheless, there is no evidence at all to suggest that the matter has any bearing on what happened to Mr Alder.

- 9.17 Had PC Blakey been more forthcoming about this information, it is possible that the family of Mr Alder, and specifically Richard Alder, might have been traced more quickly. Had that happened Richard Alder would not have had to learn of his brother's death via the media.
- 9.18 As I was concerned about the possibility that there may have been some animosity from school days between PC Blakey and the Alder family, steps were taken to trace schoolteachers from Kelvin Hall School, which was where PC Blakey and the Alder family had all been pupils. Members of the Review team met with Canon Reverend Keith Wilkinson, who had been Mr Alder's first teacher at the school. The Reverend Wilkinson had a clear recollection of the young Christopher, and was able to provide considerable detail about his school days; he had no recollection of any friction with Neil Blakey. He was also able to refer us to another retired teacher from the school, still living in the city. Unfortunately that person was unable to provide any further details.
- 9.19 Upon arrival at the hospital, the two officers made what appear to be reasonable enquiries. It is clear that the preparation of a note for Mr Alder, giving details of the number for his earlier complaint, was done at this stage. It is not possible to determine why Mr Rodgers should now deny having received the note, but this is of little consequence. The note was retrieved from the hospital records the following day and was clearly given to a member of staff for Mr Alder, prior to the decision to arrest him.
- 9.20 The behaviour of Mr Alder at the hospital was difficult and challenging for the hospital staff, and no doubt also for the officers. The medical and ancillary staff endeavoured to assist Mr Alder and were abused and spat at by him. It appears that if the officers had felt any sympathy for Mr Alder as a victim, this disappeared fairly quickly. There is, however, considerable evidence to suggest that the actions and reactions of Mr Alder were in fact a response caused by his injury. This possibility does not seem to have been considered at the time by either the hospital staff or the police officers.
- 9.21 It should also be remembered that although Mr Alder's behaviour was difficult for the hospital staff to handle, such behaviour is not in itself unusual among hospital patients. Many people who come to hospitals are reluctant patients or resist being helped. Many who pass through the accident and emergency departments of our major hospitals are the worse for drink or drugs, and techniques for handling such individuals are available.

- 9.22 What is unusual in the case of Mr Alder is that no X-ray was taken of him. In discussion with the Healthcare Commission (HCC) and with IPCC staff, the radiographer Beverley Tweed confirmed that Mr Alder was the only patient she had ever had who had been that resistant to being X-rayed. The few other cases in which X-raying had proved impossible had mainly involved small children or elderly people. Ms Tweed did, however, confirm that she regarded the situation as safe, in that she, her colleagues and the patient were not at risk, and that she had abandoned her attempts at X-raying in order to keep it so.
- 9.23 It is also worth noting the descriptions provided by Jennifer Hobson, Mr Alder's former girlfriend, of his experiences at Winchester Hospital after a dislocation of the shoulder. On that occasion, in the early 1990s, he had been equally resistant to medical assistance. Ms Hobson describes the period during which he was allowed to calm down and the fact that the hospital staff continued their efforts to help him over a couple of hours, before finally administering an anaesthetic. This contrasts with the period of under an hour that Mr Alder was at the Hull Royal Infirmary (HRI). In the former case, although difficulties were encountered, far more time was allowed.
- 9.24 I am struck by the fact that the police were permitted access to Mr Alder while he was still receiving or was due to receive treatment from the medical staff. The officers were also permitted sight of his alcohol test results. Although it may be a minor point in the context of the evening, there appears to have been a rather relaxed attitude, on the part of hospital staff, to Mr Alder's privacy. It may also be the case that, given a history of problems with the police, Mr Alder's state of mind was not improved by being questioned by police officers at that stage.
- 9.25 I accept that the hospital staff encouraged the police to remain and to play a role in keeping an eye on Mr Alder, although he had already been calmed down to some extent by Dr Aamer Khan and Mr Rodgers.
- 9.26 I am concerned that when a victim of crime is taken to hospital and refuses treatment, but commits no crime at the hospital, a police officer should ask the doctor, as PC Dawson did:
- “Is he really in a condition suitable to be kept in police custody?”
- 9.27 At the point when this was asked Mr Alder had not threatened PC Dawson or any other officer and had not used violence against any person. PC Dawson nonetheless seemed to be anticipating the arrest of Mr Alder at this time. Mr Alder was being objectionable – but no more than that. If the police believed that an offence had been committed, or that a breach of the peace was in progress, they should have acted at that stage to warn Mr Alder or to arrest him.

9.28 An important and unfortunate confusion also arose at this point, because the question asked by PC Dawson seems to have implied that Mr Alder would be kept in custody and would therefore be in a 'place of safety'. Dr Khan, who was treating him, was asked about this matter in interview with the HCC, and the notes of that interview record that:

“Dr Khan recollects the police took Christopher out of the hospital into their custody, he was happy with this, as he knew he had been taken into their care into a place of safety. Had he known that outside the police told Christopher to go home to be left on his own he would not have been happy with that decision.”

9.29 This confusion reflected a lack of communication on the part of both the doctor and the police officer.

9.30 PC Dawson and, I must assume, PC Blakey knew by then that Mr Alder was **not** deeply under the influence of drink. The incorrect assumption regarding use of amphetamines ignored the possibility of his head injury influencing his behaviour. It is fair to say that the officers could not have known which it was, nor are they medically qualified; but they were in the company of a doctor and several nurses and did not, on any version of the evidence, ask advice as to whether his behaviour might be drug induced. The conclusion that he was suffering the effects of drugs was reached on limited and unreliable evidence. It appears to me that this was a hostile conclusion, and reflected a readiness on the part of the officers to assume the worst about Mr Alder.

9.31 Having taken Mr Alder to the toilet, the officers accept that they threatened to use CS spray upon him. Had they done so in the confines of a hospital, which would have been air-conditioned, it could potentially have resulted in the closure of part or all of the hospital. Such threats may on occasion be justified, but the officers in this case may not have realised what they were suggesting. I accept that no CS spray was used in the hospital, but the threat reveals a gap in the training provided by Humberside Police and a lack of understanding on the part of officers who are authorised to use incapacitant spray.

9.32 The point is made in the report from the HCC that the hospital staff had, by this stage, begun to act as though Mr Alder was already in police custody and to accept that the police would be taking him away from the hospital. After the hospital staff had already allowed Mr Alder's privacy to be compromised while he was being examined, he was then taken to the lavatory by the two officers. Again, this amounted to a breach of his privacy, since he was not being treated by the police but by medical staff. To accept that the police rather than medical staff should take him to the lavatory, without asking him or considering the issue of his privacy, appears to ride roughshod over Mr Alder's rights.

- 9.33 An important question, in my view, is why his somewhat bizarre behaviour – unfastening his trousers in public, and urinating on the ground while standing near a toilet – did not attract more concern from the bystanders, as they already knew he was not very drunk.
- 9.34 Once Mr Alder emerged from the toilet, a conflict in the evidence emerges, which is difficult to reconcile, as outlined in the description of the evidence from the hospital in Chapter 3. The officers described Mr Alder changing his mind from being reluctant to receive treatment to wanting it, whereas Dr Khan says that he was present when Mr Alder emerged from the toilet and that he offered him treatment again but was rebuffed. Mr Rodgers also made it clear that outside the hospital Mr Alder, although he was more than ready to argue with the police, was not seeking to return to the hospital but wanted to go home.
- 9.35 The only justification for an arrest on the part of the police was their claim that Mr Alder might go back into the hospital and cause trouble. Paradoxically, the officers were describing Mr Alder volunteering to be treated while they – the officers – were saying that he could not be. If he had changed his mind and was saying he wished to return, the obvious question for the police to ask him would be whether he was willing to cooperate with the doctors. They did not ask that.
- 9.36 There is no reason to think that the hospital would not have treated Mr Alder at that stage if he had calmed down and was willing to comply. However, those who worked at the hospital describe no sign of a change of mind by Mr Alder.
- 9.37 If the evidence of Dr Khan and Mr Rodgers is correct, Mr Alder wanted to leave the hospital and go home. If that is so, then there is no basis for saying that a breach of the peace was imminent, as Mr Alder would be leaving the premises as soon as he could. It would also mean that the justification for the arrest of Mr Alder would be undermined.
- 9.38 There is a clear conflict of evidence regarding the exit of Mr Alder from the hospital. All of the medical staff saw him being taken out backwards by the police officers. The officers denied this. There is no good reason why the hospital staff should have invented this story, nor why they should all make the same mistake. The officers may well, however, have been concerned that their method of removing him did not look particularly caring. I am driven to the conclusion that the officers were not telling the truth about this incident in their statements or interviews. This suggests an element of collusion between them to try to present their actions in the best possible light.
- 9.39 In any event, no official from the hospital had told Mr Alder to leave the premises. The police were not requested or instructed by anyone to remove him, and therefore had no authority to force him from the building. Manhandling him in that way, without actually arresting him, was probably not lawful, although there is no evidence to suggest it

caused him any harm. Hospital staff observed this happening and did not interfere with it.

- 9.40 I also find it rather difficult to understand the explanation given by the officers regarding the summoning of the van. They claim to have called the van from Queen's Gardens police station in order to be able to tell Mr Alder that "if you do not leave by the time it arrives, you will be arrested".
- 9.41 This seems to be an overly elaborate and wasteful method of persuading him to leave. In any event, when the van was requested, PC Dawson was asked by the controller, "What was your prisoner arrested for?" to which he replied: "Prevent a breach of the peace".
- 9.42 He did not say anything to suggest that there was no arrest at that stage. Once again, I must conclude that they did not tell the truth about this incident in order to place themselves in a better light, and to be able to say that they had given Mr Alder every chance to leave.
- 9.43 In light of these lies, I have reservations about the truth of the evidence given by these officers in relation to Mr Alder's behaviour at the hospital. There is no doubt that Mr Alder was argumentative with the officers and that he probably could have walked away from the scene. It may well be the case that Mr Alder was not favourably inclined to them and that he would not have been happy about being told what to do by them.
- 9.44 Nonetheless, the evidence from the hospital staff suggests strongly that Mr Alder was making it clear that he did **not** want to return to the hospital for treatment. The justification of arrest to prevent a breach of the peace was not going to avail the two officers. Mr Alder was most probably arrested soon after being dragged from the hospital, on the basis that he was argumentative with the two officers. The evidence leaves me in little doubt that PC Dawson and PC Blakey decided to justify their arrest by saying that without it there would have been a risk of trouble in the hospital.
- 9.45 A potential breach of the peace occurs when:
- "harm is actually done or is likely to be done to a person or in his presence to his property or a person is in fear of being so harmed through an assault, an affray, a riot, unlawful assembly or other disturbance".⁸⁰⁹
- 9.46 If injury or harm is not threatened, then there is no breach of the peace. Difficult or obstreperous behaviour of itself could not justify an arrest under this power.

⁸⁰⁹ *R. v. Howell* [1982] Q.B. 416,73 Cr.App.R. 31, CA

9.47 This is not to say that there was **no** justification for the arrest of Mr Alder: the comments made later by PS Dunn regarding the Public Order Act were correct, in that the behaviour of Mr Alder almost certainly did place him in breach of Section 5 of that Act. The two arresting officers should have known that, in any event. So why not make the arrest on that basis? In my view it is telling that PS Dunn, when told that one of his men had made an arrest for breach of the peace, made the comment over the radio: “That’s pathetic”. When the point was raised with him later in interview he agreed that he may well have used the expression. He explained that:

“Since I’ve been in the charge room and prior to going into the charge room, as I said earlier on, I’m aware that officers will often go to incidents and arrest somebody to prevent a breach of the peace because in my opinion it involves sort of less paperwork.”

9.48 This, then, is one possible explanation for the use of the power by the officers on that evening: that it would involve less paperwork. This is supported by the evidence of Matron Winkley, when she was interviewed by the IPCC.⁸¹⁰ She said of PC Dawson that:

“He would far rather arrest them for a breach of the peace than something more serious, because then he wouldn’t have to do the paperwork. He was a good police officer, but he didn’t like the paperwork.”

9.49 The overall impression that is created by a careful examination of the evidence is that:

- the officers concluded that Mr Alder was drunk or drugged and largely responsible for his own state;
- they distrusted him as a result, and were ready to believe that he was not particularly ill but was feigning collapses – hence the readiness to attribute his collapse to that, later on;
- they regarded him as a nuisance and an annoyance to be removed from the hospital, although they did not have authority to do so;
- once outside the hospital, although they had given the hospital staff the impression that Mr Alder would be taken into custody and would therefore be kept under supervision, the police were quite content for Mr Alder to simply leave; and
- because he argued with them and used “argumentative banter” they arrested him, and sought to justify that arrest as being to prevent a breach of the peace.

9.50 As I make clear in Chapter 7 above, I believe that this treatment of Mr Alder sprang from, at the least, an unwittingly racist attitude towards Mr

⁸¹⁰ Bridget Winkley interview (10 March 2005) CA0138 p.5 [01380007]

Alder. My view is not that these were maverick officers who abused their power but that they were policemen who took a somewhat jaundiced view of a man whom they found annoying, and cut corners in their dealings with him. The suggestion – made at one stage by Ms Alder – that they were determined to arrest Mr Alder to get him back to the police station is not supported by the evidence; rather, this appears to be a case in which officers regarded him as a nuisance and wished that he would simply go away.

- 9.51 If the tragic events that followed had not taken place, one might wonder how the evening would have resolved itself. Mr Alder might have been arrested and released a few hours later without charge or have faced a minor public order charge before a Magistrates' Court. It must be acknowledged that had he been left to wander home alone he might in any event have collapsed. I do not suggest that his arrest was the reason for his death, but rather that it was one element in a tragic combination of events.

The handover from the hospital staff to the police

- 9.52 Perhaps the most crucial and yet most confused aspect of the treatment of Mr Alder during the early hours of 1 April was the handover between the hospital staff and the police. As is made clear by the HCC report, of which the Executive Summary is attached as Appendix 8, this exchange was muddled and beset by misunderstanding. As it states:

“the decision to discharge him was flawed. The doctor had yet to make a diagnosis. He was unable to carry out his plan of treatment for Christopher Alder, for example admit him for observation, x-ray his skull and refer him to a maxilla-facial surgeon. Despite this he decided to discharge him without seeking advice from a senior colleague...

It is also unclear whether the doctor thought that Christopher Alder was already in police custody as there is conflicting information in earlier statements. When the doctor first went to assess Christopher Alder the police were already present in his cubicle. The doctor did not seek to clarify why they were there and the police did not offer an explanation. In his interview by the Healthcare Commission the doctor said that either way it would not have affected the care Christopher Alder received from him. However it is likely that the presence of the police altered his decision to discharge Christopher Alder. He appears to have assumed that Christopher Alder was already in police custody and that in discharging him, he was discharging him to the care of the police.

There was a lack of clarity between the doctor and the police about expectations once the police removed Mr Alder from the hospital. The doctor discharged Mr Alder believing that the police would bring him back once he had calmed down. Once outside the hospital the police were initially going to let Mr Alder go home by himself.

There was a lack of understanding by nursing and medical staff about the implications of letting the police take Mr Alder into custody. This was a patient who was seen as difficult and aggressive, but who required ongoing medical care and had not been charged with committing a crime, and in the circumstance the police station was used inappropriately as a place of safety.”

- 9.53 The report also goes on to make the point that the officers had no real understanding of head injury symptoms that might manifest themselves after his discharge or of warning signs that something was wrong. The report does not, however, excuse the subsequent behaviour of the officers, and it criticises them for their lack of care of Mr Alder.
- 9.54 I accept fully the assessment of the HCC in these matters, including the necessary criticism of some aspects of the handling of Mr Alder by the hospital staff. I also accept that the officers would not necessarily know what to look for in head injury victims. The decision to discharge Mr Alder was evidently interpreted by the police as meaning that his condition was not very serious.
- 9.55 Comments made since the time of the events by Humberside Police, and specifically by DCC Clark, have tended to reflect a viewpoint that the behaviour of the police officers should be excused, as they could not be expected to diagnose medical symptoms. It has also been said that any criticism of their behaviour is made with the benefit of hindsight, and that it would be unreasonable to have expected any better judgement from them at the time. DCC Clark specifically stated that he thought the behaviour of PCs Dawson and Blakey was “reasonable”.⁸¹¹
- 9.56 However, in my view this does not properly address the problem. The officers knew that the X-ray had not been taken. They knew that Mr Alder still required further treatment at the hospital, and they knew that he had been collapsing earlier: the hospital staff did not say or do anything that would have suggested that his collapsing was an act or was not genuine. The two arresting officers were, nonetheless, content to say this to the custody officer on arrival at the police station.
- 9.57 More importantly, the officers were content to ignore his obvious later symptom – unconsciousness – or to attribute it to play-acting, which was their diagnosis of his behaviour. At the very least they could have

⁸¹¹ DCC Clark letter (11 November 2002) CA002 D61 [00020368]

telephoned the hospital to speak to Dr Khan or called for another doctor to examine Mr Alder. Instead, they did nothing.

Use of CS spray

9.58 I have already addressed the threat of CS spray being used in the hospital. It has been suggested not only that use of the spray was threatened outside the hospital, but that the spray was actually used. I do not believe that this happened, for the following reasons:

- No person saw the CS spray being used; Mr Rodgers did not even recall its use being threatened outside the hospital.
- The police admit drawing the canister and threatening the use of CS spray; if use was necessary, there was no reason not to admit to it.
- Nobody noticed the smell or effects of the spray later on.
- Mr Alder's body showed no signs of the spray's adverse effects, and neither did any other person, although Mr Rodgers and the officers themselves would almost certainly have been affected.
- No smell or trace from the van was noticed by Mr Gallagher, who checked for blood traces and who said that he would have noticed it. No reference to the clothes of the two arresting officers smelling of CS when seized is recorded.
- The tests on the spray containers, although not ideal, showed no signs of use.
- The medical tests carried out post mortem upon Mr Alder, although not absolutely conclusive, showed no evidence of his having been sprayed.

9.59 Even the most cynical commentator on the actions of the police would accept that if CS spray were used, and the officers wished to cover up the circumstances in which it was done, the easier path would be to admit its use and to invent a reason, after the death of Mr Alder, that could not be contradicted. I conclude that such use simply did not occur.

The van journey

9.60 A major concern raised on behalf of the family of Mr Alder is the possibility that an officer may have travelled in the rear of the van with Mr Alder and used the opportunity to inflict additional injury upon him. Alternatively, it has been suggested that the journey may have been interrupted and stopped to enable one of the officers, out of sight, to assault the detainee.

9.61 The evidence concerning the collection and delivery of Mr Alder by A/PS Ellerington suggests that he made the round trip to collect and

take Mr Alder to the police station in 12 minutes. That fits in closely with the assessment of (one-way) journey times carried out by Insp. Tolan of West Yorkshire Police, which suggests an average time of around five minutes. There is nothing in the timing of the journey that would lead me to conclude that the van journey was interrupted on the way back to the station.

- 9.62 I regard it as relevant that A/PS Ellerington was new to the shift that included PC Dawson and PC Blakey. Although a colleague, he was not a friend of theirs and does not appear to have known them well. A/PS Ellerington had virtually no dealings with Mr Alder. He described Mr Alder as being compliant on being placed in the rear of the vehicle. His attitude to his detainee would not have been in any way influenced by the earlier arguments between Mr Alder and the other officers.
- 9.63 I also bear in mind the evidence of Jim Elliott of the PCA, who attended the post mortem examination. Mr Elliott explained in interview with the IPCC that at the time of Mr Alder's death the new style of handcuffs used on Mr Alder had been in use for a number of months. Injuries to the wrists of detainees caused by such handcuffs were the cause of regular and frequent complaints, and this was something that Mr Elliott had been anxious to have checked at the post mortem examination. At his request John Clark, the pathologist, had taken care to examine Mr Alder's wrists but found no evidence of handcuff injuries.
- 9.64 As Mr Elliott was aware, if Mr Alder had been assaulted once he had handcuffs on, he was very likely to have suffered wrist injuries or cuts, resulting from voluntary or involuntary movement.
- 9.65 The evidence of Mr Crichton, the gatekeeper at the police station, appears to suggest that he thought that only PC Dawson emerged from the police car, therefore suggesting that PC Blakey may have travelled in the van with A/PS Ellerington and Mr Alder. However, the evidence given by Mr Crichton also suggests that he did not clearly recollect the events (for which I do not criticise him).
- 9.66 Mr Crichton believed that only two officers were at the back of the van and that the detainee was "being helped" in an "upright" position into the custody suite. The video evidence contradicts this view. Three officers were present; Mr Alder was not upright but almost horizontal when he was brought, being carried, into the custody suite. The description of him by the arresting officers as being wholly unresponsive is borne out by the CCTV.
- 9.67 For these reasons I do not feel able to rely much on Mr Crichton's recollection. As I have already observed, the events prior to the tragic death of Mr Alder would not have been unusual or noteworthy, and there was no reason why Mr Crichton should have recalled them particularly. The fact that no statement was taken from him until June would have allowed any contemporary recollection to slip away.

- 9.68 In addition to this, although there were shortcomings in the analysis of the forensic evidence, there was no evidence of blood spattering inside the van that would suggest that an assault had taken place inside the van. This was a matter on which the forensic scientist Gillian Leak was specifically questioned, and on which she remained firm in her evidence.
- 9.69 Further elements that gave rise to concern are certain differences between Dr Khan's records of the injuries and the observations recorded by Dr Clark at the inquest. Most striking among these was that Dr Khan recorded that Mr Alder had lost one tooth (believed to be the tooth found on the pavement by staff from the Waterfront Club) and that a second was loosened and out of alignment. At the inquest, however, the second tooth was also found to be missing and was never traced.
- 9.70 One of the main injuries to Mr Alder was the large abrasion to the back of his head, where it had come into contact with the ground. This was 3 cm in diameter, with a large underlying bruise and a small cut to the surface of the skin. He also suffered injuries to his mouth, specifically a deep cut, 1.5 cm long, to the inside of his left upper lip and a slightly larger cut to his left lower lip both inside and outside. Apart from a small bruise, there were also two teeth missing. Other injuries noted at the post mortem were:
- a 1 cm fine laceration at the front of head;
 - a 1 cm superficial graze on the right eyelid;
 - a 1 cm abrasion on the lower left arm; and
 - a tiny abrasion on the back of the left hand.
- 9.71 Dr Khan's examination of Mr Alder's head had been recorded by him as showing:
- "a 2cm x 4cm haematoma with some skin breakage to the lower border".
- 9.72 Dr Khan recorded the mouth as having:
- "a localised swelling to the area of the left side of his upper lip, with two wounds to the left side of his upper lip which were not bleeding".
- 9.73 He accepted that examination of the mouth was difficult but that he established that one tooth was missing and the tooth next to it was pushed back some 10 degrees from normal. He did not record the minor abrasions noted in the post mortem report.
- 9.74 The IPCC, in conducting this Review, sought advice from Dr Richard Shepherd, a consultant forensic pathologist. Dr Shepherd, who had

had no previous involvement in the case of Mr Alder, was asked to provide an impartial and expert view of the work undertaken by the other experts recruited to advise on behalf of the various parties to the case.

- 9.75 Dr Shepherd reviewed all of the available material regarding the possible changes in the injuries to Mr Alder and the loss of his second tooth. As will be seen from his report (Appendix 7) he was of the view that:

“Neither the reported differences in the injury to the back of the head nor the loss of the second tooth are, in themselves, sufficient to confirm beyond doubt that a further blow has been struck to the face and / or head of Mr Alder.

However the discrepancies in the descriptions of the injuries to the lips mean the possibility of a further blow in the same area of the face cannot be completely excluded.”

- 9.76 Dr Shepherd was also firmly of the view that the different circumstances in which the examinations were carried out meant that no significance should be attached to the four minor injuries to face, arm and hand that were noted by the pathologist. He also noted that the minor differences in description of the injury to the back of the head were most likely a reflection of the different circumstances in which the measurements were taken, since Dr Khan would not have had the opportunity to measure the injury precisely.
- 9.77 I have had the opportunity to consider all of this evidence, including the analysis of Dr Shepherd, and I accept that a scientific analysis will never absolutely rule out a possible scenario. Nonetheless, I strongly believe that the only reasonable conclusion that can be drawn from the evidence is that there was no assault during the van journey. I bear in mind that it would be grossly unjust to accuse the three officers of an assault on a detainee without evidence: there is no positive evidence of such an assault, and there is much that points firmly the other way.
- 9.78 There was no evidence in circumstances where one would expect such evidence if an assault had actually occurred: no blood pattern was found in the van to suggest blows having been struck inside it; there were no wrist injuries on Mr Alder to suggest his having struggled or attempted to avoid assault; and all his significant injuries were in one area, namely his mouth. Given the difficulties in examination at the hospital, it is quite likely that the full extent of injuries to his mouth was not appreciated at the time.
- 9.79 In addition to all of this, the timing of the journey from the hospital to the police station is not such as to allow for stops along the route; and A/PS Ellerington was not a friend of the two arresting officers and would have had no reason to cover up illegal or brutal activity by those

officers. He had had no prior contact with Mr Alder that would suggest he would have any reason to assault his own detainee.

- 9.80 Finally, it should be noted that the officers who carried Mr Alder into the custody suite took pains to place him carefully on the floor. Although the officers' behaviour at this point might be seen to be as putting on an act, their subsequent behaviour indicated a disregard for how their attitudes might be viewed later. Their behaviour when under observation was not brutal or aggressive, even if it was subsequently casual and, in my view, negligent.
- 9.81 Ultimately, the assertion that Mr Alder was assaulted by the police presupposes that he was important to them, beyond being viewed by them as a nuisance. The truth that emerges from the evidence was that he was not sufficiently important and that it was their disregard for him that was to prove their biggest failure.
- 9.82 I do not believe that Mr Alder was assaulted by any person after the fight at the Waterfront Club.

At the police station

- 9.83 A thorough comparison of the different explanations given by officers regarding the events at the police station shows quite clearly that the views of PS Dunn, A/PS Ellerington and PC Barr were all formed by reference to the comments made at the time by PC Dawson and PC Blakey. From the outset, even at the point when the doors of the van were opened, those two officers were expressing the view that Mr Alder was acting and feigning sleep.
- 9.84 When the two officers entered the custody suite they immediately stated that Mr Alder's behaviour was an act; no alternative view was ever stated by them, and it is clear that PS Dunn accepted their assessment; A/PS Ellerington and PC Barr did not dispute the view, and later they said that they also accepted the assessment. There is of course no direct evidence, one way or the other, to say whether Mr Alder faked his collapses at the hospital, but subsequent events suggest very strongly that he did not do so. It is now clear that he was not faking his unconsciousness in the van or custody suite, and the view put forward by the two arresting officers was not only wrong but positively misleading. This was a dismissive assessment of him, which was based upon no real evidence.
- 9.85 Indeed, the assessment that they made ignored real and immediate evidence: Mr Alder had not faked unconsciousness at the hospital at any stage. They had seen him collapse, in the sense that his legs gave way, but he had continually been loud and vocal, to the point of being offensive. The behaviour at the police station was wholly different in character. They also ignored the fact that he was now incontinent, even

though they believed he was not suffering from any serious condition and knew that he was not very drunk. This latter aspect should have reminded them that he had urinated only minutes before his arrest and was unlikely to have needed to do so again: double incontinence suggests a dramatic loss of control. They ignored the fact that he was clearly wholly unresponsive and not reactive to any stimulus, even when laid face down on a hard floor with his trousers coming down.

- 9.86 One comment that is recorded on the audio track in the custody suite during the time when the officers are standing discussing possible charges is, however, telling:

“Yeah he’s disabled...mentally disabled”.

- 9.87 Although it is not possible to be sure who makes the comment, it appears to have been one of the arresting officers. This bears out the attitude shown towards Mr Alder throughout their dealings with him.

- 9.88 The explanations given subsequently by PC Dawson in interview, in so far as they are comprehensible, are not credible. He protests that he thought Mr Alder may have been in a very deep sleep. He appears to change his explanation during the interview when it is pointed out that he was describing Mr Alder as acting. He then claims that he thought it might be acting but that he **later** concluded that Mr Alder was probably sleeping, and that he came to this conclusion around the time the handcuffs were removed. This change of heart is not demonstrated by any event on the video recording of the custody suite. Indeed, the view that Mr Alder may be suffering the effects of amphetamine is not mentioned to the custody sergeant at any time.

- 9.89 This stance is, however, positively contradicted by the conversation that he is seen and heard to have at about 04.03, recorded on the custody suite video. He is at that stage talking to Insp. Ford. PC Blakey is standing on the opposite side of the counter and is party to the conversation. During the brief explanation that PC Dawson gives to Insp. Ford, he says of Mr Alder – seemingly endorsed by his colleague – that:

“we had to drag him in here because he was...refusing to walk”.

- 9.90 Whether the final three words are actually spoken by PC Dawson or PC Blakey or both is unclear, but both appear to present them as their own. PC Dawson goes on to say that “it was his own fault”.
- 9.91 In light of all this, it would appear that PC Dawson’s view of Mr Alder did not change even when the arrested man was being vigorously, albeit ineffectively, resuscitated by other officers a few feet away from him.

- 9.92 A/PS Ellerington described the two arresting officers telling him that the “sleep” was an act when Mr Alder did not respond in the van. PC Dawson maintained this explanation in the custody suite and did not deviate from it. No other suggestion was put forward. He did not say that the man on the floor may have fallen asleep. When PC Dawson claimed in interview that he was always convinced that the collapsing that he saw at the hospital was genuine, this can only be seen as an attempt to justify his position; he had clearly told A/PS Ellerington something different in the police station yard.
- 9.93 Everything that I have seen suggests that PC Dawson’s consistent view, right up to the point when Mr Alder stops breathing, and indeed beyond, was that Mr Alder was simply being deliberately awkward. His explanations in interview can only read as attempts to rationalise and defend his position. They do not ring true.
- 9.94 PC Blakey was more candid than PC Dawson, in that he accepted that he always regarded Mr Alder’s behaviour as being feigned; he described his collapsing at the hospital as being a “dying swan act”, suggesting that the man they saw there was already putting on a pretence at the hospital. This, of course is a view that PC Dawson does not seek to dispute when it is said in his presence. However, PC Blakey required two minutes’ work to remove the handcuffs from Mr Alder’s wrists. Although I do not suggest that the time taken should be held against PC Blakey (the handcuffs are known to be easier to fasten than to unfasten), he is the one officer who had the most physical contact with the man on the floor. The complete lack of response from him should have been evident to the officer. PC Blakey had clearly made up his mind about Mr Alder and was not to be shifted from that view, despite the evidence already referred to.
- 9.95 PC Blakey claimed in his interview with West Yorkshire Police that Mr Alder was breathing “evenly” while lying on the floor. It is evident from the soundtrack to the CCTV that this was not the case and that Mr Alder’s breathing was uneven and laboured. PC Blakey was, therefore, either deluding himself or being deliberately untruthful about this.
- 9.96 The explanation given at the time that Mr Alder was feigning his behaviour was in itself a form of justification for his arrest; in effect the two officers were making the point to the custody sergeant that ‘this man is a troublemaker’. The other officers who had not been involved in the arrest of Mr Alder seemed prepared to accept and believe this assessment. It is also noteworthy that PC Barr sought to justify his failure to rouse Mr Alder by saying that he did not do so for the safety of the people present. Given that Mr Alder was handcuffed and face down, this is somewhat difficult to accept.
- 9.97 PC Barr was to tell the West Yorkshire Police officers in interview that he thought that Mr Alder was asleep. However, when he noticed the

lack of sound from Mr Alder, it is striking that he does not say, “He has stopped snoring”, but rather, “He’s not making those noises any more”.

- 9.98 This suggests that he did not in fact believe them to be the sounds of sleep but, rather, deliberate noises.
- 9.99 PS Dunn made it clear that he accepted the explanation of play-acting that was given to him. He described the sounds coming from Mr Alder as being “noises” rather than simply the sound of snoring. His recall of the noises that he heard was that they were unpleasant and designed to be upsetting. This is wholly at odds with the impression that the arresting officers sought to give: of a man sleeping soundly.
- 9.100 In the case of PS Dunn, the duty placed upon him as a custody officer was greater than that of his colleagues. As was quoted by the coroner at the inquest,⁸¹² Paragraph 9.2 of the Codes of Practice of the Police and Criminal Evidence Act (PACE) states that in cases of medical illness:

“The custody officer must immediately call the Police Surgeon (or in urgent cases, for example when a person does not show signs of sensibility or awareness, must send the person to hospital or call the nearest available medical practitioner). The custody officer must do that if a person is brought to the police station or already detained there who appears to be suffering from physical illness, or a mental disorder, or is injured, or fails to respond normally to questions or conversation other than through drunkenness alone, or otherwise appears to need medical attention.”

The coroner pointed out that it goes on to say:

“This applies even if the person makes no request for medical attention, on whether or not he has already had medical treatment elsewhere, unless brought to the police station direct from the hospital.”

- 9.101 The duty of care is therefore spelt out. The exception within the codes that allows the custody officer not to seek help if someone has come from hospital does not apply to this case. The reason for that is simply that PS Dunn failed to take sufficient steps to establish the status of the man brought in to the police station or to ask the obvious questions as to whether Mr Alder had been in the same state at the hospital as he was on arrival at the police station. The arresting officers made comments that point to the fact that he was **not** in the same state as

⁸¹² Inquest Day 30, p.66

when he left hospital. The sergeant failed to make the crucial connection and to appreciate that a dramatic change had occurred. He seemed all too prepared to accept the assessment of the arresting officers without making any independent checks of his own.

- 9.102 Analysis of the actions, inaction and responses of the officers in the custody suite, while appropriate, does not convey the inescapable sense of shock that is the response of almost everyone who has watched the videotape. As Supt Bates described it.⁸¹³

“I sat and watched it with my team. I remember the silence in the room as we watched it. Every minute that went by that he was laid on the floor, I was actually willing, I remember mentally willing someone to go and look at him. Eventually they did, but it seemed an age. I remember being shocked.”

- 9.103 The videotape shows that after the officers' discussion of Mr Alder and the handcuffs were removed, there is a gap of over four minutes from when PS Dunn looks at him [03:53:15] to when PC Barr looks over the counter [03:57:18] and says that he is not making noises. During that time, despite the laboured breaths and then silence, no other officer looks at, touches or goes near Mr Alder. Only PC Barr noticed the change in the sound he was making.
- 9.104 The indifference to the plight of the man on the floor, and the cynical dismissal of his obvious distress, is simply disgraceful. All of the arguments and hearings that took place have, in my view, clouded this simple truth.
- 9.105 The support of Humberside Police for their colleagues is understandable to a point. However, the acquittal of the charges does not amount to an endorsement of their behaviour. The duty to extend basic human concern and compassion to a man who was lying face down, half naked, incontinent and bleeding does not need to be established in a court of law. It should be self-evident. The failure of Humberside Police to acknowledge this fully and frankly has exacerbated the pain of the family of Mr Alder and made the process as long and painful as it has been.
- 9.106 My assessment of PC Dawson and PC Blakey taken together is that they behaved in a lazy, cynical and complacent way regarding the man in their care. They, and particularly PC Dawson, were less than fully frank in their explanation of the events and their reactions, in order to justify their position. They showed a marked lack of concern and care for the man in their custody. This is summed up in the comment made by PC Dawson to Insp. Ford when he said of Mr Alder that “It was his own fault”.

⁸¹³Supt Bates interview (22 April 2005) Tape 1 p.21 [01320023]

- 9.107 PS Dunn, in my view, relied far too heavily on the judgement of the arresting officers and may have allowed himself to be influenced by the judgement of PC Dawson, with whom he had previously worked when the latter was a warder in the custody suite. As a result PS Dunn failed in his duty to the man who was brought in, by accepting without question or check the assertion that he was faking illness, when in fact he was in profound and ultimately fatal difficulties.
- 9.108 The obvious incontinence, laboured breathing and fresh bleeding from the mouth should have alerted PS Dunn to the need for further investigation, at the very least. Apparent unconsciousness on its own should have been enough to cause him to try to rouse the man on the floor. There is no evidence of an awareness of risk on his part that one would hope for in a custody officer.
- 9.109 The two other officers, A/PS Ellerington and PC Barr, both allowed themselves to be swayed by the assessment of the arresting officers and to ignore obvious and urgent signs of distress shown by the detainee in their care. However, they were clearly less responsible than the custody sergeant, who had the primary duty of care over Mr Alder. A/PS Ellerington clearly has less responsibility than the others involved – I regret that he has not clearly distinguished himself from them.
- 9.110 I remind myself of the comments made by the medical experts in their third joint report, quoted above in Chapter 5. The report said:

“All the experts were agreed that they could be sure that granted that the causes of Christopher Alder’s unconsciousness are and were then unknown, in effect his chances of survival would be equally unknown. Therefore **the actions of the policemen in their positioning of him, coupled with their failures to monitor him, for example to take his pulse, or to render him any first aid whatever effectively deprived him of the very chance of living**, or the chance of having his life saved by emergency medical intervention...

All agreed...that **Christopher Alder had at least a chance of survival, which was denied to him by the actions and inaction of the policemen.**” [My emphasis]

The failure to acknowledge this responsibility on the part of the officers is the reason why, notwithstanding their acquittals at trial, their attitude is an affront to the Alder family. The failure by Humberside Police to recognise openly that the officers failed is, similarly, offensive to the family.

- 9.111 Mr Alder was laid face down on the floor at Queen’s Gardens police station. I cannot say for certain that the position he was placed in contributed to his death. However, all the experts who discussed this issue considered it was dangerous and might have caused positional

asphyxia. However high or low Mr Alder's chances of survival were at that stage, the position he was placed in resulted in additional unnecessary risk.

- 9.112 The issue of first aid training is one that has received careful consideration subsequently. The activities of the officers at the police station in trying to resuscitate Mr Alder were vigorous but not well organised. It is fair to point out that PS Dunn and PC Barr were obviously concerned by this stage and made anxious attempts to try to revive Mr Alder. I have seen nothing on the videotape to suggest that the efforts were merely token gestures, and I am left in no doubt that theirs was a sincere and concerted effort to save the man's life.
- 9.113 The lack of first aid training among the officers on duty was an obvious area of risk that has since been addressed by Humberside Police.

Developments since 1998

- 9.114 From discussions with Humberside Police officers and witnesses in the case I am left in no doubt that the level of awareness among custody officers within the force has improved and that there is a heightened concern about detainees with injuries. PS Jenny Mordew is an officer of Humberside Police who is based for a large proportion of her time at Hull Royal Infirmary, to liaise between the HRI and the police. In interview she described the reluctance of her colleagues to allow persons with injuries to be received into custody. I take some reassurance from Humberside Police's willingness to build links with local hospitals that there is a determination on its part to avoid the same misunderstandings that occurred on the night of Mr Alder's death.
- 9.115 The understandable anxiety of Humberside Police to prevent the type of failures in Mr Alder's case from re-occurring was highlighted only a matter of days before IPCC staff visited Hull to speak with the various witnesses. They were told that a detainee had been brought into Queen's Gardens police station who was black, and who was suffering from a head wound and appeared to be less than fully conscious. The custody officer on duty made immediate arrangements for transfer of the man to hospital, and I am led to understand that he made a full recovery. Matron Bridget Winkley, who was on duty the night this man was brought to the station, was so traumatised by the obvious parallels with what had happened to Mr Alder that she was unable to continue working and had to be allowed to go home. The incident resonates all too clearly with that of Mr Alder.
- 9.116 During the course of the Review, Matron Winkley was interviewed by the IPCC.⁸¹⁴ She said of her experiences that:

⁸¹⁴ Bridget Winkley interview (10 March 2005) CA0138 p.5 [01380007]

“this is the first time that I have ever had an opportunity to tell anyone about what I saw that night. Other than when I made my statement, no-one has ever asked me to give my account. I was ill during the inquest, and at the trial it all stopped before I had the chance to give evidence. This has had an enormous emotional impact on me, I’ve never had a debrief, I was never visited when I was off sick and I’ve had no proper help in trying to come to terms with what happened. I did have some phone calls when I was off but they only really asked when I was coming back to work. When I did get back no-one asked me how I was or gave me any support.”

- 9.117 The IPCC was also contacted by Chief Superintendent Cheeseman of Humberside Police. Although C/Supt Cheeseman had no involvement in the events of April 1998 or the subsequent hearings, he became Divisional Commander of D Division (Hull) within Humberside Police in April 2000. He informed the IPCC that he had spoken to Matron Winkley concerning her welfare needs on a regular but informal basis, and that Insp. Ford, and later C/Insp. Julie Davies, had also provided some welfare support on a more formal basis. He had received no indication that Matron Winkley was dissatisfied with the latter support.
- 9.118 C/Supt Cheeseman acknowledged that the force had moved on in the intervening years, and that if such an incident happened in 2005 “the needs of staff would be better responded to”.
- 9.119 I accept that Matron Winkley is still deeply affected by the experiences of April 1998 and the ensuing years. It may well be the case that Matron Winkley is not the only employee within Humberside Police for whom the circumstances of Mr Alder’s death remain a traumatic and unresolved issue. This is an issue that Humberside Police still needs to address.

The making of racist noises

- 9.120 Ms Alder highlighted the concerns of the family in a comment on the queried noises, quoted in an article in the *Guardian* newspaper following the end of the trial. She said that:⁸¹⁵

“West Yorkshire Police and the CPS have seen everything. How could they miss it? They just wanted this to go away. It’s typical of the racist, inhuman and disgraceful way they’ve treated my family and my brother...”

- 9.121 The issue falls into two parts. The first is whether the noises were deliberate racist insults, made because of the presence of Mr Alder’s

⁸¹⁵ *Guardian* article (23 July 2002) CA002 D22 [00020522]

body in the custody suite. The second question is why the noises went undetected for four years and whether this was in itself an attempt to cover up disreputable behaviour.

9.122 Ms Alder has been adamant in her conversations with my staff, and before that with the PCA, that the conversations do refer to 'banana boats' rather than boots, which she, for obvious reasons, sees as being more capable of being a racist insult. Ms Alder may have heard the relevant part of the tape at some point, but I am unable to say whether she has had a chance to listen to an enhanced version of the tape.

9.123 I bear in mind that the experts who analysed the tape could not agree what words were uttered, let alone what those words meant. Ms McClelland described the original phrase as:

"I'll not go down in that fucking blue suit [laughter] fucking banana boat...I'm not going home in [(one)]"

Whereas Dr French thought the words were:

"I'm not going out in a fucking blue suit.
[Questioned sounds for 3.7 seconds]
Fucking banana boots, I'm not going home in them."

9.124 Given the evidence that emerged concerning the use by Humberside Police of blue forensic suits and yellow overshoes, I believe the explanation put forward to the effect that PC Barr had been grumbling about wearing forensic over-clothes in place of his seized uniform is the correct one. The view taken by Ms Hawkins of the PCA and her comments on this make eminent sense, in my view. This behaviour by the police officers was entirely of a piece with their earlier approach to Mr Alder: they forgot that he was even there.

9.125 The issue of the associated noises, which were thought to be potentially "monkey noises", is difficult. The noise that is recorded is capable of interpretation either as monkey-like grunts or as laughter. It is possible that the sound is merely that of Matron Winkley laughing at the comments made by PC Barr (as Matron Winkley asserts). It is also possible that the noises are an attempt at a joke by PS Dunn, based on the reference to "banana boots". Despite repeated listening, it is not possible to say for certain, taking the noises *in isolation*, which of these it is.

9.126 In light of the allegations made by the family that the matter was deliberately missed or covered up by the West Yorkshire Police's investigation, the tape has been carefully considered and the offending comments have been listened to and analysed on behalf of the IPCC. They are indistinct and faint on the tape. Despite repeated listening with ordinary equipment, it is still not possible to establish precisely what the words or sounds used are.

- 9.127 I also have to consider the issue of the noises made earlier in the evening by PS Dunn when LM, the woman admitted into custody at this time, passed through the custody suite. The making of monkey noises, if that is what they were (in my view, the actions and noises at this time are capable of no other explanation) would appear to be a joke by PS Dunn; whether it was one that he employed regularly it is not possible to say.
- 9.128 I do not agree with the interpretation placed on these sounds by Ms McClelland. It is clear to me that noises were being made by PS Dunn in a mocking fashion towards the detainee in question. The noises were accompanied by monkey-like gestures. Gestures and noises of this kind are the common currency of racist abuse. Even if on this occasion the insult was directed at a white person, I have no doubt it was intended to be abusive and find it hard to believe that PS Dunn was unaware of the racist connotations that this insult carried.
- 9.129 Furthermore, bearing in mind the analysis of Dr French, and the events earlier in the evening, I believe that the most likely explanation of these noises on the second occasion they are heard is that they are indeed 'monkey noises'. They were made as a black man lay dead on the custody suite floor.
- 9.130 Given that the same officers had watched and heard him die on the floor of the custody suite less than two hours before, it is easy to appreciate the Alder family's dismay and anger at this level of casual indifference. Whatever the intention, these noises have a general use as a racist insult. I cannot be sure they were directed at Mr Alder, even on the second occasion when they appear to have been made. However, I am certain they contribute to the impression of unwitting racism that I believe influenced the officers who were dealing with Mr Alder on that night.
- 9.131 The enhancement of the audiotapes, as described in the introduction to this report, enabled members of the Review team to assess independently the sounds that were recorded by the custody suite microphone. The transcript of this particular period is appended to this report at Appendix 24.
- 9.132 As part of this Review, the West Yorkshire Police officers were given the opportunity to comment on the complaints raised by Ms Alder concerning the missing of these sounds. In interview Supt Holt said of this process that:⁸¹⁶
- A. ...our role was to view all the available CCTV. In the first instance it focused on the point from which Christopher Alder is brought into custody up to the point where the paramedics

⁸¹⁶ Supt Holt interview (8 March 2005) CA0114 Tape 3, pp.11–13 [01140052–4]

finish trying to resuscitate him. But subsequent to that it was extended to view the CCTV from the time when the call from the dispatch centre was received into the custody suite that there was a prisoner en route, and then beyond that to the point at which Humberside were called in to commence the homicide investigation, so where DI Alan Brookes first goes into the custody suite. Then the examination of Christopher Alder by the pathologist and ultimately the whole of the period”

Q. One of the concerns that the family of Christopher Alder has raised, and it is a question simply put, why was the full CCTV not viewed for four years?

A. It was. It is a nonsense to suggest that it was not viewed for four years...counsel on behalf of the family at the Inquest had all the CCTV tape and had listened to the whole of the CCTV and had not picked up on the issues that I am allegedly – or myself and Keith Tolan have allegedly not picked up on until four years later.

9.133 Insp. Tolan was also invited to comment on the suggestion that there was a failure to view the tapes prior to the trial:⁸¹⁷

“we made sure that they were going to preserve the tapes that related to the, to the full shift...so we knew that that was all secured and as the, as it progressed we got to the stage where we viewed the entire tour of duty to see what was, what the officers...were doing and what their demeanour were like, how busy they were, that type of thing, and listened to the conversations as well, and then we did the same, we got copies of the tape that then ran through all the way to the body being removed, and it was, it was to, it was subsequent conduct, as it were, to listen to what they were talking about, and also the demeanour, and looking really for any racist language as well as any conversation that related to the incident.”

9.134 Insp. Tolan made it clear that **all** the tapes were listened to, with a view to finding comments that revealed any views expressed by the officers, including anything racist. He was emphatic that the comments were far from clear and that they were not recognised as potentially racist as a result of that lack of clarity. Even the experts could not agree on what was actually said, but he pointed out that the final conclusion was that the original transcription that excited the debate was wrong, and that it referred to “banana boots” and not “banana boats”.

9.135 C/Supt Holt and Insp. Tolan both confirmed that lawyers for the family at the inquest had been provided with a copy of the videotape for all of

⁸¹⁷ Insp. Tolan interview (14 February 2005) CA0112 Tape 3 pp.5–9 [01120059–63]

the relevant period. It is evident, and I make no criticism, that those lawyers did not spot these noises either. This, in my view, illustrates how difficult the tapes were to decipher.

- 9.136 I am of the view that the failure to appreciate the potential significance of a snatch of indistinct conversation does not substantiate an allegation of racism. Moreover, the prompt disclosure to all concerned, and the trial prosecution's efforts to get a transcript, demonstrate that the matter was taken seriously.

Assessment of Humberside Police: the investigation

- 9.137 Humberside Police was allowed to take too much of the initiative in the investigatory process and undertook tasks that should have fallen to West Yorkshire Police. The consequence is that the jury in Mr Paul's civil case reached the damning conclusion that Humberside Police continued with their investigation against him to draw attention away from their own failings with regard to their treatment of Mr Alder. I have not seen evidence that suggests this was a deliberate intention. Mr Paul was arrested and charged before any of the investigators had seen the devastating content of the Queen's Gardens custody suite tapes., Whatever the intention, however, the effect of the Humberside investigation was indeed to marginalise the inquiry carried out by West Yorkshire.
- 9.138 Humberside Police continued to describe their investigation as a "murder inquiry" throughout the month of April, despite the decision having been taken to charge Mr Paul with an assault, and not homicide. The summing up in Mr Paul's second civil trial makes clear that the police had confirmed to the Crown Prosecution Service on 3 April that Mr Paul was not to be charged with the death.
- 9.139 The senior officers of Humberside Police who were interviewed as part of this Review were clear in their disappointment that the CPS eventually chose to abandon the prosecution of Mr Paul for an assault. They cited the force of the blow that resulted in the immediate loss of one tooth and the loosening of another as being clear evidence that the blow went beyond mere self-defence.
- 9.140 Be that as it may, I am at a loss as to why Humberside Police could justify calling their inquiry a murder investigation for so long. The effect of so doing may well have encouraged West Yorkshire Police to take the view that Humberside Police were going to resolve the issue, and to accept a 'back-seat' role.
- 9.141 I am most concerned about the lack of clarity in planning and the failure to divide responsibilities on the correct lines between the two forces. Although both sides needed a clearer approach, I find more fault with

West Yorkshire Police for sitting back and allowing Humberside Police to take the initiative.

- 9.142 Although Humberside Police did use the HOLMES system for the investigation, no policy or strategy was documented by them at the outset of the investigation, and there is no formal record of the briefing that should have been given to the West Yorkshire Police or to the PCA representative. Indeed, it later became clear that Insp. Tolan had been given misleading information, in that he was told that Mr Alder walked into the station and collapsed at the desk.⁸¹⁸ It was only at the point that he was shown the video of the arrival that Insp. Tolan appreciated that this was not the case.
- 9.143 Although the local Race Equality Council (REC) was contacted, there does not seem to have been an assessment of the impact of the incident upon the local community, although it is clear that the effect was fairly far-reaching.
- 9.144 Another area of weakness that emerges from the investigation was the lack of any proper forensic strategy. Supt Bates was content to leave this to the discretion of the senior scene of crime officer, without becoming involved in the strategic planning of forensic evidence gathering. It may well be that as a result of this the yard was not treated as a potential crime scene. It certainly led to the confusion between Mr Gallagher and Mrs Leak; the latter was left to her own devices and expected simply to use her initiative in deciding what needed examining. This was not the fault of Mrs Leak, who did all that she reasonably could have done to ensure a full examination.
- 9.145 The subsequent failure to have all of the collected samples properly examined is almost certainly a result of the poor interaction between Humberside Police and West Yorkshire Police. I understand that Humberside Police may have regarded such an examination as being redundant once its investigation had come to an end. The same cannot be said for West Yorkshire Police. Because neither force had a forensic strategy, and because West Yorkshire Police assumed that Humberside Police would undertake virtually all of the work, when the latter failed to have analysis done, West Yorkshire Police did not pick this up or ensure that it was undertaken.
- 9.146 The overall lack of coordination between the two forces and lack of proper contact between the two SIOs meant that each force was 'ploughing its own furrow', with little regard for what was being done by the other party. Supt Bates informed us that material gathered by Humberside Police was left in a tray for Insp. Tolan, but there was no formal record of what he was given or even whether he collected it. There is no record of which briefings were attended by Insp. Tolan, although it is thought that he went to some, and that Supt Holt went to

⁸¹⁸ Insp. Tolan interview (14 February 2005) Tape 1 p.10 [01120012]

only a very few. The Humberside Police HOLMES material was eventually all made available to West Yorkshire Police, but what use was made of it is not recorded. Again, the failure here lies more with West Yorkshire Police than with Humberside Police.

9.147 I deal below with the problem over family liaison, caused in large part by overlap between the two forces.

Complaints of harassment made by Ms Alder

9.148 At a relatively early stage Ms Alder made allegations to the effect that she was being followed by the police and that her telephone was tapped and her mail interrupted. She clearly believed this to be true and that Humberside Police regarded her in some way as a threat. I am not aware of any evidence to support these allegations. They are denied by Supt Bates. They do not appear to me to be justified.

Search of Mr Alder's flat and enquiries about his personal circumstances

9.149 No record has been disclosed to this Review that states whether or not the items seized during the search of Mr Alder's flat on 3 April 1998 were subjected to any tests for drugs. There is no record on the face of the HOLMES log to say why drugs or steroids might be thought to be a possible factor in the death of Mr Alder, although I have found reference in a later statement by Leonard Bottomley to the suspected use of steroids by Mr Alder in 1997.⁸¹⁹ By the time of the search, it was already known (in the words of Supt Holt, recorded as 16.00 on 3 April⁸²⁰) that:

“Following tests carried out on samples taken by Dr CLARK during the Post Mortem it has been established that no trace of the commonly used drugs such as Cannabis, Heroin, Cocaine, Amphetamine or Ecstasy were found and that the alcohol level was approximately 2½ times the legal driving limit. At this stage the results do not assist in identifying a cause of death.”

9.150 Why Humberside Police, who had access to the same information, should therefore regard drugs as being a relevant factor in his death is unclear. Given that Mr Alder was the victim of a crime, and that this crime did not involve his home address, the need for six officers to search the one-bedroom flat is questionable. The approach taken appears to have been based upon the assumption that he was a potential drug user. The thoroughness of this search and the decision to seize his computer, pager and filofax would seem to indicate that he

⁸¹⁹ Leonard Bottomley statement (16 April 1998) CA0095 p.152 [00950153]

⁸²⁰ W. Yorks. policy log (3 April 1998) CA0085 [00850009]

was being investigated as thoroughly as Mr Paul – who was by then under arrest – if not more so.

- 9.151 The need to seal off the flat for the following two weeks, to draw a map of where the items were found and, subsequently, to photograph the premises is, similarly, not apparent. The handling of the flat is far more in keeping with what might be expected if Mr Alder were a suspect rather than a victim. The lack of a proper policy on family liaison would only have exacerbated the impression given to the family that a thorough investigation into the background of the victim, when the family regarded the investigators' colleagues as being his potential killers, was done for the purposes of finding something that could be used against the dead man. That can only have been seen as insult on top of injury.
- 9.152 A similar concern arises from the decision by Humberside Police to pursue very detailed research into the family history of Mr Alder and his siblings. Detailed social service records going back to their birth were obtained for all of the children. Although it is appropriate for the police to consider the background of people involved in any investigation – including the victims – the detail that was retrieved in this case did not have seem to have any relevance to a case in which the police's main theory was that he died after a punch-up outside a nightclub.
- 9.153 Although this material does not seem to have been used by the police in any fashion at all, its collection may call into question the attitude of the Humberside Police investigators. Nothing relevant came of these enquiries.

Assessment of family liaison

- 9.154 This topic touches upon the activities of both the major police forces involved and the PCA. It is most easily treated as a discrete area.
- 9.155 Liaison with a family in the circumstances of the death of a loved one is inevitably difficult. The circumstances of this case made it, if anything, more difficult than most. Mr Richard Alder and Ms Alder were understandably distraught and were sceptical about the information that they were given after the death of their brother. That scepticism was appropriate, given that at least some of the details passed to them were incorrect. The delay in producing answers to a series of pressing questions and the inconclusive results of the various post mortem examinations added to their confusion and distress.
- 9.156 Any relative of a person who has died in custody is likely to be unfamiliar with the process following a death or the extended investigations that ensue. Relatives want answers to their questions. Unfortunately answers are not always available, and family members will understandably view this as a sign that the police are covering up

their own liability. This is a pattern that has been seen in previous cases of death in custody. The reasonable reactions of the bereaved family members should not have come as a surprise to the investigating officers.

- 9.157 Regrettably, I am driven to the conclusion that the family liaison in this case went wrong from an early stage, despite dedication and goodwill on the part of some of the authorities and repeated attempts to get it back on track. Several of the bodies involved were responsible for this, and these failures are best looked at as a whole, because the failures arise as much from a lack of coordination between these bodies as from individual shortcomings.
- 9.158 It should be noted from the outset that family liaison did **not** fail as a result of any lack of dedication or goodwill on the part of individuals. The efforts made by Mr Elliott to build up a bond with the family and to keep them informed of the investigation as it proceeded were undoubtedly sincere. I am left with the impression that he expended great physical and emotional energy in seeking to build bridges, with sadly limited results.
- 9.159 PC Beatrice Smith of Humberside Police also displayed great dedication and worked very hard in attempting to assist the family. I commend her for her efforts. PC Smith made the point, in interview with the IPCC, that she was qualified as a victim liaison officer (VLO) to deal with the victims of sexual assault. She was not in fact qualified to act as a family liaison officer (FLO), which would have required a different form of training. The fact that her qualifications were not entirely appropriate is something that her superior officer should have considered. Ultimately she was, in my view, let down and compromised by her senior officers, through no fault of her own.
- 9.160 The difficulties in this case reflect the difficult position of family liaison in dealing with deaths in custody. Family liaison was developed essentially to provide a link between the family and the investigation team, to assist in solving a crime. Where a person dies in police custody, this link can be an exceptionally difficult one for any police officer to build if the family regards the police themselves as the suspects. In such circumstances it is possible that nothing that the authorities did would necessarily have satisfied Ms Alder. That does not, however, excuse the failings that did take place. I set out below some of those failings.

Appointment of the family liaison officer

- 9.161 Humberside Police officers were correct in realising that a FLO should be appointed, but given that it was known that the PCA would be involved it would have been a wiser policy to discuss this aspect with West Yorkshire Police from the outset.

- 9.162 West Yorkshire Police, as stated elsewhere, employed too few officers on its investigation team. Three police officers to investigate a death is an inadequate number, and the FLO role should have fallen at least as much on their shoulders as on those of Humberside Police. Given the small team from West Yorkshire Police, that was likely to prove impossible. It should not have been so. The Humberside officers were investigating a potential murder, and were looking for culprits; the West Yorkshire officers were asking: 'how and why did this man die, in the circumstances that he did?' This was the question the family was likely to ask, and West Yorkshire Police should have been answering it.
- 9.163 Supt Holt does not seem to have appreciated the importance of family liaison in such matters; this is perhaps explained by his lack of previous experience of cases of death in custody. I am also left with the impression that he had no great enthusiasm for such liaison. His comment in the policy log to the effect that the family should "come to terms with their grief first" rather misses the point that family liaison is about assisting that process by the provision of information. The task of the FLO is not simply to express sympathy and to give the victim the opportunity to talk about their grief; it is also to be a conduit for information between the family and the investigation.
- 9.164 Mr Elliott, to his credit, appreciated the importance of that role. I fully accept that Mr Elliott was going beyond the normal remit of the PCA at that time, by attempting to give greater emphasis to the family. He sought to avoid unnecessary misunderstandings by means of early meetings and passing on such information as he could. His intentions were of the best. He was adamant that he was not taking on the role of FLO himself. I am, however, driven to the conclusion that this is what he did, even if that was not his intention. He expressed the view that he had seen officers in other cases mishandle family liaison and was anxious that this should not happen in this case. Supt Holt was obviously happy to let him get on with this.
- 9.165 The drawback to this approach was firstly that Mr Elliott did not have time to do this job. He had a caseload of about 100 live investigations. The death of Mr Alder was only one of over a dozen deaths in custody that he dealt with that year. As a result, Mr Elliott's involvement in the case was, after the first few days, bound to be limited to the information that he was receiving from the West Yorkshire police officers.
- 9.166 A second drawback was that Mr Elliott was not trained to take on this role. The fact that he had seen it done badly was not a reason for him to take it on himself. It was an error, in my view, to assume that his previous experience qualified him to do so. I believe that Mr Elliott should have insisted that West Yorkshire Police took the primary role in family liaison and bring in an officer dedicated to that task. By undertaking as much as he did, Mr Elliott effectively excused West Yorkshire Police from doing anything about family liaison.

- 9.167 The prime example of misunderstanding arose when Mr Elliott attempted to explain to Mr Richard Alder that there were likely to be inconsistencies in the early versions of the facts, as matters were still being clarified: Richard Alder interpreted this as meaning ‘the police are lying to you’, which, I accept, is not at all what Mr Elliott meant to convey. Mr Elliott was ultimately no more successful with Ms Alder, although he was subsequently to receive many hours of telephone calls from her. His file notes contain many references to her suspicions of him and assertions that he was covering up for the police.
- 9.168 I am also satisfied that Humberside Police acted in good faith, but made errors that caused difficulties for themselves and others. The earliest meetings with Ms Alder quickly gave rise to distress and misunderstanding. The fact that an officer was eating a sweet while discussing the death of her brother would have left the inevitable impression that his death was a matter of little consequence to the police. This is a matter of simple human sensibility, and an officer of the rank of inspector should not have needed this to be spelt out.
- 9.169 The appointment of PC Smith – one of the very few black officers on the force – was done, I accept, with the best of intentions. PC Smith had some relevant training and knew members of the local black population, such as Mr Dennis Fyle, leader of the local Race Equality Council, before the case began. She was not, therefore, merely a token presence in the Humberside Police team. No objection was taken to her by Mr Richard Alder.
- 9.170 Ms Alder, however, clearly did feel that being allocated a black FLO was patronising. A more sensitive approach to this by Humberside Police – giving her a choice as to the FLO – would have gone some way to improving relations and building trust. The fact that Mr Richard Alder did not mind, and indeed seems to have welcomed the appointment of a black officer, does not mean that such an approach should have been assumed as correct for Ms Alder.
- 9.171 Ms Alder also criticised the fact that she was being allocated a FLO who was not part of the investigation. It is easy to understand that she would feel entitled to the best information available: she did speak directly to Insp. Brookes and to Supt Bates, although she was unhappy with both of those officers. Had she been allocated an officer who was involved in the West Yorkshire Police enquiries, who could speak directly about what they were doing, this would also have worked to the benefit of both sides. This might also have avoided the confusion that was created, unintentionally, in speaking to different officers at different stages of the investigation.
- 9.172 The need for liaison to be carried out by an officer involved in the investigation was also highlighted in the events that occurred towards the end of April. Supt Holt decided to meet with Richard Alder, and the

meeting that was arranged also involved PC Smith. As this was the first meeting that Supt Holt had with the family, there was no reason for them to necessarily trust him, and no effort had been made by West Yorkshire Police, as opposed to Humberside Police, to pass on any details of the work that they had done. The meeting was accordingly acrimonious.

- 9.173 Within two to three days of this meeting the five officers were suspended from duty. There is no record of the family being told in advance. It is equally evident that PC Smith was not told in advance that it would be happening. As a result her credibility with the local REC was destroyed. In interview with the IPCC she explained that since that time she has been unable to rebuild some of the bridges with the community that had been broken.
- 9.174 Humberside Police's approach to liaison with the family displayed a lack of planning and on occasions a woeful insensitivity to the stresses on and concerns of the family members. A more carefully planned and inclusive policy on their part would have recognised their fears and concerns from the outset. Good family liaison does require what may appear to be a disproportionate investment of time and energy in an investigation. It is, nonetheless, crucial to handling such cases.
- 9.175 West Yorkshire Police, similarly, made wholly inadequate efforts and delegated the task to Humberside Police from the earliest stages. The loss of confidence that resulted could not then be put right.
- 9.176 Both forces made the fundamental error of assuming certain things about the case and acting only in accordance with those assumptions. They assumed that Mr Alder died as a result of the assault at the Waterfront Club; they assumed, therefore, that the death of Mr Alder in police custody amounted to no more than unfortunate timing. They further assumed that everyone else would view it in similar terms. The major assumption made by both forces concerning the family of Mr Alder was that they would be content simply to be told the conclusion of the investigation and (after 'tea and sympathy' from a liaison officer) would accept that conclusion. In all those assumptions they were wrong.

Changes in approach

- 9.177 In contrast, the approach taken in 2006 would be different to that adopted in 1998. There is now a greater awareness that the family of a deceased person has a potential role to play in the investigation and indeed is entitled to that role. There should be a family liaison strategy, and in determining that strategy the SIO in the case should consider the needs of both the family and the FLO.
- 9.178 Guidance set out in the *Murder Investigation Manual*, used by police forces around England and Wales, indicates that although the SIO

should carefully consider the appointment of an officer who reflects the cultural or lifestyle background of the family members, to do so without consultation can be detrimental to the relationship between the police and the family and could be viewed as tokenism. Appointment in such circumstances should be made only after discussion with family members and should be endorsed as appropriate by the SIO as the result of a carefully reasoned and recorded decision.

- 9.179 The aim of the SIO must be to achieve a partnership approach with the family. For this reason, defining and developing the family liaison strategy should take into consideration the needs of the family, the lines of enquiry and the available intelligence. This strategy should be recorded by the SIO in a policy file.
- 9.180 At the outset of an investigation, the SIO should meet the family as soon as is practical, as a main priority. The onus is therefore on the SIO to take all possible steps to overcome any barriers or difficulties. There is also an onus on the FLO to inform the SIO of any factors that the FLO is aware of that make his or her deployment or continued retention inappropriate. These factors might include views expressed by the family or conflicts with the family.
- 9.181 In all cases referred to the IPCC, within 24 hours of referral the IPCC will consider whether or not it is appropriate to meet personally with the bereaved, or potentially bereaved, family members and their legal representatives. This was not a requirement for the PCA, although it is clear that Mr Elliott made it a personal priority, which is very much to his credit.

Assessment of West Yorkshire Police

- 9.182 The referral of the investigation of the death in custody of Mr Alder to a second police force by Humberside Police was undertaken under the Police and Criminal Evidence Act 1984 ('PACE'), Section 89. That Act permitted referral to another police force by the 'home force' on the grounds of gravity or exceptional circumstances.
- 9.183 Humberside Police were quick to recognise the serious nature of this incident and the implications for the involvement of the PCA. C/Insp. Beckett of the Humberside Police Force's Discipline and Complaints Department was contacted at 05.23 on 1 April 1998 and began the process of informing the PCA by telephone. This referral was made formally through the submission of a faxed form at 11.02 that confirmed the known details at that time and that Supt Holt of West Yorkshire Police had been appointed as SIO.⁸²¹ The prompt and appropriate action by Humberside Police ensured that there was an opportunity for the members of the outside force's team, and the PCA member, Jim

⁸²¹ Humberside Police fax [00010384]

Elliott, to attend the scene on the first day and at a very early stage of the enquiry.

- 9.184 Since the creation of the IPCC in 2004, the process for investigation of such matters has changed radically. Today the Police Reform Act 2002, in Schedule 3, Paragraphs 4(1), 13(1) and 14A(1)⁸²², outlines the circumstances in which cases should be referred to the IPCC; and whereas before it involved an exercise of discretion on the part of the home force, today it would be mandatory that any case involving a death or serious injury should be passed to the Commission. The Commission would then determine the nature of the investigation that should follow the referral.
- 9.185 It is the aim of the IPCC to address the issue of reducing the involvement of external or nearby police forces in such investigations, apart from in exceptional circumstances. I regard the process as inherently unsatisfactory, and it is the aim of the IPCC to work to reduce the need for this to happen. We have yet to completely achieve this aim.
- 9.186 The method for appointment of outside forces was (and often still is) unscientific, as C/Insp. Beckett commented, and appears often to have been no more than a case of one senior officer calling in a favour from his or her opposite number in another force.
- 9.187 The risk with such an approach, unfortunately, is that it serves to undermine confidence in the impartiality of the secondary force. In this case one Yorkshire force was investigated by another Yorkshire force, and the fact that the West Yorkshire officers were able to travel home every night, although being convenient for them, tended to highlight the physical proximity and undermine the impression of separation that is fundamental to an 'independent' investigation.

Appointment of the senior investigating officer

- 9.188 The appointment of Supt Holt by West Yorkshire Police was, on the face of it, a perfectly reasonable decision to make, as he was a senior officer with a background in detective work and with experience of a range of police work. At the time of his appointment he was a divisional commander in Huddersfield. In interview with the IPCC he confirmed that he did not have experience of 'external enquiries' of this type,⁸²³ and his comment on this was:⁸²⁴

"The way that this has progressed that it is something I have

⁸²² Para. 14A (1) inserted into the Police Reform Act 2002 by para. 12 of Sched 12 of the Serious Organised Crime and Police Act 2005

⁸²³ Supt Holt interview (8 March 2005) CA0114 Tape 1 p.6 [01140008]

⁸²⁴ Supt Holt interview (8 March 2005) CA0114 Tape 1 pp.13–14 [01140015–17]

reviewed individually, not on a daily basis, and I am happy that I conducted and moved that investigation the way that it needed to be progressed. Could I have been given a picture and understood, or should I have understood, personally, the potential consequences of this? Possibly. But I did not receive any advice, and I suppose it is naivety to suggest that at the time I conducted it like any other investigation that I had undertaken, because that is what my experience and exposure to investigations had told me. But there were certainly different issues at play here that I only became aware of much later down the line.”

- 9.189 It is a matter for regret that Supt Holt did not have prior experience of a death-in-custody case; it is clearly not something for which he deserves any blame. In any event, deaths in custody, although a serious problem, are still relatively rare events, and therefore officers with specific experience of handling such cases are likely to be few in number. It is clear, nonetheless, that Supt Holt approached the investigation of this case without having been given any specialist advice or briefing, and therefore he may not have drawn a distinction between the handling of such a case and the handling of any other serious investigation.
- 9.190 The lack of such experience has been addressed by the role of the IPCC in such cases from 2004 onwards. It is the aim of the IPCC to ensure that specific training to deal with death-in-custody cases should become more readily available and to achieve a consistently higher quality of investigation by people with the skills to perform this role.
- 9.191 The appointment of SIOs in such cases required the approval of the PCA, which was given in this case. There does not appear to have been any discussion with the PCA about the size or membership of the investigating team or the qualifications of its members to ensure that the team could meet the requirements of the investigation and could be available during the early part of the enquiry. In the circumstances the approval of the PCA does not seem to have meant a great deal, since the PCA member allotted to the case would be unlikely to know the investigating officers and, unless there was something strikingly wrong with their fitness for the role, could not raise any realistic objection.
- 9.192 I do not make this observation as a criticism of the PCA member, Mr Elliott, as the investigation of such cases was still in a developmental stage. It is worthy of note that the investigation of such matters has moved on since that time, and the IPCC can and does require higher levels of qualification from investigating officers appointed to such roles, whether from the IPCC itself or from a police force. These requirements include investigative and/or appropriate complaints experience. High-risk cases also require a SIO with family liaison awareness training and experience of media-handling techniques and HOLMES II, where appropriate.

Attendance at the scene

- 9.193 It was not a requirement in 1998 for either the SIO appointed from an external force or the PCA member to attend the scene within the first few hours of an incident occurring. However, once Supt Holt and his team had been appointed, they made their way promptly to Queen's Gardens police station in Hull. The PCA member, Jim Elliott, was contacted by pager message while travelling to work. As a result of this message he made contact with Humberside Police and immediately made his way to Hull. Both Supt Holt and Mr Elliott were therefore in the city within a few hours of notification.
- 9.194 Mr Elliott pointed out that his swift attendance was not in keeping with normal practice for PCA members at that time, and that it was entirely a matter for the discretion of the individual member.⁸²⁵
- 9.195 The attendance at an early stage by both the West Yorkshire Police team and the PCA was entirely appropriate. It is to be commended. I appreciate that making such arrangements at short notice was not convenient for any of those involved, and Supt Holt was candid in accepting that it did not come at an ideal time for him.
- 9.196 Supt Holt indicated in interview that he gave the investigation his full attention once he moved across to it and appointed another officer in West Yorkshire Police to act as superintendent and to supervise the division in his absence. I have no reason to doubt Supt Holt's commitment to the task he was set or his good faith in endeavouring to do his best. Similarly, everything that I have seen of Mr Elliott's work indicates that he brought commitment, dedication and goodwill to his role.
- 9.197 There can be little doubt that police techniques have improved and moved on since April 1998. I am conscious that it would be invidious to criticise officers for failing to reach the standards expected in 2006, if the officers had fulfilled everything that would have been expected of them in 1998. Nonetheless there are aspects of the West Yorkshire Police investigation that fell short of what would have been expected even at the time, and it is these that I address below.

Size of team

- 9.198 The decision as to the size of the team to be taken to Humberside by Supt Holt appears to have been made by him. The use of only three officers for the investigation of a death is worrying and was, in my view, a major failing from the outset. This does not seem to have been addressed by the PCA. The size of the team greatly restricted the enquiries that could be carried out by the West Yorkshire Police officers and meant they had to rely heavily on the Humberside Police

⁸²⁵ Jim Elliott interview (31 January 2005) CA0110 Tape 1 p.6 [01100009]

officers investigating the assault on Mr Alder. This was wholly at odds with an independent investigation. Matters were exacerbated by the fact that two of the three officers took annual leave for a week, just five days into the investigation.

- 9.199 Supt Holt acknowledged in interview with the IPCC that he was told that he could have more staff from West Yorkshire Police if he required them. Although he sought some assistance for Insp. Tolan while he was on leave, no other officers were requested. In my view this was an error on his part, in that he remained content to allow Humberside Police to undertake most of the work that should have been carried out by his team.
- 9.200 It is unlikely in circumstances such as the death of Mr Alder that a team of three investigators would be considered adequate by the IPCC, and modern expectations would require more officers to be deployed. I am, however, of the view that this should have been obvious to the West Yorkshire Police team, and that Supt Holt should have sought more resources for his investigation from the start.

Terms of reference

- 9.201 The terms of reference for the West Yorkshire Police team were drafted by ACC Clark of Humberside Police and were agreed by Jim Elliott on behalf of the PCA. They were:

“To investigate the circumstances leading to the death of Mr Christopher Alder at Queen’s Gardens Police Station Hull on April 1st 1998 and any matters arising.”

- 9.202 No guidelines or protocols existed at that time to determine either the responsibility for producing the terms of reference or their content. However, once drafted, these were viewed by Mr Elliott, who added the last four words before approving them.
- 9.203 Although they provided some broad focus for West Yorkshire Police, these terms of reference did not clearly quantify the scope of their investigation, in particular its relationship to the parallel investigation being conducted by Humberside Police into the earlier assault on Mr Alder by Mr Paul.
- 9.204 As Supt Holt noted, the terms of reference drawn up by the PCA were “bland”, and he agreed that they made little difference to him. Supt Bates admitted in interview that he was not really aware of the terms of reference for the West Yorkshire Police investigation.
- 9.205 Since that time the approach to the drafting of such terms of reference has moved on, and there is now a greater emphasis on detailed terms being prepared. The nebulous nature of West Yorkshire Police’s terms

probably made little difference to the investigation: they were certainly regarded as a virtual irrelevance by all the senior officers. Unfortunately this reflects the somewhat woolly approach to the divisions between the two investigations that followed. The terms of reference might be seen as a missed opportunity to draw the dividing lines rather more clearly.

Interaction with Humberside Police

9.206 Supt Holt set the tone for the West Yorkshire Police investigation with an early entry in the policy log covering the period until 18.00 on 2 April.⁸²⁶ This is, in my view, telling:

“Detective Superintendent Ken BATES has been appointed S.I.O. for the initial incident outside The Waterfront night-club which resulted in the assault of Mr ALDER. The I.O. in consultation with Mr ELLIOT has discussed the investigation with Detective Superintendent BATES and accepts **the criminal investigation will assume primacy** with all incoming information being shared. Lines of enquiry when identified for each enquiry will be discussed **to avoid duplication.**” [My emphasis]

9.207 This was a case in which there was one victim and one death; it was, however, being investigated by two separate teams. There was bound to be contact between them and an element of overlap. Nonetheless, the employment of a second force was intended to reassure the public and the family of the deceased that the force in whose care he died was not investigating the death itself. Although this was acknowledged by both senior officers, Supt Bates and Supt Holt, the reality was that the division between them started out as minimal and became more tenuous as April progressed.

9.208 As a result, the appearance of independence of the West Yorkshire Police investigation was compromised from an early stage. That is not to say that Humberside Police dictated to their West Yorkshire Police colleagues or set out to subvert the West Yorkshire Police investigation. It is, in my view, a consequence of Supt Holt having no experience of ‘external enquiries’. His approach appears to have been that efficient policing required that the work be divided up between the two forces. He therefore trusted the Humberside Police officers to undertake the bulk of the work and relied upon their judgement in the way that they conducted their investigation.

9.209 In the conduct of ordinary police work, such an approach is laudable. Professional officers must trust one another and rely on one another’s

⁸²⁶ West Yorks policy log (3 April 1998) CA001 D11 [00010368–74]

judgement; work is divided in such a way as to allow for best use of resources, and scrutiny is in the hands of other professional officers.

- 9.210 What Supt Holt lost sight of, in my view, was that he was required not only to undertake an investigation, but to do so in a visibly and transparently separate way from Humberside Police. This was not what happened. Rather, it was a case of the two forces working so closely together, and West Yorkshire Police allowing themselves to be so heavily dependent upon Humberside Police, that the distance between them was not evident to the outside observer. This caused the appearance of impartiality to be lost and gave the impression that the forces were paying lip service to the notion of independent scrutiny.
- 9.211 This is a failing on the part of West Yorkshire Police rather than Humberside Police. It is not surprising, therefore, that distraught and suspicious family members would regard the police as acting as one institution without drawing any distinction between different police services.
- 9.212 I have little doubt that the West Yorkshire Police officers did not see themselves as being compromised and would not have deliberately set out to be so. There is also no doubt that they regarded efficiency as important and wished to avoid unnecessary duplication. Nonetheless, they did not consider the impression that might be created by this approach or, if they did consider it, did not give it sufficient priority.
- 9.213 The policy log also gives rise to other concerns. The decision that the criminal investigation would take priority appears to be based on certain assumptions. Firstly, the very description of the Humberside Police enquiry as “the criminal investigation” implies that the investigation being carried out by West Yorkshire Police was not a criminal investigation. The second assumption was that the interests of the two enquiries were essentially the same, and the third was that West Yorkshire Police could safely delegate much of the responsibility for basic enquiries to Humberside Police. The emphasis in the log is placed upon the need “to avoid duplication”, rather than on the need for consultation in advance, to ensure that the needs of both enquiries were being served. Subsequently, a number of witnesses seen by Humberside Police officers had to be seen again by West Yorkshire Police to clarify matters, suggesting that even the modest ambition of avoiding duplication was not fully achieved.
- 9.214 The log continued:

“The Investigating Officer has therefore decided that the following are priority lines of enquiry for the Police Complaints Authority investigation, **not solely but partly based on the fact they could be lower priority enquiries for the criminal investigation.**” [My emphasis]

9.215 This paragraph, coupled with the earlier section, appears to be an acknowledgement in part that Humberside Police was setting the priorities in the investigation and that West Yorkshire Police was effectively sweeping up what was left. This in turn seems to reflect an assumption at the outset that the Humberside Police investigation would effectively resolve both matters and that the death-in-custody investigation would simply follow in the wake of the enquiry into the assault and murder. Supt Holt accepted in interview⁸²⁷ with the IPCC that:

“I didn’t suggest any lines of enquiry for Humberside that I recollect”.

9.216 The “priority lines of enquiry” listed by Supt Holt were these:

1. Trace and Interview other prisoners held in custody at Queen’s Gardens at the time of Mr ALDER’s death.
2. Trace and interview recorded attendees at H.R.I. at or between the times of the deceased’s attendance at the Hospital
3. Viewing of C.C.T.V tapes to establish confirmation of statements taken from witnesses.
4. Examination of officers’ statements covering transfer from hospital to police station and action at police station.
5. Examination of all relevant incident logs.”

9.217 Of 220 statements identified from the early stages of the investigations, only 27 were taken by the officers from West Yorkshire Police, three of which were their own, and 13 of which were negative statements from other detainees at Queen’s Gardens police station or patients at Hull Royal Infirmary. The first statement taken by West Yorkshire Police outside those two groups was not taken until 30 April, when the West Yorkshire Police officers took follow-up statements from some of the medical staff. The only other witnesses seen and documented by West Yorkshire Police in April, May and June who had not already been interviewed by Humberside Police officers were A/PS Bulless, Mr Crichton and Mr Dunne, who trained officers in the use of CS spray.

9.218 The decision to make interviews with other patients and detainees the top two priorities for enquiry seems to me a curious one: the very small team of West Yorkshire Police officers effectively dedicated themselves to a series of peripheral tasks. Given that the hospital afforded Mr Alder what privacy it could, other patients could scarcely have seen more than the doctors and nurses would have done. As one might

⁸²⁷ Supt Holt interview (8 March 2005) CA0114 Tape 2 p.7 [01140036]

reasonably expect medical staff to be awake, sober, attentive and reasonably intelligent, the need to double check their evidence by asking members of the public who may have overheard exchanges from another cubicle does not seem a priority.

- 9.219 The events at the police station were all recorded on extensive video- and audiotapes. West Yorkshire Police knew this. Therefore the need to question other detainees, who would necessarily be in cells without any line of sight and in many cases would, most probably, not be awake, sober or attentive, does, again, not seem to be a priority.
- 9.220 The main witnesses who could provide useful material for the West Yorkshire Police investigation were the medical staff and security staff at Hull Royal Infirmary who observed the behaviour of Mr Alder and his interaction with police officers. Dr Khan, Nurses Townend, Merrills and Smith and Ms Tweed the radiographer were all highly relevant. Similarly the porter Mr Frankland and the hospital security guard Mr Rodgers were potentially important. However, every one of these witnesses was seen first by Humberside Police officers, although they were of less importance to the assault enquiry than to the death-in-custody enquiry. The effect of this was that West Yorkshire Police officers were occupied in interviewing the other detainees and other patients several days before anyone had questioned important witnesses such as Mr Rodgers.
- 9.221 Similarly, although witnesses at the police station must have been available, West Yorkshire Police did not interview two civilian employees, Mr Crichton the gate-keeper and Matron Bridget Winkley, until 5 June 1998. Both of these persons were highly relevant witnesses to the death in custody and who saw some or most of the relevant events. Matron Winkley was seen by Humberside Police shortly after the event, but Mr Crichton was not spoken to at all until June. The willingness to cede responsibility for interviewing Matron Winkley to Humberside Police, and the failure to ensure that anyone took a statement from Mr Crichton, seems to me to be highly remiss on the part of the West Yorkshire Police team.
- 9.222 West Yorkshire Police did not interview PC Wildbore until 19 May 1998, although he was actually in the room at the time of Mr Alder's death. It is striking, when one examines the videotape of the custody suite and compares that with the explanation given by PC Wildbore, that this officer was present by 03.50. He was, therefore, present for considerably more of the time than his original statement indicated – more time indeed than A/PS Ellerington. West Yorkshire Police do not seem to have noticed this discrepancy, and there is no record of his having been challenged as to the accuracy of his statement. I do not suggest that PC Wildbore set out to deceive the investigators, as confusion over times might explain the discrepancy. I am simply concerned that this obvious element was not commented on by the West Yorkshire Police officers.

- 9.223 I am also very surprised that, given that the investigation was bound to consider the behaviour and actions of the arresting officers, Insp. Tolan does not seem to have received the duty statements and notebooks of those officers until a full week after the start of the investigation. This emerged in his evidence to the inquest and is dealt with in Chapter 4 above. One might have expected those documents to have been among the very first to be required, as they did not need any processing and existed in immediately usable format.
- 9.224 The only explanation put forward to the IPCC by Supt Holt was that the officers were not on duty, although he believed that the documents were received sooner than Insp. Tolan recalled. Indeed, Insp. Tolan told the IPCC in 2005 that he thought he had received the documents earlier than he had told the inquest, although he could not be sure. This uncertainty serves to highlight the paucity of written records for the West Yorkshire Police investigation, as there is no definitive record of what was received and when.

Lack of any formal system

- 9.225 The West Yorkshire Police did not follow the Humberside force's lead in setting up an account on the HOLMES computer to organise its investigation. This is not necessarily wrong, as the system is not appropriate for every enquiry. What is unacceptable, however, is that no log of decisions or actions was kept on paper after the first four days of the investigation. Three policy log documents have been referred to that were created in the early days of the investigation. However, by the weekend following the death of Mr Alder these were abandoned and no further logs created. There was, accordingly, no formal system for the administration of their enquiries or for recording progress.
- 9.226 As a result, it is difficult to follow the pattern of the West Yorkshire Police investigation, or to tell what form of structure was being imposed upon it. No record of decisions made is available. C/Supt Bates recalled that Insp. Tolan attended the Humberside Police briefings and was given access to the Humberside Police HOLMES material. He thought that Supt Holt also attended on a couple of occasions, but there is no record of which briefings these were or whether he contributed anything to them.
- 9.227 Informal systems were put in place in the main incident room by Humberside Police, which were intended to ensure that West Yorkshire Police had access to and were aware of what was being done by the Humberside Police officers. It was also suggested by DCI. Davison that the office manager for Humberside Police had set up an 'out' tray in the incident room in which copies of all the documents and statements were placed for the attention of the West Yorkshire Police officers. There is no formal record of this being done, and neither Supt Holt nor Insp. Tolan described this when talking about how information was

drawn to their attention. There are also indications that some information may not have been noted by them, in particular the details of Mr Alder's army medical history, which neither could recall.

9.228 On 2 April 1998 a policy log entry was made by Supt Holt relating to the downloading of the HOLMES data. After consultation with the West Yorkshire Police HOLMES supervisor it was decided to leave the downloading of the HOLMES enquiry for seven days to allow for completion of the allocated enquiries.⁸²⁸ There is no record of this being done.

Return of officers' clothing

9.229 In the same policy log, Supt Holt indicates that he has authorised the return of clothing to the officers, rather than retain it for exhibit purposes. This decision, which he describes as "following discussion with Mr Elliott", was made because:

"There is no suggestion at this stage of malpractice or criminal conduct by any of the officers involved, to retain clothing under these circumstances could create unnecessary concerns amongst those involved and could be considered grossly unjust."

9.230 This decision bears out the impression that Supt Holt, who was aware that there was no identified cause of death at that stage, was already making assumptions in favour of the officers, rather than keeping an open mind as to the reasons for the death. One might properly contrast the approach taken with that adopted by police officers dealing with the civilians being investigated: potential evidence, no matter how compromised, would not be handed back to a civilian under investigation simply to avoid "unnecessary concerns". Moreover, Supt Holt does not identify what those concerns might be, since all that was involved was retention of uniforms that belonged to Humberside Police, and not the personal property of the officers.

9.231 The policy log does not properly identify why the clothing was seized in the first instance (by Humberside Police). Had that been done, perhaps Supt Holt would not have been so ready to return the items. The impression that is left is one of confusion, in that items are seized and then returned to two officers, while two others are allowed to go home but try to bring their clothing in shortly afterwards (this was also taken and then returned). No clothing was ever seized from A/PS Ellerington.

9.232 The significance of releasing the clothing is also relevant in the context of the lack of a forensic strategy, which is dealt with below.

⁸²⁸ Policy log 15 CA0085 [00850008]

9.233 It is evident from the nature of the West Yorkshire Police policy log, and its timing at 18.00 on 2 April, that the decision to return the clothing was made prior to the viewing of the tapes from the custody suite. The comment that viewing of the tapes was intended “to establish confirmation of statements taken from witnesses” points to the assumption that the tapes would do simply that. The possibility that the tapes would reveal far more than was admitted to in the statements or would even contradict what was claimed in the documentation does not seem to have been considered.

9.234 In interview, Supt Holt said that he was confident that the CCTV had been viewed prior to the decision to return the clothes; he thought the policy log was a handwritten document and was not a contemporaneous log.⁸²⁹ However, the copy of the log provided to me as part of the Review came from the PCA file of Mr Elliott. That document is typed up and includes the decision to return the clothes. It is dictated as being 18.00 on Thursday 2 April, and this particular document was faxed to the PCA from West Yorkshire Police, from a Wakefield number between 13.15 and 13.18 on Friday 3 April. That document refers to CCTV evidence only to say that all relevant tapes have been seized by Humberside Police officers and “will be” exhibited and copied and “will be” handed to the IO (Supt Holt) for the PCA enquiry.

9.235 Insp. Tolan in interview with the IPCC recalled that:⁸³⁰

“We didn’t actually get a copy, a working copy of the tape from the custody area **until the Friday afternoon** and when we saw that and we realised that things weren’t as we’d been told at the initial briefing.” [My emphasis]

9.236 Mr Hutchinson, a civilian technician employed by Humberside Police, made a statement saying that he had copied the custody suite videotapes on 3 April, and Mr Elliott did make a file note of a telephone conversation on 3 April in which he recorded that Supt Holt described the video to him. The policy log dated 3 April and timed at 16.00 does refer to the video recording, therefore confirming that it was seen that day. Notwithstanding that, the insistence that the decision was taken only after the video was viewed does not make sense, since Supt Holt said in interview that:⁸³¹

“I made a decision that the officers had been in contact, all the officers had been in contact, had some form of contact with Christopher Alder. It was not going to progress an investigation relating to my primary line of enquiry, which was around negligence, duty of care, as a result of which I did not need the

⁸²⁹ Supt Holt interview (8 March 2005) CA0114 Tape 3 p.5 [01140046]

⁸³⁰ Insp. Tolan interview (14 February 2005) CA0112 Tape 1 p.5 [01120007]

⁸³¹ Supt Holt interview (8 March 2005) CA0114 Tape 3 p.6 [01140047]

clothing to progress that investigation. To have retained it another week, month, year, would have done no more in terms of the line of enquiry I had chosen to pursue. On that basis following discussion with the PCA it was returned to the officers.”

9.237 The statement that, having seen the video, his primary line of enquiry had become one of “negligence, duty of care” is understandable; however, it is a different justification to that given in the policy log, and it makes no sense when juxtaposed with the policy log assertion that:

“There is no suggestion at this stage of malpractice or criminal conduct by any of the officers involved”.

9.238 I am therefore driven to the conclusion that Supt Holt did indeed authorise the return of the clothing prior to seeing the video. But even if I am mistaken about this, it is clear that if he did see the video before the clothing was actually returned, no attempt was made to countermand the direction.

9.239 When Mr Elliott of the PCA was asked about the sanctioning of the return of the clothes he answered as follows:⁸³²

Q. Did he [Supt Holt], you say you discussed it, did he consult you before you authorised the return or was he simply telling you that he had authorised the return?

A. I’m reasonably sure, I think he discussed it with me before it was done. I would have expected that.

Q. Did you sanction the return of it?

A. Again, I’m just struggling to remember. I think I did. I can’t be sure without looking at the records.

9.240 Accordingly, it seems clear that although Supt Holt seems to think that he had seen the video before the clothes were returned to the officers, his own records make it clear that he had not done so. I do not criticise Supt Holt for a failure of memory, given the passage of time. It does, however, point up the lack of a proper log for the investigation.

9.241 Even had the officers’ clothing added nothing to the scientific analysis of the scene, the impression created by the willingness to hand back the clothes is a negative one. Although Supt Holt was correct in having regard for the feelings of the officers, his overriding duty was to establish the truth and to keep an open mind in his approach to the investigation. This early slip suggests a mind that was already made up.

⁸³² Jim Elliott interview (31 January 2005) Tape 2 p.21 [01100052]

Forensic evidence

9.242 A great deal of criticism has been raised in respect of the approach of West Yorkshire Police to forensic evidence. Although the initial forensic examinations of the scenes were organised by Humberside Police, West Yorkshire Police became involved in the handling of the forensic evidence, and made some surprising decisions.

9.243 Supt Holt was asked in interview⁸³³ what his forensic strategy was. He replied that:

“it was to ensure that all appropriate forensic matters relating to the circumstances surrounding the death in custody of Christopher Alder had been addressed”.

9.244 This is, frankly, a meaningless response. The fundamental assumption made by Supt Holt at an early stage was that the scientific evidence was unlikely to assist in his investigation. In acting upon that assumption, it would appear that despite his explanation he had no forensic strategy.

9.245 He did not order the analysis of any of the swabs taken or of the tooth retrieved by Humberside Police. As is made clear in the factual history of the investigation, Supt Holt admitted at the inquest that he had agreed that he saw no reason to test the swabs taken from the custody suite and the van, as he had no reason to believe that they did not come from Mr Alder. Mrs Leak, who had taken samples at the scene, was asked about this by the IPCC,⁸³⁴ and she said:

“I think it is the wrong assumption to assume that any blood inside that vehicle was from Christopher Alder.”

9.246 Mrs Leak would, no doubt, have been available to advise Supt Holt, had he chosen to seek advice. In addition, Supt Holt did not place any impediment on the swabs being destroyed, and he accepted that a fingerprint in blood was also not examined.⁸³⁵

9.247 He returned the police officers' clothes without any testing; he sought to justify this on the grounds that as contact with Mr Alder was a given, no useful purpose could be served by any examination. In this case, the later suggestions that CS spray had actually been used could have been countered far more effectively if the officers' clothing had been retained intact and had been shown to have no signs of the spray.

⁸³³ Supt Holt interview (8 March 2005) CA0114 Tape 2 p.7 [01140038]

⁸³⁴ Gillian Leak interview (9 March 2005) CA0115 Tape 2 p.16 [01150055]

⁸³⁵ Inquest Day 21, p.36

9.248 When asked in interview whether he had considered the possibility that the police officers may have assaulted Mr Alder he said, “I had not ruled it out”,⁸³⁶ although he wrote on 2 April that:

“There is no suggestion at this stage of malpractice or criminal conduct by any of the officers involved”,

which would not tend to suggest that a possible assault was being considered very seriously at that stage.

9.249 Mrs Leak gave the following answer in interview with the IPCC:⁸³⁷

- Q. So in terms determining whether Christopher Alder was or was not assaulted by police officers, would the examination of their clothing worn at the time have assisted you in coming to some decision?
- A. It has the potential to do that, yes.

Destruction of Mr Alder’s clothing

9.250 Similarly Supt Holt allowed Mr Alder’s clothes to be destroyed without any tests being conducted. The CS gas issue could also have been addressed by retention of these clothes, and they would have been useful in addressing the suggestions of a second assault.

9.251 For an experienced SIO, Supt Holt seems to have had little concept of the purposes of forensic scientific analysis. One may begin with a hypothesis and then devise tests that will prove or disprove it. The danger of error arises when one is committed to a single theory and ignores or fails to look for evidence that contradicts it. Excluding possibilities – particularly of misconduct – should have been a priority in itself. Moreover, the discarding of potential evidence, even if regarded of little relevance, excludes the possibility of subsequent peer review.

9.252 Perhaps more telling is that he had no insight into the effect that destruction of samples would have upon the credibility of his investigation. The principles of openness and independence were evidently not considerations that occurred to him, and it was, in my view, naive of him to think that he could treat his investigation as just another enquiry. The whole purpose of being an external force looking into police activity is to allay the concerns of the public, because of the danger that police may be seen as ‘covering for one another’. Abandoning items of evidence does not serve to assist in this aim.

⁸³⁶ Supt Holt interview (8 March 2005) CA0114 Tape 2 p.8 [01140039]

⁸³⁷ Gillian Leak interview, (9 March 2005) CA0115 Tape 2 p.111 [01150050–1]

9.253 To his credit, Supt Holt apologised to the family of Mr Alder for not giving them the option of having the clothes returned to them. I do not believe that Supt Holt had any intention to harm the investigation or to cast any slight upon the family of Mr Alder. His actions were insensitive to them and lacked insight into the possible interpretations that could be placed on his actions; there was, however, no malice behind them.

Regulation 7 notices

9.254 Supt Holt was also to acknowledge that he was wrong not to have suggested service of Regulation 7 notices before he went on leave. He attributed this to a misunderstanding of the rules, and accepted that Insp. Tolan was right to suggest that they should be served.

Medical examination of officers

9.255 Supt Holt indicated during the inquest that he understood that the officers had been checked over by a doctor, but he had to acknowledge that he had never seen a statement to this effect. The matter does not appear to have been chased up at any stage by the West Yorkshire Police investigation.⁸³⁸ Again, an opportunity to reassure the family of Mr Alder was lost.

Interviews of the officers

9.256 Supt Holt initially made handwritten notes and then, later, typed interview plans in preparing for the formal interviews of the five officers.⁸³⁹ These plans listed the main issues to be covered in the interview of each officer and were signed and dated by Supt Holt on 21 May 1998.

9.257 Mr Elliott was asked in interview whether he was consulted on the approach to be taken in the interviews.⁸⁴⁰ His response was:

“I’m struggling to remember. I certainly recall the interviews being discussed. On other investigations I would certainly have gone through line by line interview plans with people. I don’t think I did on this particular case. I think that practice only came later with a bit more room to manoeuvre, but certainly aspects of the interviews – I certainly remember discussing with John Holt the approach he was going to take on various things.”

⁸³⁸ Inquest Day 21, p.32

⁸³⁹ Supt Holt notes for interview CA104 [01040003–179]

⁸⁴⁰ Jim Elliott interview (31 January 2005) Tape 5 p.21 [01100104]

9.258 Whether the interview plans were discussed in detail or not, the actual interviews were not as thorough as I would have hoped.

9.259 Some issues were not covered, and others, such as potential racism, were dealt with through a closed or single question. Examples of questions not covered in the interviews included:

- Why was no attempt made to speak to Mr Alder at the Waterfront Club?
- Why were no details obtained from the potential witnesses who were still present?
- Why was the use of CS spray threatened inside the hospital?
- Why were the accounts of hospital staff at variance with those of the officers?
- Which persons were present and involved outside the hospital?

9.260 The fact that Mr Alder had urinated and defecated yet was still believed to be faking his condition either was not raised at all in the interviews or was done so fleetingly.

9.261 I have seen nothing to suggest that West Yorkshire Police carried out any review of the content of the interviews at a later stage or gave consideration to whether or not further interviews should be conducted.

9.262 In summary, I believe that the following errors were made in the handling of the West Yorkshire Police investigation:

- The team quickly adopted the attitude of the Humberside Police that the case was almost certainly one of murder, in which the death in custody was merely an unfortunate coincidence of timing.
- Too few officers were appointed to the team.
- Two of the three officers involved went on leave after just five days of the enquiry.
- The team failed to secure the officers' notebooks and duty statements as a matter of priority.
- They allowed themselves to be guided by initial assumptions without challenging or questioning the sequence of events when Mr Alder was brought into custody.
- As a result the investigation allowed the Humberside Police investigations to take priority and allowed Humberside Police to take the lead on all important lines of enquiry.
- Even when the videotape became available the pace of their enquiries did not step up until Humberside Police had completed theirs.
- Supt Holt failed to appreciate the importance of the videotape at the time when he first saw it and therefore failed to order the issuance of Regulation 7 notices.

- The West Yorkshire Police investigation failed to take any proper control of family liaison and had no strategy for family liaison.
- The West Yorkshire team pursued minor and probably irrelevant lines of enquiry in the opening weeks, on the basis that Humberside Police would deal with anything of substance.
- As a result of the assumption regarding the likely outcome of the investigation, there was no proper forensic evidence strategy. A series of tests were not carried out that should have been, and this led to a loss of confidence on the part of the Alder family.
- The officers' clothes were returned to them, suggesting an eagerness to exonerate them without considering the evidence properly.
- Mr Alder's clothes were destroyed without being offered to his family, suggesting a disregard for their wishes or interests. Other scientific samples were also destroyed.

9.263 It was fortunate for West Yorkshire Police, although not an excuse, that in many respects the investigation by Humberside Police was thorough and detailed although misdirected. Regrettably, there were two areas in which both forces fell short of an ideal investigation. I have dealt separately with the Humberside Police investigation, but it is clear that the two common areas of failure are the lack of a proper forensic evidence strategy and the lack of proper family liaison.

9.264 One is therefore faced with a curiously lopsided approach to the investigation. On the one hand the two police forces both failed to follow up on basic tests that should have been carried out on the bloodstains in the police van and passageway and the tooth recovered from the scene of the initial fracas. By way of contrast, the cause of Mr Alder's death was examined in close detail and at inordinate length by the cream of the UK's pathology expertise.

9.265 The failures of West Yorkshire Police in the investigation, and by extension those of the PCA as an oversight body, were such as to undermine confidence in the police and their ability to investigate themselves. The investigation was in some regards heavy handed and insensitive; I have found no evidence, however to suggest that any failings were deliberate or malicious.

9.266 Perhaps more importantly, I can say with some confidence that even if the investigation had been carried out more carefully and more sensitively, the upshot would not have been markedly different.

9.267 Had the identified errors not occurred, what might have been expected?

- West Yorkshire Police would have deployed a larger team of officers and taken responsibility from the outset for gathering the evidence surrounding the death of Mr Alder.

- Earlier and more searching interviews with some witnesses would have taken place (such as with Mr Crichton, the gate-keeper).
- A proper forensic evidence strategy would have been applied, so that items gathered at the scene would have been fully tested and every possibility considered, not just certain ones.
- Blood in the van would have been identified as Mr Alder's (as assumed) or excluded from the enquiries.
- The tooth from outside the Waterfront Club would have been tested to confirm that it was his.
- Officers' clothing and medical check-up results would have been presented at court.
- Mr Alder's clothing would have been available as evidence and could ultimately have been offered back to his family, if they wanted it.
- Officers' statements and notebooks would have been examined at an earlier stage and the videotape viewed.
- The officers might have been put on notice of disciplinary action and/or suspended slightly earlier than they were.
- A clear, consistent and careful family liaison strategy might have been put into action, to inform and assist the family at all stages.

9.268 If all of this had come to pass, what extra evidence might have emerged? If one assumes the worst, it is possible that CS spray might have been detected on clothing of the officers or Mr Alder. Blood might have been found on the officers' clothing, suggesting proximity to an extra assault. Either of these elements might have assisted in the prosecution for misconduct.

9.269 Set against that, one must ask, is it likely that such evidence would have been found? The answer is no. There was no evidence of use of CS spray in any of the medical evidence that emerged from Mr Alder's four post mortem examinations, and no evidence of any effects of it upon him. Such matters can almost never be excluded absolutely, but this is not a realistic likelihood. The suggestion of a further assault can be argued from the basis of the missing second tooth, but one must also take into account the lack of blood splatter that one might have expected in the van had he been struck there. The possibility cannot be totally excluded.

9.270 What can be excluded is the suggestion that any of these 'possible extras' caused Mr Alder's death. The analysis of the experts did not suggest at any stage that he was beaten severely (one extra blow could not be excluded); it did not suggest that he died from undetected wounds or suffocated on CS spray. Even if the evidence for these items had been found, which would be at odds with most of the evidence that was found, it would not have cast dramatic new light on the death of Mr Alder in custody.

9.271 There is no basis for concluding that the trial would not have ended the same way. In all likelihood the inquest and trial would have been shorter and more focused: the failure to explain matters damaged the cases of the officers as much as the prosecution did and left them open to suggestions that West Yorkshire Police could have assisted in disproving. For this reason, the failures in investigation risked injustice to the defendants, just as it did to the family of the deceased.

Assessment of Lancashire Constabulary

9.272 Lancashire Constabulary, by reason merely of geographical accident, was drawn into this Review because it happened to be the local police service for Ms Alder. As has been seen, Ms Alder has expressed criticism of a number of aspects of the handling of the case as a whole by 'the police', and those criticisms appear to have arisen from her earliest contacts with her local force. I am of the view that Ms Alder, as a family member of a deceased person, was entitled to feel somewhat aggrieved at the handling of the breaking of bad news to her.

9.273 The faxed information sent by Humberside Police to Lancashire Constabulary was timed at 10.55 on 17 April. Ms Alder was only seen by police officers at approximately 23.00 that night. The passage of nearly three weeks before Ms Alder was located cannot be blamed on the police; she was not in regular contact with her family and had not told her brother Richard that she was now living in Lancashire (Richard Alder did not know where she lived, and Ms Alder had to ask PC Smith for contact details for Richard). It would also be unreasonable to have expected Lancashire Constabulary to treat the notification as being urgent, given the delay since the event.

9.274 Nonetheless, notification of the death of a loved one, particularly in the context of a 'murder investigation', is a sensitive and important task. The message from Humberside Police made it clear that the contact officer was only available for a few hours, and yet the message was not acted on for 12 hours and appears to have been left over to a night shift. Calling on a household at 23.00 may, in my view, have added to the trauma of receiving such news.

9.275 In the current case, Humberside Police had committed considerable manpower and facilities to tracing and liaising with the family members, and yet the first contact with Ms Alder was mishandled by being delegated to a junior officer of another force with minimal knowledge of the background to the case. In the case of Mr Alder's former girlfriend, Mrs O'Brien, by way of contrast, an officer from Humberside Police spent some time in the Andover area, tracing her and contacting her in person.

9.276 It is clear that in the case of Ms Alder, PC North of Lancashire Constabulary inadvertently gave her incorrect and misleading

information that contributed to the confusion and mistrust that followed. I do not criticise PC North, who was placed in an invidious and difficult position. That position was created by failures in management by the Humberside, West Yorkshire and Lancashire forces. This was an error that could easily have been avoided through a modicum of better planning.

- 9.277 Ideally, the first notification of such a death should be made by an officer of the investigating force, with the best available information as to the circumstances. If this is not practical, much more detail should be forwarded to the local force, and the officer of the local force who is asked to make the notification should take the time to familiarise him or herself more fully with the facts of the case.
- 9.278 However, the greater failure here is in the mishandled family liaison policy, which reflects on a number of bodies, as is set out above.

The Police Complaints Authority

- 9.279 The PCA was set up by the Police and Criminal Evidence Act 1984 (PACE). It consisted of members appointed by the Home Secretary, supported by a small staff of seconded civil servants. The PCA had the power to supervise police investigations referred to it but not to carry them out itself. Accordingly it did not acquire the staffing levels or the skills to do so.
- 9.280 The members of the PCA tended not to have any background in police work and were expected to learn 'on the job'. This was hampered, however, by the lack of any formal training for members in handling complex investigations, as well as by their substantial caseloads.
- 9.281 It is evident from discussions with those who were members of the PCA that there was a debate within the ranks of the organisation as to the direction that should be taken. One school of thought favoured the reactive role that had been adopted in the early stages of the PCA. Other members favoured a more proactive stance. An example of this given to us by Mr Elliott was that some members did not wish to be contacted out of office hours, even for instances of deaths in custody. Other members wished to be told as soon as possible.
- 9.282 It is to their credit, in my view, that some PCA members foresaw the need for a more active and interventionist authority; this approach foreshadowed the eventual creation of the IPCC. I recognise that the main difficulty for the PCA in the late 1990s was that, even with the willingness of its members, it had neither the facilities nor the backup to perform a full and detailed supervision of an investigation.
- 9.283 Although the PACE provisions were repealed and re-enacted by the Police Act 1996, the Police Reform Act of 2002 abolished the PCA and

replaced it with the IPCC. The PCA ceased to exist, and the IPCC took over operationally on 1 April 2004.

- 9.284 The establishment of the IPCC reflected the concerns that had been expressed by some members of the PCA. The aim of the IPCC, which has a number of new, stronger powers, was to radically change the way that complaints were handled. The IPCC was empowered to manage or supervise police investigations and, in the most serious cases, to independently investigate. The IPCC was also given responsibilities for guardianship, requiring it to promote confidence in the system while setting standards and monitoring the system as a whole. Ensuring accessibility to the system is an integral part of this. In working towards these aims the IPCC issued statutory guidance at the end of 2005.
- 9.285 Mr Elliott of the PCA made great efforts to meet members of the Review team and to provide the most detailed possible history of his involvement with the case. He spent many hours refreshing his memory from the documents and discussing the case with IPCC staff. I am very grateful for the diligence and concern that he showed, which in my view reflected his application and concern when he was originally handling the case.
- 9.286 Mr Elliott had moved on from the PCA prior to its closure and had taken up other employment. He has never worked for the IPCC. As he has pointed out, the structure of the PCA, at the time when he was employed there, meant that he was personally responsible for the oversight of about 100 cases, which resulted in stresses and demands from many different quarters.
- 9.287 I applaud the decision of Mr Elliott to travel directly to Hull and to involve himself as closely as he did in the investigation in the opening hours. It was inevitable that such a level of involvement could not be maintained indefinitely, given his other commitments.
- 9.288 From the papers presented to this Review, and from the discussions that Mr Elliott has had with the IPCC, it is abundantly clear that he viewed the case of Mr Alder with great seriousness and expended enormous energy upon it.
- 9.289 Ms Alder's attitude to the PCA has varied enormously. Mr Elliott described very difficult telephone conversations with Ms Alder, but when he enquired why she continued to call him, if she did not trust or believe him, Ms Alder indicated that she had no-one else to talk to about her concerns.
- 9.290 Telephone notes kept by Ms Sally Hawkins illustrate the continuation of such criticisms⁸⁴¹ in August 2002:

⁸⁴¹ PCA telephone note (13 August 2002) CA002 D28 [00020500]

“Everything was done wrong on purpose; there has been a cover up; evidence of racism not to find monkey noises...SH allocated to smooth things over, as Jim Elliott was chosen to cover things up.”

9.291 And in September 2002:⁸⁴²

“PCA knew by the time of the PM [post mortem] about the importance of what had happened but it took a month to suspend the officers...PCA colluded in attempts to avoid manslaughter charges.”

9.292 I do note, however, that Ms Alder was quoted extensively in the *Daily Mirror* newspaper,⁸⁴³ on 24 February 2003, following the decision of Humberside Police to deny legal representation in the disciplinary hearing:

“Janet Alder said ‘The PCA has done its utmost to ensure justice is done and an internal inquiry is brought. But this is Humberside Police again doing its utmost to do as little as it can.’”

9.293 If criticisms are to be made of the PCA, these do not arise from any lack of commitment or willingness on the part of the members or the staff. I deal elsewhere with Mr Elliott’s involvement in the family liaison process, which ultimately proved to be a source of some frustration to him. In addition, the PCA’s resources and facilities to deal with such cases were insufficient.

9.294 Although the West Yorkshire Police sought and relied upon the endorsement of the PCA for certain decisions, such as the return of the officers’ clothing, the PCA was limited by the information that it received from the West Yorkshire Police officers. I do not suggest that the police officers involved sought to mislead Mr Elliott, but it is clear that he was reliant to a large extent upon their judgement, as he could only spend limited time in Hull.

9.295 Once the misconduct review was passed from Mr Elliott to Ms Hawkins, the case continued to be handled, in my view, with care and close attention. She worked assiduously to ensure that Humberside Police held a proper disciplinary hearing, and she shared the frustration of several of the other parties to this process when Humberside Police sought to avoid that process. Her decisions regarding the disciplinary tribunal showed real resolution under pressure.

9.296 I accept the assessment of Ms Alder, referred to above, that the PCA had done its utmost to ensure that justice was done. I recognise that

⁸⁴² PCA telephone note (4 September 2002) CA002 D38 [00020489]

⁸⁴³ *Daily Mirror* article (24 February 2003) CA002 D108 [00020035]

the system within which the PCA worked was a flawed and underpowered one that did not permit of proper oversight or control. Therefore, although there were failings in the West Yorkshire Police investigation that a better system of oversight might have picked up, the fact that they were not identified by the PCA is attributable to systemic weaknesses, rather than to any individual failings or negligence.

9.297 The oversight exercised by the PCA was, accordingly, of limited value, in that it appears in most cases to have been merely endorsement after the event of decisions taken. With the benefit of hindsight it is now possible to say that the limitations on oversight could not be resolved within the structure as it then was. The upshot was the replacement of the PCA by the IPCC. There is probably little to be gained in a detailed critique of the failures of a now defunct system.

The Crown Prosecution Service

9.298 The CPS has rendered assistance to the IPCC in production of this report, for which I am grateful. I recognise, as does the CPS, that the purpose of the Review is not to examine the decisions taken by the organisation. I can say, however, that the explanations given to me by the CPS as to the actions that it took appear to me to be justified by the information that it received.

9.299 I have considered the issue raised by Ms Alder regarding the involvement in the case of Mr O’Doherty, as detailed above in Chapter 6. In the absence of any detailed allegation, or evidence from Ms Alder, I have no reason to doubt the explanation provided by the DPP or the Attorney General. The same explanation was provided to me by Mr Enzor of the CPS, who took over the role from Mr O’Doherty and who guided the case through to the trial.

9.300 In all of the evidence that I have seen, and the information that has been made available regarding the trial, there is nothing that justifies the assertion that the trial was ‘thrown’ or that any of the officials involved did less than their best to present the case fairly and firmly.

9.301 I am left in no doubt that Ms Alder and her supporters had strong views as to the way that they thought a trial should be pursued. They attempted to provide instructions to Ms Ivens to cross-examine on their behalf, believing her to be “their counsel”. It was explained to them that she did not represent them, and although there was scope for discussion between the prosecuting authority and the family, this did not amount to the prosecution representing the family, as if the matter were a civil trial.

9.302 It is worthy of note that the CPS laid out considerable funds to permit the attendance of the family and their supporter, Ruggie Johnson, to be

present at the trial and for a third counsel to facilitate communication with the family.

- 9.303 I have not had any detailed or evidence-supported explanations from Ms Alder as to her dissatisfaction with the CPS, so I cannot say whether there is any substance in them. Examining what I do know about the handling of the trial, I am driven to the conclusion that the prosecution failed because there was a fundamental lack of the necessary evidence to support a manslaughter conviction. The misconduct charges failed because the trial judge assessed the available evidence as falling short of the necessary standard for a conviction. Neither of these failings represents a lack of commitment or good faith on the part of the prosecuting authorities.
- 9.304 The family of Mr Alder, and particularly Ms Alder, believe that the death of Mr Alder should have led to a criminal conviction. This is entirely understandable. Also understandable is their distrust of the authorities, given their belief that those authorities were ultimately responsible for his death. Such pain, confusion and suspicion are regular features of death-in-custody cases: that does not make the family 'difficult' or 'awkward'. These responses are normal human reactions and should have been anticipated by the police.
- 9.305 The family now believe that the lack of a conviction must reflect negligence or worse on the part of some person, persons or organisation. I respect and sympathise with this viewpoint, although I cannot share it. The contradictions in the evidence existed regardless of the handling of the case: they could not be ignored or forgotten in running a prosecution. They were not created by mishandling on the part of those investigating or presenting the case, but rather were brought to light by their efforts, and could not – should not – have been hidden. This does not make the trauma of the family any easier to bear.

Assessment of the Humberside Police discipline hearings

- 9.306 The decision on the part of Humberside Police not to pursue disciplinary hearings is one over which I have the gravest misgivings. The history of the case makes it clear that in their correspondence with the PCA, Humberside Police were intransigent in their approach to possible disciplinary hearings and sought to resist holding any formal hearing. Their reluctance appears to be best summed up by the comment that DCC Steve Love recalled from his meeting with his predecessor, DCC Gordon Clark, when he was told that the view in the force was "the officers have suffered enough" ..
- 9.307 In a meeting with my staff, Mr Clark accepted that this view was the general view of the rank and file of Humberside Police. He denied that it was his own view, and was adamant that he had made a professional

judgement of the situation. He pointed out that as an ACC he had originally authorised the suspension of the officers. He also pointed out that he had sanctioned disciplinary action against PS Dunn, albeit action falling short of a hearing.

- 9.308 Despite this insistence, I am struck in reading the correspondence from DCC Clark, by the tone of the letters, that appear to argue in defence of the officers, and to take a partial position. Whilst Mr Clark may not realise the impression that is given by his correspondence, the feeling of sympathy for the five men is conveyed very strongly.
- 9.309 I do not suggest that Mr Clark is being dishonest in his assertions. I do not question DCC Clark's integrity; I do question his judgement in this case. I am of the view that he – and many others in Humberside Police – lost the necessary perspective on the case that was required to make a proper judgement. **2 lines redacted. Legal and Professional Privilege.** Instead, I believe that the position that he adopted in correspondence with the PCA was unreasonable and unjustifiable.
- 9.310 It was entirely appropriate for the PCA to insist that there be a disciplinary hearing because of public concern over the case. For the very same reason, it was wrong of Humberside Police, and specifically DCC Clark, effectively to hobble the proceedings by deeming them as not requiring legal representation. The mere fact that a man died in the process, even if the cause of his death was not to be debated at the proceedings, meant that this hearing should have called automatically for the most serious consideration. It is worth noting that even Chief Constable Sean Price of Cleveland Police, who was ultimately the presiding officer, took the same view, but was unable to influence the decision to deny legal representation.
- 9.311 I am driven to the conclusion that DCC Clark, while demonstrating loyalty to the officers under his command, failed in his judgement and by limiting the disciplinary process ensured that his view of the case could not be effectively reversed, even though the PCA forced a hearing to be held. The family of Mr Alder and the public at large were entitled to feel let down and sold short by this. His failure contrasts unfavourably with the judgement and resolution shown by the (in comparison) 'amateur' members of the PCA.
- 9.312 I am satisfied that once the disciplinary process got underway Chief Constable Price took his duties seriously and showed commitment to the process. He clearly believed that he was not entitled to obtain legal advice at the close of the presenting side's case. This resulted in a series of problems:
- He failed to appreciate that the decision to be taken at that stage was principally a legal rather than a factual decision.

- He failed to appreciate that the Police Federation representative, in making such a submission, was not entitled to introduce evidence as part of the submission.
- He failed to appreciate that the correct test at that stage was not ‘is this case proven beyond a reasonable doubt?’ but rather should have been ‘has a prima facie case been made out?’

9.313 It is only fair to point out that neither of the two parties appearing in front of him appears to have understood these distinctions either. There is no evidence to suggest that the federation representative who appeared before Chief Constable Price was seeking do anything other than his level best to represent the interests of his members. C/Supt Everett took no objection to the evidence submitted and did not seek an adjournment. Even when the Chief Constable Price read out his decision and reasons making clear how he came to his conclusion, neither side took issue with it.

9.314 It is regrettable that C/Supt Everett did not take exception to these matters, but I recognise that he is not legally qualified. I have seen the opening presentation prepared by C/Supt Everett, and it is a robust summary of the failings of the officers. There is no basis for suggesting that he was not doing his best in difficult circumstances. There is no evidence to suggest that the reluctance of DCC Clark to allow the hearing to occur led to any lack of application on the part of C/Supt Everett in doing his job: Ms Hawkins of the PCA observed the hearing and was said to have expressed satisfaction at the way it was run (although she acknowledged to the IPCC that she was surprised at the outcome and would have wished the matter presented by counsel).

9.315 I am strongly of the view that this was a hearing that reflected a matter of public interest, and it obviously required legal representation. The deliberate failure of DCC Clark to acknowledge this resulted in a skewed hearing, which did not serve the public interest.

9.316 Chief Constable Price pointed out to the IPCC that even had the correct process been followed, the result might have been the same. I have read the decision of the Chief Constable, and the full text of his conclusions is attached as Appendix 30. I disagree strongly with the conclusions that he reached. I recognise, however, that his was a lawfully constituted tribunal and that his discretion in such matters was final. I do not seek to go behind that discretion, and I am satisfied that it was exercised in good faith by Chief Constable Price. I believe that he was placed in an impossible situation.

9.317 I am of the view that had legal advice been made available to Chief Constable Price at the close of the presenting officer’s case, and if, as should have happened, both sides had been legally represented, then the case would have gone beyond the close of the presenting side’s case. Whether this would have resulted in some or all of the officers giving evidence it is not possible to say. I am aware that medical

evidence was prepared on behalf of the officers, although I have not seen any of the content of this evidence. Clearly, it is not possible to say how this would have influenced the final decision of the tribunal as to the disciplinary process.

9.318 In my view, Humberside Police must show they accept several simple truths of the case:

- The acquittal of the officers in the trial and disciplinary hearings did not amount to an endorsement of their actions.
- Right-minded people watching the videotape of Mr Alder's death are quite properly appalled by what they see.
- Even if the officers did not cause the death of Mr Alder their behaviour was not acceptable and fell seriously short of the standards that are expected of police officers.
- The officers were not the victims in this case.
- Humberside Police still owe the Alder family an apology.

9.319 I appreciate that there was concern for the safety of officers, after Humberside Police received death threats against a number of policemen. I believe, however, that the reluctance of Humberside Police to release the videotape of the events of the evening to the family of Mr Alder was motivated, in no small part, by a tacit acceptance that the behaviour of the officers shown on the video was deplorable.

9.320 It will no doubt be said on behalf of Humberside Police that they are unwilling to offer any apology while civil litigation is ongoing. I do not accept this view. Other forces have taken a different stance in similar circumstances. The Chief Constable should offer an unreserved apology for the force's failing in relation to the death of Christopher Alder, and he should do it now.

Conclusions

9.321 The truth about the death of Mr Alder was not simple or straightforward. It is not reflected in the defensive denials and evasions of some of the police explanations. Neither is it to be found in some of the unfounded allegations made by others.

9.322 Rather, the truth is that Mr Alder was in a poor state of health on the night of 31 March and 1 April 1998. The contributing factors that led to that state of health were several, but the first of these was a combination of drink, tiredness and a very hard blow to his head that undoubtedly knocked a tooth clean out of his jaw, coupled with the collision of his head with the ground. The fact that he was on the ground – dazed, unconscious or semiconscious and confused – for 11 minutes indicates how hard he was struck.

- 9.323 Those factors alone may well not have killed him. His behaviour at the hospital clearly indicated distress of some type. Whether a consequence of his injury, the drink he had consumed or his documented fear of hospitals – or some combination of all three – he was not making rational decisions, and he required assistance.
- 9.324 As will be clear from its report, the HCC considers that the care provided by the ambulance crew and, to some extent, the hospital staff fell short of what was required. The IPCC accepts that assessment, but I make no comment on this.
- 9.325 What does lie within the remit of this report is the behaviour of the arresting officers, who made assumptions about the behaviour of Mr Alder to the effect that his troubles were self-induced and accordingly deserved: that he was “well in drink”; that he was suffering from amphetamine abuse; and that he was feigning illness. Those assumptions, and confusion between the officers and the hospital, saw him ejected from the hospital and arrested without any clear instructions as to his further treatment.
- 9.326 I believe the assumptions of the officers arose from a stereotyped view of Mr Alder that was a consequence of an ‘unwitting racism’, as defined in the Lord Macpherson report.
- 9.327 At the police station the complacency and cynicism of the arresting officers persuaded other officers to ignore Mr Alder’s obvious and dramatic deterioration in condition, which the arresting officers themselves were not qualified to interpret. A readiness on the part of the custody sergeant to allow a crucial element of his duty to be discharged by the two arresting officers meant that an important double-check on the health of a detainee was missed.
- 9.328 The position in which Mr Alder was placed, through ignorance and lack of training, led to his airway being obstructed. As a result the deterioration that had already begun was accelerated and was brought to a tragic conclusion.
- 9.329 The two investigations into Mr Alder’s death by Humberside and West Yorkshire police were out of balance. The Humberside investigation was given primacy and marginalised what should have been an independent West Yorkshire investigation.
- 9.330 The actions of the officers led to a verdict at the inquest of unlawful killing but an acquittal at the subsequent trial. These apparently contradictory results are not unique. The courts have held that there is insufficient evidence that the actions of the officers caused the death of Mr Alder. Nevertheless it is clear that their actions denied him the chance of survival. This was not, in my view, out of malice on their part but was due to negligence and complacency.

- 9.331 Regardless of the death of Mr Alder, the actions of the officers in the custody suite quite obviously amounted to neglect of duty: the same would have been true even had he lived. The callous disregard of the detained man rightly appals all reasonable people who watch the CCTV footage from the custody suite. The failure of Humberside Police to recognise that disciplinary proceedings were necessary, and the deliberate downgrading of the proceedings when obliged to hold them, reflected an avoidance and denial of the reality of the situation. That decision on the part of Humberside Police was the principal reason for the failure of the disciplinary hearing.
- 9.332 I accept the decision of the Crown Court as to the lack of sufficient evidence of causation. In my view this is not a case of police officers 'getting away with murder'. It is not even that they are 'getting away with manslaughter'. It is, however, a case of them 'getting away with neglect of duty'. The criminal and disciplinary proceedings are now at an end and cannot realistically be reopened.
- 9.333 I recognise that the consequences of these proceedings have been profound and long lasting for all involved. The case took over five years from the death of Mr Alder until the disciplinary proceedings were resolved. This was simply too long, and the health of all of those involved, both family and officers, has suffered as a result. The careers of all of the five officers were put on hold, and those of four were prematurely ended by the case. Although I would not expect the family of Mr Alder to sympathise with the position of the officers, I believe that everyone who wishes to see good and effective policing would agree that this was not a proper outcome. The issues should have been resolved, and if sanctions were appropriate they should have been imposed. Wearing the officers out with stress and delay is neither desirable nor appropriate as an alternative to a prompt and just adjudication.
- 9.334 Following these events, the failures of individuals, organisations and systems meant that not one of them was held accountable. It remains the case today that no-one seems prepared to accept responsibility. The family of Christopher Alder are entitled to feel that justice has not been done and has not been seen to be done.

CHAPTER 10: THE CONCERNS OF MR ALDER'S FAMILY

Introduction

- 10.1 The case of Mr Alder attracted considerable attention at the time of his death, but has remained in the public eye for longer than many examples of death in custody due to the determined and persistent campaigning of his family and their supporters. That campaigning and the unusual history of the subsequent events led directly to the establishment of this Review.
- 10.2 The Home Secretary enjoined the IPCC to take account of the concerns of Mr Alder's family in preparing this report. For completeness, I aim in the next few pages to set out what is known about the family's concerns, and to deal with each of them in turn.

The approach taken

- 10.3 During the course of the Review, invitations were extended to all the known family members of Mr Alder, offering to meet with them and to discuss their concerns. I met with the solicitor for Leon and Kelvin Wilson, Jane Deighton, who indicated a number of concerns on behalf of the two men. Correspondence was also sent to Richard Alder and to Tracy Alder, but no response was received from either of them.
- 10.4 Apart from the complaints raised by Janet Alder, none of the other family members has, to my knowledge, made any formal complaint to Humberside Police, West Yorkshire Police, the Police Complaints Authority (PCA) or the Crown Prosecution Service (CPS). The only formal proceedings are the civil suits for damages commenced in the names of Mr Alder's two sons, and by Ms Alder, against a number of parties.
- 10.5 Accordingly, apart from the matters raised by Ms Deighton, the concerns of the Alder family can best be identified by reference to the complaints made over an extended period by Janet Alder, sister of Christopher.
- 10.6 Ms Alder met the IPCC at an early stage of our Review when we discussed the approach we intended to take. Since then, she has declined to meet with IPCC staff to clarify her complaints for the purposes of this Review. She has, however, made frequent telephone calls to the IPCC to discuss her concerns. On the one hand, the view that she has expressed is that the Review cannot achieve anything because she does not regard it as being a legitimate method of examining the circumstances and consequences of her brother's death. She has made it clear that she regards it as a poor alternative to her expressed preference, which is for a public inquiry. On the other hand, her frequent and legitimate requests for information indicate, I hope, that the information contained in this report will be of value to her.

- 10.7 On 9 November 2004, she sent an e-mail addressed to me, under the heading "Justice by your means impossible".⁸⁴⁴ In that e-mail she indicated that she regarded the Review as "a farce" and would not cooperate with it. She said that:

"It is now clearer to me than originally that the purpose of your inquiry is to try to lay the blame of Christopher's horrific death on the hospital or the fight rather than those who have been responsible for his undignified death and the grosse [sic] attempt to cover up!

Myself and the public and supporters have no interest in what happened outside the nightclub or in the hospital, but have very grave concern about the lack of concentration from the time my brother left the hospital perfectly alright then ended up dying a death worse than we as normal people with empathy and compassion would put an animal through. Clearly we would like to know what happened on the van journey, at the police station right up to and after post-mortem, about the total destruction of evidence in this case and the failure of the CPS bring [sic] an honest professional prosecution."

- 10.8 To this extent, while refusing to provide details of her concerns, she has provided a broad outline of them. Ruth Bunday, a solicitor acting for Ms Alder, in correspondence with the IPCC on 19 May 2004,⁸⁴⁵ defined Ms Alder's questions as being, simply:

"What actually happened, and what is going to be done about it?"

- 10.9 In order to further clarify Ms Alder's and the family's past or current concerns, I have sought to identify them by reference to the issues that were raised at the inquest and the trial, and documents either produced by her or which quote her comments.

- 10.10 A number of specific issues have been identified, which arise on several occasions. Many of these have been mentioned as being among the principal concerns of Ms Alder and the other family members. Documents that have been relied on in identifying Ms Alder's concerns were largely letters, notes of telephone conversations, newspaper articles and, in a couple of cases, leaflets issued by those campaigning with or for the family. I deal with some of the more detailed documents, and issues that arise from them, at greater length below. These include:

- the notes of Jim Elliott regarding his early dealings with Ms Alder;
- a leaflet dated 13 November 2000 sent to Mr Peter Pike MP;
- a letter from Harrison Bunday solicitors dated 27 February 2001;
- the meeting between Mr Enzor of the CPS, Ms Alder and Mr Johnson on 21 March 2002; and

⁸⁴⁴ Janet Alder e-mail (9 November 2004) CA005 D200 [00050040-1]

⁸⁴⁵ Harrison Bunday letter (19 May 2004) CA004 D62 [00040101-2]

- a letter from Harrison Bunday dated 23 July 2002.

The evening of 1 April 1998

10.11 **Was Mr Alder murdered?** Mr Elliott had contact with Ms Alder from an early stage, when he visited her in Burnley. He summarised his experience as follows:

“It was clear from the start that Janet Alder believed that the conduct of Humberside Police towards her brother was motivated by racism. This was stated when I visited her at home in Burnley. Her opening position was that the officers had engineered the confrontation at the Waterfront Club in order to get Christopher Alder to the police station where they could murder him. In her opinion this was because he was black.”⁸⁴⁶

10.12 Mr Peter Pike MP had also written to the Chief Constable of Humberside on 29 April 1998, saying that:

“She is deeply distressed and concerned at the position regarding her brother. She now believes he was murdered.”⁸⁴⁷

10.13 The suspicion of authority and the early conclusion that her brother was deliberately murdered has clearly influenced all subsequent dealings that Ms Alder has had with official bodies. As recently as May 2005, shortly before the general election, the Press Association⁸⁴⁸ quoted Ms Alder as saying to the Home Secretary at an election hustings in London that:

“It was murder and you know it.”

10.14 On occasion, Ms Alder has also been quoted as referring to the police as having beaten her brother or “giving him a pasting”.

10.15 The suggestion that the officers were “motivated” by racism (as opposed to being **demotivated** by the stereotypical assumptions they made) and that they deliberately engineered the confrontation with Mr Alder in order to get him to the police station so that they could murder him was not put forward at the inquest. Similarly, it has not been put forward in the subsequent letters sent on Ms Alder's behalf by Harrison Bunday and Deighton Guedalla. The possibility of a deliberate assault by the police on Mr Alder, probably on the return journey, is of course a possibility that neither firm would dismiss.

10.16 While I have endeavoured to look objectively at all the evidence relating to the activities of the police, there is no evidence at all to suggest that the events of the evening were planned in any form; there is no evidence to

⁸⁴⁶ Jim Elliott file note for PCA (undated) CA002 D88 [00020166]

⁸⁴⁷ Peter Pike MP letter (29 April 1998) CA001 D17 [00010356]

⁸⁴⁸ Emily Pennink, Press Association (5 May 2005)

suggest that Mr Alder was targeted by police because he was a black man; there is no evidence to suggest a conspiracy between officers to deliberately kill him.

- 10.17 The fact that the police went to the hospital following the assault on Mr Alder and attempted to give him a note with the details of his case number indicates to me that they set out with the right intentions. The real problems arose later that night. There was no conspiracy to murder Mr Alder by police officers because he was black.

Hospital treatment and arrest

- 10.18 Ms Alder has at times been very suspicious of any attempt to discuss what happened outside the Waterfront Club, or the treatment that her brother received at the hospital. Her concern has been that any criticism made of what went on at those stages might distract attention away from the incidents at the police station. While I understand this concern, it is not one that I share; I regard it as appropriate to examine all the events of the evening, in order to put them in context.
- 10.19 As should be clear from previous chapters, it has been established that Mr Alder did not die from the direct effects of the blow that was struck by Mr Paul. My view is that he was treated well and appropriately by the staff of the Waterfront Club and by Mr Jarvis, who went to his assistance while he was on the ground.
- 10.20 The actions of the ambulance crew are criticised to some extent in the report of the Healthcare Commission (HCC) which deals with the healthcare professionals who dealt with him. The HCC accepts, as do I, that any shortcomings in his treatment did not lead to Mr Alder's death.
- 10.21 The findings of the HCC report (the executive summary of which is at Appendix 8) address the issue of the handover from the hospital to the police and the misunderstandings that arose from that. These, as I have made clear above, contributed to the situation in which Mr Alder died, and to that extent were a factor in his death.
- 10.22 During the meeting held between Ms Alder and Mr Enzor on 21 March 2002 at Burnley CPS, Ms Alder made the point regarding her brother that:

“At the hospital he was agitated/irritable and at one point wanted to leave...the actions of the police contributed to Christopher Alder being in the state he was because they did not want to deal with him properly. The hospital also has some responsibility here too. There are a number of contributory factors. First of all, nobody at the hospital seems to have recognised that it may well have been due to the punch and cerebral irritation that Christopher was acting in a difficult way. They looked on him as a trouble maker and the police were in effect

asked to sort him out...Christopher Alder was being treated not as though he had had a head injury but as though he was a nuisance.”

10.23 I agree almost entirely with this explanation by Ms Alder. This bears out the impression that is given by studying the statements of those dealing with Mr Alder at the hospital and the views of the HCC in their report.

From the hospital to the police station

10.24 Given that Mr Alder's condition appears to have changed between his arrest at the hospital and his arrival at the police station, and that this change occurred when he was least observed, the family's concerns about his treatment have concentrated heavily upon this short period. Inevitably, this period has also been a topic of major concern in considering the evidence, and many of the concerns expressed are already set out above.

10.25 Just as with the concerns about the possibility of murder, the idea of a deliberate assault upon Mr Alder is clearly a very upsetting prospect for his family to consider. For this reason, the topics below have already been covered in some considerable detail in the preceding chapters.

10.26 **CS spray:** A topic raised frequently by Ms Alder has been that of CS incapacitant spray and the possibility that, having threatened its use, one of the officers may in fact have used the spray. The family was understandably concerned lest the use of CS spray might have led to Mr Alder's unconsciousness. There is no medical evidence to suggest that this would have been the case. The various medical experts who dealt with this topic considered the possible scenarios, but none could say that there was any clear evidence of CS usage.

10.27 The only evidence that was used by the family to support the view that Mr Alder might have been sprayed was that Ms Alder thought one of the officers was sneezing or coughing at the police station. I have not seen anything on the videos of the custody suite that would suggest that any of the officers were suffering the adverse effects of CS.

10.28 In Chapter 9 I have set out my full explanation as to why I do not believe that CS was used.

10.29 **Possible assault by the police:** Another major concern for the family has been the possibility that Mr Alder might have been physically assaulted by being struck or beaten en route from the hospital to the police station. This encompasses a number of concerns and matters that remain less than fully explained. The most obvious of these is the fact that he appears to have lost consciousness while travelling. Professor Crane, in his initial report, considered that a second blow to the mouth, either accidental or deliberate, was a possible explanation for his unconsciousness. However, there was no positive evidence for such an assault, and a joint meeting of experts, including Professor Crane, stated that:

“All were agreed that there was no medical basis for inferring to the criminal standard that Christopher Alder had been assaulted in some way while in police custody or care so as to account for his condition on arrival in the charge-room.”⁸⁴⁹

- 10.30 In addition, concerns were raised regarding the loss of the second tooth and the variations in injuries recorded between the hospital examination and the first post mortem examination. I have considered these matters in Chapter 9, and the conclusions that I draw are set out there. I am driven to the conclusion that this concern, while being very real, is simply unsupported by the available evidence. The fact that no definitive explanation for Mr Alder's loss of consciousness was identified does not, of itself, point to an assault, or make an assault more likely; the issue was considered at great length by the medical experts, and not even those instructed on behalf of Mr Alder's family could say that this conclusion could be drawn.
- 10.31 What happened to the second tooth that was lost by Mr Alder was, and remains, a mystery. While it might have cast light upon the events of the day, the failure to find it is not assisted by speculation. I have seen no evidence to suggest that the forensic scientists or the medical experts in the case have done anything less than their best in locating and interpreting evidence.
- 10.32 **Loss of Mr Alder's belt:** From an early stage in the case, the family of Mr Alder has been concerned that no belt was found with Mr Alder's clothes when he was seen by the Home Office pathologist. The reason for this concern was based on a statement made by his brother, Richard Alder, to the effect that Christopher always wore a belt and owned several belts. There is no record of any belt being found on his trousers, nor of any belts being found at his flat. Richard Alder was not with his brother during the evening and does not say how long it had been since he had last visited his brother's flat.
- 10.33 The implicit concern of the family has been that the loss of a belt might indicate that he was assaulted, or that there was some attempt to humiliate him prior to his arrival at the police station.
- 10.34 The actual evidence as to whether he was wearing a belt at all is equivocal at best and is considered in the context of the descriptions given by hospital staff in Chapter 3. It remains a possibility that Mr Alder did not wear a belt that night, or that it was taken off at the hospital and left there when he went to the lavatory.
- 10.35 There is, in any event, no evidence at all to suggest that the loss of a belt, if he had one at the time, indicates any misconduct on the part of the police officers. Therefore, while the issue as to whether he had or lost a belt may remain incapable of resolution, and the family may regard this matter as being in some way suspicious, there is simply no basis for concluding that it amounts to suppression of evidence by the police.

⁸⁴⁹ Joint report CA0099 pp.651–3 [00990271–3]

- 10.36 **Why did Mr Alder's trousers come down?** Mr Alder is seen on video being brought into the police station at 03.46 and being placed on the ground by the officers. By the time he was placed down, his trousers and boxer shorts were coming down and were around his thighs. He was also doubly incontinent by this stage. The fact that his trousers were coming down at all has been a source of distress and concern that has been expressed repeatedly by family members.
- 10.37 As with the issue of the missing belt, the evidence regarding the trousers has been difficult to clarify with any certainty. Mr Alder is known to have loosened his trousers at the hospital prior to going to the lavatory. He is presumed to have refastened his trousers before being arrested outside the hospital, as he was seen walking around by Mr Rodgers and others, with no reference made to his trousers being loose or falling down. When his trousers were seen by Dr Clark, the pathologist referred to them as having:
- “the top two metal buttons undone”.
- 10.38 I think it is likely that Mr Alder was too confused and disoriented by his injury to fully refasten his trousers after he had gone to the lavatory in the hospital.
- 10.39 By the time he was placed in the police van his hands were handcuffed behind his back, and so, if it were the case that his trousers came down, he would have had difficulties in pulling them up again. The officers who took him from the van do not refer to his trousers being loose at that stage.
- 10.40 What becomes clear from an examination of the video showing his arrival at the police station is that the two officers who brought him into the corridor, and then into the custody suite, were having difficulties carrying him. As is recorded in the original post mortem report by Dr Clark, Mr Alder weighed approximately 13 stones or 81 kilos. It is also clear from the recording that he was wholly unresponsive and did not bear his own weight. As he is about to be brought into the corridor, the officers can be seen lifting him from the ground, immediately outside the door. He is lifted by each officer taking an upper arm, thereby lifting Mr Alder's upper body from the floor. His lower body, for the most part, is dragged along the ground.
- 10.41 This, then, presents an immediate and obvious explanation as to why his trousers, probably already not fully fastened, were likely to have come down. Indeed, this concern may already have been addressed to the satisfaction of Ms Alder, in that she acknowledged this explanation in a statement to the National Civil Rights Movement (NCRM) meeting in March 1999,⁸⁵⁰ when she said:

“The police dragged him out and in the process his trousers and his boxer-shorts ended up down his legs. They dragged him into the police station, put him on the floor.”

⁸⁵⁰ www.ncrm.org.uk/campaigns/alder.html

- 10.42 In my meeting with Jane Deighton, solicitor for the sons of Mr Alder, she expressed to me concern that there may be more to the incident than this, and that she had been told that there was a practice among certain police officers in Hull of pulling down the trousers of arrested men to prevent them running away. Ms Deighton was not prepared to identify the source of this information. I instituted enquiries with the D&C department of Humberside Police, as a result of this assertion. Given that officers would not have authority to pull down detainees' trousers, it is a practice that would have been likely to attract complaints at some stage. The department was not able to identify a single complaint about such a practice ever being used by Humberside police officers. In the absence of further information from Ms Deighton regarding her source, I am unable to take the matter any further.
- 10.43 In any event, there is no suggestion in the evidence of Mr Rodgers that Mr Alder's trousers were interfered with prior to his being placed in the van. The van doors would not need to be opened until the vehicle reached the secure yard behind Queen's Gardens police station a few minutes later. Accordingly, there would have been no basis for concern that Mr Alder might try to run away. With his hands handcuffed behind his back, he was already considerably restricted in his movements.
- 10.44 **Mud on Mr Alder's thighs:** Closely linked to the concern about the trousers was the question as to why Mr Alder had mud on his thighs. This information came from Dr Clark's post mortem report, where it is mentioned in the context of the clothing. In the report, he says that Mr Alder was wearing:
- "Dark blue cord jeans, pulled down to just above the knees, with the top two metal buttons undone. There was patchy mud staining of the front of both thighs."
- 10.45 What is ambiguous in this description is whether it means the skin of his thighs or the thigh area of the trousers. Given the context, the latter seems more likely. The description was also given at the inquest when Dr Clark was asked to describe the clothing, and he said:
- "Well, this is the clothing: it was a pair of dark blue cord jeans. As I say they had been pulled down to just above the knees and the top two studs were undone. There was some mud staining of the front of both thighs as if he'd been – well, in contact with a muddy surface at some stage. There was also a pair of boxer shorts, again pulled down to his lower thighs..."⁸⁵¹
- 10.46 Dr Clark was not questioned on this topic. I have had the opportunity to examine the post mortem photographs, which are not appended to this report for obvious reasons. I can say, however, that the body of Mr Alder showed no obvious marks on the front of his thighs, and the body itself had no marks that could be described as "mud" stains.

⁸⁵¹ Inquest Day 15, p.6

- 10.47 I conclude that Dr Clark did indeed mean the trousers of Mr Alder, which are known to have been dragged along the ground. While the term "mud" is rather a wide one, it is reasonable to conclude that the dragging of Mr Alder along the ground, as well as having the effect of pulling his trousers down, would be likely also to have the effect of gathering dirt and dust on the clothing that dragged along the ground.
- 10.48 Again, I must conclude that, given an obvious and reasonable explanation, and with no evidence for any other source of this dirt, the dragging of Mr Alder into the custody suite is the correct explanation for what occurred.
- 10.49 **What was said prior to the arrival of Mr Alder at the police station, and was any of the conversation racist in nature?** Following on from the investigations into the nature of noises and conversation that appear on the tape from the custody suite in the hours following the death of Mr Alder, a great deal of attention has been paid to the general nature of the conversations that took place in the custody suite that night. Concern has been expressed by Ms Alder that these tapes might reveal a racist attitude on the part of the police officers.
- 10.50 I have reviewed all the material available, covering the shifts at Queen's Gardens police station, from 22.00 on the evening of 31 March until noon the next day. There is a great deal of banter and joking among the officers; while the cameras within the custody suite were clearly visible and obvious to all there, it is evident that their constant presence has rendered the officers oblivious to them. Strong language is a regular feature of the conversation, and one does not sense that the officers are in any way performing for the camera.
- 10.51 Given that the cameras are set to record the custody suite from nine different angles, for 24 hours every day, it is reasonable to conclude that very little of the actual tape would normally be viewed, and the vast majority of it would not normally need to be retained.
- 10.52 The aspects of the officers' behaviour, prior to the time when Mr Alder was brought in, which cause me great concern arise in relation to the jokes made by Police Sergeant (PS) Dunn about a drunk female detainee at approximately 23.45, and when Police Constable (PC) Barr jokes about deaths in custody. I deal separately with the jokes made by PS Dunn. The practical jokes carried out by PC Barr in telephoning other police stations are set out in Chapter 3. Ms Alder was understandably concerned that these jokes were being made at the expense of her brother. Careful viewing of the video demonstrates that they clearly occurred before the arrival of her brother at the station. They do, however, demonstrate a crass insensitivity on the part of PC Barr. In my view, deaths in custody are not a joking matter, and an on-duty, serving police officer should have appreciated that.

The treatment of Mr Alder at the police station

10.53 The most fundamental questions for the family of Mr Alder revolve, inevitably, around the treatment that he received at the police station following his arrival. I have dealt at great length with the behaviour of the individual officers, and I do not seek to repeat here what has already been said. I do wish to make clear that, while my views of the case do not coincide, in a number of respects, with those of Mr Alder's family, I accept unreservedly that Mr Alder was treated with a callous disregard and a lack of humanity when he was left unattended on the floor of the police station. That was unjust and wrong. The outrage expressed by Mr Alder's family is appropriate and justified.

The two investigations

10.54 **Why was Mr Alder's family not represented at the post mortem examination?** The issue of family representation at the actual post mortem examination has been raised on a number of occasions, particularly by Ms Alder. The assertion that the family was entitled to be represented at the post mortem examination is understandable but not strictly correct; there is no right in law to be present, and it is virtually unknown for family members to be present in person at such a procedure. The family may be represented by an approved pathologist with the agreement of the coroner.

10.55 In any event, no family member was identified, or contacted the police, until after the first post mortem examination took place. To have delayed a post mortem until a relative had been identified would have been negligent on the part of those involved and would have risked compromising evidence. The family was represented at the second, third and fourth post mortem examinations, by two separate pathologists.

10.56 At an early stage, there were concerns raised by Ms Alder concerning the transfer of Mr Alder's body to Sheffield for the post mortem examination. Although the correspondence from Harrison Bunday raising the issue is not available, the coroner forwarded a letter from them dated 16 March 2000 to Inspector (Insp.) Tolan. In that letter, Harrison Bunday stated that:

"My client Janet Alder accepts the position relating to the closure of the mortuary on the 1st April 1998 and takes no issue with your decision for the post mortem to be held in Sheffield, and there would therefore be no barrier at all that we can see in you conducting the Inquest..."⁸⁵²

10.57 I take it from this letter that the issue of the transfer of Mr Alder's body is not one that continues to give concern.

⁸⁵² Harrison Bunday letter (16 March 2000) CA98 p.137 [00980150]

- 10.58 **Why were the officers' clothes returned to them?** As will be clear from the earlier chapters, I share the concern of the family regarding the return of clothing to some of the officers, and the failure to take receipt of clothing from others. I do not conclude from this that there was an attempt to cover up malicious activity. I do, however, regard it as indicative of a poorly started investigation, in which assumptions in favour of the officers were being made from the outset. I do not accept the explanation of Superintendent (Supt) Holt that he made the decision to sanction return after the video had been viewed. If he had done so, after seeing the tape, this would have been even more astounding.
- 10.59 I am of the view that the return of the clothing did not prevent the proper investigation of the case, but it was responsible for much of the subsequent suspicion that arose between the family and the police, and it prevented a number of legitimate questions being answered. The lack of foresight and sensitivity shown by Supt Holt in permitting this was deeply unfortunate.
- 10.60 **Why were different explanations given in the early stages of the inquiry?** The case of Mr Alder is not unique in that the facts about the evening were pieced together over a period of time. Not every source of information was accurate, and in some cases they would be inconsistent with one another. The process of establishing the full truth is still continuing today. This process would not, however, have been familiar to Mr Alder's family, who could not be expected to understand the mechanics of a police investigation. For that reason, a strong and clear family liaison policy was essential.
- 10.61 It is worthy of note that the initial understanding even of the West Yorkshire Police team was incorrect, as they were told that Mr Alder "collapsed" in the custody suite, and assumed from this that he had walked in prior to his collapse (as explained by Insp. Tolan in Chapter 4). It is therefore easy to see how incorrect information was being provided to family members. The failure of West Yorkshire Police to secure immediately the duty statements meant that they continued under their incorrect understanding until such time as the CCTV tape was made available on 3 April.
- 10.62 As I have already set out in the sections of this report dealing with family liaison, the delegation of this task by West Yorkshire Police to Humberside Police led to a series of problems that were entirely avoidable. West Yorkshire Police should have been the force providing information to the family from the earliest stages. The family knew that Mr Alder had died while in the custody of Humberside Police, and yet they were being offered family liaison support from that same force; this could only undermine assertions of independence in the investigation.
- 10.63 Much of the liaison with Ms Alder ultimately fell on the shoulders of Mr Elliott of the PCA. He alone seemed to have appreciated the risk that confusing signals can emerge in the first few days of such an inquiry. That is exactly what happened, and the family was left with the impression of at best confusion and at worst duplicity.

- 10.64 Similarly, mishandling by Humberside Police resulted in the alienation of local officials from the Race Equality Council, because PC Smith was not provided with the correct information in advance of the suspension of the five officers. This was entirely avoidable.
- 10.65 **Was Ms Alder treated appropriately by Humberside Police?** As the case progressed, it is also clear that an atmosphere of antagonism developed between Ms Alder and Humberside Police. While Ms Alder might have been perceived as confrontational in her approach, it is evident that, from her earliest meetings with Humberside police officers, she was viewed as a nuisance and an irritant. Humberside Police made a number of errors that, while each of a minor nature, served to further damage the relationship with her.
- 10.66 Examples of these include an officer chewing gum or eating a sweet while explaining to her how her brother died, or the assumption that Ms Alder would prefer a black family liaison officer. While other parties have subsequently overstated these matters, it is still understandable that Ms Alder would have felt very sensitive and suspicious in her first dealings with the police. Although individual officers might have felt aggrieved about her antagonism, it should have been appreciated that the loss of a close relative affects different people to different degrees, and a more sensitive approach from the outset might have avoided the acrimony that developed.
- 10.67 **Possible criticisms in the pathologist's report:** Ms Alder expressed distress about the language used in the initial pathology report, issued following the first post mortem examination, as it appeared to be critical of her brother. This issue was also raised by Ms Alder with Mr Elliott of the PCA.⁸⁵³ His telephone note of 30 October 1998 recorded that:
- “she remains angry about the Home Office pathologist report, in particular inclusion of information she feels is inappropriate, inaccurate or critical of her brother. She insisted I should approach the pathologist in order to get the report changed; and was unable to accept that it was not my place to interfere with evidence in such a manner.”
- 10.68 The issue arose again in a letter that Mr Elliott wrote to Ms Alder on 30 November 1998, in which he addressed an earlier note from her, asking him to approach Dr Clark and “get his report changed”.⁸⁵⁴ Mr Elliott explained that he could not do that.
- 10.69 The report, when read as a whole, does not speculate as to Mr Alder's lifestyle or character. It addresses issues in order to deal with them, and indeed to dismiss them, including the use of drugs. It is easy to see that a person who felt close to the victim in such a case would feel strongly that the writer did not know the person described in the report. However, any scientific

⁸⁵³ PCA file note (30 October 1998) CA001 D146 [00010039]

⁸⁵⁴ PCA letter (30 November 1998) CA001 D57 [00010232–3]

report would be required to deal with all reasonable possibilities, even if merely to say why they did not apply. It is worth noting that the pathologists subsequently recruited on behalf of Ms Alder had to deal with the same issues, and made no criticism of the approach adopted by Dr Clark.

- 10.70 **The forensic process:** Family concerns arose in relation to several aspects of the early investigation into Mr Alder's death. A number of these focused on failings in the collection and treatment of scientific samples. The failures complained of came to light at various stages, but mostly during the public hearings of the inquest and subsequent trial. The failure of the police to analyse the blood samples taken from the van and the tooth retrieved from the municipal landfill site were two prime examples. A handprint on the wall of the van was not checked and eliminated for some time after the events. The yard immediately outside the custody suite was not treated as a forensic crime scene. It became clear that there was no coordination between the scenes of crime officer (SOCO) who performed the initial sampling and the forensic analyst, Mrs Leak.
- 10.71 The available material indicates that the failures in this area of the case were not those of individual SOCOs or scientists, but rather a failure by the senior officers involved in the case to set a forensic strategy. Mrs Leak's description in interview was that when she arrived she was told very little of what had gone on, and was not told at all that samples had already been removed from the van. While records of the samples existed, and the evidence was not "lost" or "destroyed", there was a lack of order in the approach taken.
- 10.72 Matters were, however, made worse by the destruction of the tooth and other samples once the Humberside Police investigation was over. West Yorkshire Police could have preserved these samples, and did not do so. This indicated a short-sighted approach to the case.
- 10.73 Linked to these concerns is the issue as to **why the officers' clothes were returned to them**. This is also dealt with in other parts of this report. It is a further valid concern and reflects a failure on the part of West Yorkshire Police, about which the family was entitled to be worried.
- 10.74 The main concern that this causes for me lies in the assumptions made in the early stages of the investigation, and what I view as a lax approach by investigating officers in assuming that the case was one of murder or manslaughter by a third party, outside the police.
- 10.75 **Why were Mr Alder's clothes not returned to his family?** This has been highlighted as a cause of concern and distress by the family on several occasions. It is appropriate to note the apology offered, very properly, by Supt Holt following this error. As explained elsewhere, I view this failure as being as much a family liaison error as an evidential one. There is no independent evidence to suggest that the clothing of Mr Alder contained evidence that was not already in the hands of the investigators, but the family was entitled to have the option to take back the clothes. They should not have been denied that chance.

- 10.76 **Why were the officers not suspended sooner?** The officers were suspended from duty around the end of April 1998, although Regulation 7 notices had been served on them much earlier in the month. The available evidence suggests that once the video had been viewed, although Supt Holt failed to serve Regulation 7 notices (and later acknowledged that this was a mistake), Insp. Tolan did so. Suspension of an officer from duty is a serious step, and in this case senior officers up to the level of assistant chief constable (ACC) were consulted prior to it happening. The criteria for suspension were, and remain, that it should be "necessary and in the public interest". One can well understand that Mr Alder's family would feel that the video should have given rise to immediate suspension; the decision was ultimately taken following the meeting with the pathologist, when it became clear that the blow struck by Mr Paul did not lead to the death of Mr Alder.
- 10.77 I recognise the reluctance of senior police officers to suspend officers in a precipitate fashion, before being sure of the full facts. I also recognise that it was not assumed that the behaviour of the police caused or hastened Mr Alder's death. The issue at that stage was whether there had been neglect of duty. Given what followed, the difference of a few days or even weeks in reaching formal suspension is probably not of great importance.
- 10.78 **Why was Mr Alder's flat not released to the family for two weeks?** Although I accept that Humberside Police needed to ascertain the facts about Mr Alder, I have been unable to establish why they went to the lengths that they did. This matter was raised with the deputy senior investigating officer, Chief Inspector Davison. Despite his explanation, I do not see why Mr Alder's flat required a search by a large group of officers, why it needed to be mapped and photographed, and why it was then left sealed for two weeks before the family was given access to it. It may be simply that no request was made for access to the premises, and that this was regarded as a low priority, but the elaborate efforts made in searching the premises left the impression that Mr Alder was being investigated as a suspect rather than a victim. A better policy of communication and liaison with the family might have served to avoid such an unfortunate impression.
- 10.79 **Was there any history between PC Blakey and Mr Alder?** This issue has been explored at some length during the course of this Review. Although there is no evidence to suggest that there was any history of problems between them, there is good reason to believe that PC Blakey was aware of who Mr Alder was. It was a matter that deserved exploration and was rightly highlighted by Mr Alder's family. This is something that would have been discussed with PC Blakey, had he been prepared to cooperate with this Review.
- 10.80 **Was the investigation into the death of Mr Alder deliberately mishandled?** The accumulation of concerns about the nature of the investigation reached a point beyond which the family of Mr Alder clearly feared that there was no enthusiasm on the part of the police to prosecute their own colleagues. The failure by the two police services involved to

reassure Mr Alder's family, the failure to demonstrate clear independence, and the poor supply of information to the family all contributed to this effect. The police have only themselves to blame for this impression, even if the impression is not a true reflection of what did in fact happen.

The trial

- 10.81 **Why was the CPS reluctant to charge manslaughter, given the inquest verdict, and why did they bring in all the contradictory medical evidence?** The family of Mr Alder struggled to persuade the prosecuting authorities that a charge of manslaughter should be added to the indictment. The CPS and prosecuting counsel agreed to this only when the additional evidence of Professor Adgey became available, and the decision was made that there was sufficient evidence to justify adding the count. I sympathise entirely with the identification that the family members would have felt with the prosecution process, given the physical and emotional energy that they had invested in pursuing the case.
- 10.82 The nature of a public prosecution, however, is that it is mounted on behalf of the public, and not simply the family of the deceased person. The interests of the two are not necessarily the same, and the duty to the public interest must guide the prosecutor's hand. This gives rise to the possibility of disagreements and conflicts as to the course a prosecution should take.
- 10.83 The correspondence between Ms Alder and the CPS records a stormy relationship, during which she expressed many criticisms of the way they carried out their tasks. It is probably scant consolation to her or to the rest of the family to know that many 'unlawful killing' verdicts do not lead to prosecutions.
- 10.84 The task of the CPS is to make a dispassionate assessment of the evidential merits of a case, and to decide whether there is a realistic prospect of a conviction before proceeding to trial. What may have appeared obvious to the family would have looked different to the eyes of a prosecutor. Evidence in a trial is like a chain: it is only as strong as its weakest link. The fact that there may be very strong evidence of, say, mistreatment will not make up for very weak evidence that the mistreatment actually caused the death.
- 10.85 The eventual decision of Mr Justice Roderick Evans, that there was not sufficient evidence to be left to the jury to demonstrate causation of death, was simply an assessment of the weakest link in the Crown's case. That vulnerability was always recognised by the CPS, and the decision to proceed with the prosecution once Professor Adgey's evidence was obtained was clearly taken in the knowledge that the weaknesses were known and had not gone away; they might, however, be overcome. In the event, the new material was not sufficient to overcome what had already been established.

- 10.86 Therefore, the “failure” in evidence did not point to evidence having been missed, but rather it was a conflict that emerged when all the facts had been brought to light.
- 10.87 The duty of prosecuting lawyers, both counsel and the CPS, is to disclose contradictory evidence to the defence, or to call all the witnesses themselves. The weaknesses in the Crown's case could not, therefore, be hidden or wished away. They had to be examined in public: this is the law. I deal with this at some length in relation to the handling of the trial. I make clear in respect of this that I do not agree with the criticisms of the CPS made by Ms Alder, and I have seen no evidence to suggest that the CPS did less than their duty – in several instances they went well beyond that duty to seek to accommodate the interests of the family.
- 10.88 The inquest jury was making a decision that was not a determination of the guilt of one or more individuals (indeed they were forbidden by the coroner to name any individual as being responsible), no matter how strong they thought that evidence was. Their decision did not bind the CPS and was not made from the same standpoint.
- 10.89 **The disciplinary hearing:** The family concerns regarding the disciplinary hearing were several, but chief among these was the decision to limit legal representation and therefore to limit the potential sanctions for the officers. As is made clear elsewhere in this report, this is a concern that I regard as valid and that I share. The Humberside Police decision was taken deliberately, in my view, to prevent the dismissal of their officers; it represented a major failure of judgement on the part of the Humberside Police hierarchy, and of DCC Clark in particular.
- 10.90 The premature end of the disciplinary hearing was brought about in large part by this decision to deny legal representation. This led to Chief Constable Price making a legal error in his judgement, resulting in the early dismissal of the charges. Again, I view this as a valid concern, and a proper cause for complaint by the family.
- 10.91 The lack of any family presence at the disciplinary hearing reflected, in my view, a legalistic approach on the part of Humberside Police, which is somewhat at odds with their anxiety to avoid legal involvement in the discipline hearings. The refusal to allow a family presence was based on the rules in place at the time, but, given the sensitivity of the case, Humberside Police might have wished to build bridges with the family of the dead man. Instead, they relied on the rules to keep the family at a distance.
- 10.92 As I make clear elsewhere, the fact that there had been death threats following the publication of a newspaper article did not mean that the family could not be told when a disciplinary hearing was going to take place. In my view, this would not have compromised security. Nor would the presence of a family representative have posed any physical threat to the five officers. Humberside Police, I am forced to conclude, viewed the Alder family representatives as irrelevant to the process, and as an irritation. It is no

wonder that the family, and Ms Alder in particular, would continue to feel that there was a conspiracy to exclude her from the process set in train by her brother's death, and to interpret this as a cover-up. It is a matter of regret that yet another opportunity to build bridges with the family was lost.

The Ku Klux Klan allegation

10.93 Following the end of the disciplinary hearing, on 24 June 2003, Ms Alder was interviewed by the BBC programme *Look North*. At this stage, for the first time, she alleged that the officers who had been standing in the custody suite near her brother's body had been discussing the Ku Klux Klan. Although no copy of this programme has been seen by the Review, the reference was recorded as part of a summary of press coverage by Steve Page of Humberside Police:

"BBC Look North and YTV Calendar carried the story but in a balanced way and BBC home affairs correspondent put together a story for the 6.30 p.m. news which carried our point of view exceptionally well. Ms Janet ALDER was interviewed in what looked like a live interview and made a shocking and disturbing statement about the tape containing references to the Ku Klux Klan [sic]. The interviewer did not give her a particularly easy time and Ms ALDER criticised the interviewer when it was suggested that it was 'time to let go'."⁸⁵⁵

10.94 This allegation was repeated by Ms Alder in a "feature article" written by her for the *Socialist Review* in May 2005, entitled "Fighting for Our Rights",⁸⁵⁶ in which she said:

"The police officers responsible for the death of my brother were heard making monkey and chimpanzee noises and referring to the Ku Klux Klan while Christopher was lying there."

10.95 Minutes of a Humberside Police staff meeting⁸⁵⁷ recorded that the force was aware of Ms Alder's comments and that Mr Adil Khan was "disturbed" by them. Although a representative of the Police Federation commented that his members were considering their legal options, no further indication of legal action has followed. Humberside Police chose not to respond to the allegations.

10.96 The reference in the television interview to the Ku Klux Klan is the first time such a comment had been made by Ms Alder. The issue was not raised at the inquest or trial at any point, and Ms Alder has not provided any more detail to me regarding the basis for the allegation. The only reference I have

⁸⁵⁵ Press summary for Humberside Police (26 June 2003) CA0065 [00650219]

⁸⁵⁶ www.socialistreview.org.uk/article.php?articlenumber=9382

⁸⁵⁷ Minutes of staff meeting (26 June 2003) CA0065 [00650215]

seen that might have given rise to this view is a comment made by an officer as part of the disputed conversation from 05.45. That comment is believed to be by PC Barr, in which he says:

“Or if I go in and open the doors, it'll be on me chin, pull it over with two eyeholes in it.”

- 10.97 That conversation, which was originally thought to be about “banana boats”, appears to be a series of complaints by PC Barr about the blue forensic over-suit and yellow forensic overshoes that he had been given. His comments about not going home in them seem to reflect resentment at being made to look ridiculous. Pulling the hood of the suit over his head and cutting eyeholes would be, I believe, to hide his embarrassment.
- 10.98 Miss Alder seems to have interpreted the words used by PC Barr as indicating that he intended to wear a hood with eyeholes cut in it. Hence she has made a link between this and the wearing of hoods with eyeholes as worn by the Ku Klux Klan in the southern states of the USA.
- 10.99 I am entirely sympathetic to Ms Alder's view, as when I first listened to the soundtrack of the CCTV I reached a similar conclusion. Having now had the benefit of a detailed forensic analysis of the tape and of the words used, I am satisfied that this was not the nature of the conversation being held, and that it is indeed a discussion regarding the forensic over-suit. I am still strongly of the view that joking banter of the sort used by PC Barr was wholly inappropriate in the same room as the body of the deceased man, and Humberside Police has already accepted that such behaviour was wholly unacceptable.

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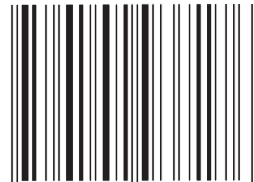
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