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

Volume 1 of Appendices

HC 971-II

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

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

Volume 1 of Appendices

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5	**6**	**7**	**8**	**9**	**10**	**11**
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19	**20**	**21**	**22**	**23**	**24**	**25**
26	**27**	**28**	**29**	**30**		

April 1998

Appendix 2: Persons interviewed for the Review

The following persons kindly agreed to assist the Review. and were interviewed by staff acting for the IPCC and/or the HCC.

PCA

Mr Jim Elliott

Sally Hawkins

Philip Johnston

West Yorkshire Police

Insp. Keith Tolan

C/Supt. John Holt

Forensic Science Service

Gillian Leak

Humberside Police

C/Supt Ken Bates (Retired)

C/Supt Paul Davison

C/Supt Andrew Everett

C/Insp. Alan Beckett (Retired)

C/Insp Alan Brookes

Insp. John Ford

Sgt Darren Wildbore

Sgt Jenny Mordew

PC Beatrice Smith

Bridget Winkley

Kenneth Crichton

Michael Gallagher

Adil Khan

Appendix 2: People interviewed for the Review

Tees East & North Yorkshire Ambulance Service NHS Trust

Stephen Krebs

Victoria Drennan

Hull Royal Infirmary

Dr Gosnold

Beverley Tweed

Jacqueline Smith

Jem Osman

Dr Aamer Khan

Helen Hudson (nee Townend)

Carole Walker

David Frankland

Alison Newlove (Risk Manager)

Gary Hewitt (Charge Nurse/Training officer)

Malcolm Rodgers

Crown Prosecution Service

Christopher Enzor

Kelvin Hall School

Canon Rev. Keith Wilkinson

Appendix 3: List Of Names Appearing In The Report

SURNAME	FORENAMES	ROLE	ORIGIN
Adams	Richard	Friend and flatmate of Christopher Alder	
Adams	Samantha	Ambulance Dispatcher	Tees, East & North Yorkshire Ambulance Service NHS Trust
Adediran	Julius	Waterfront Witness	
Adgey (Professor)	Jennifer	Medical Expert Witness	Instructed by Harrison Bundy, solicitors on behalf of Janet Alder
Alder	Emmanuel	Brother of Christopher Alder	
Alder	Janet	Sister of Christopher Alder	
Alder	Laura	Niece of Christopher Alder	
Alder	Richard	Brother of Christopher Alder	
Arshad	Shehzad	Waterfront Witness	
Atkinson	Marc	Waterfront Witness	
Barr	John McDermott	Detective Inspector	Humberside Police
Barr	Matthew	Police Constable	Humberside Police
Bales	Julia	Police Constable	Humberside Police
Bates	Kenneth	Detective Superintendent	Humberside Police
Baynes	Christopher	Friend of Christopher Alder	
Beckett	Alan	Chief Inspector	Humberside Police
Beckett	Sally	Police Dispatcher	Humberside Police
Bennett	Lana	Police	Humberside Police

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		Constable	
Berridge	David	SOCO	Humberside Police
Bird	Jonathan	Waterfront Witness	
Blakey	Neil	Police Constable	Humberside Police
Boothby	John	Waterfront Employee	
Bottomley	Leonard	Friend of Christopher Alder	
Broadhead	Adrian	Waterfront Witness	
Brookes	Alan	Detective Inspector	Humberside Police
Brown	Keith	Refuse Collector	
Bulless	Kevin	Police Officer	Humberside Police
Carey (Dr)	Nathaniel Roger	Medical Expert Witness	Instructed by Dr. John Clark and CPS
Carrick	Robert	Hostel Warden	
Carter	Eileen Ellen	Person In Custody Queens Gardens Police Station	
Chapman	Philip	Police Constable	Humberside Police
Clark (Dr)	John Chalmers	Pathologist	Instructed by the Coroner
Cook (Dr)	Graham Edward	Medical Expert Witness	Instructed by the PCA
Coombs	Michael	Waterfront Employee	
Cooney	Jason Andrew	Waterfront Employee	
Cooper	Deborah Louise	Person In Custody Queens Gardens Police Station	
Cooper (Dr)	Peter Nigel	Medical Expert Witness	Instructed by Harrison Bundy, solicitors on behalf of Janet Alder
Cowell	David	Police Constable	Humberside Police
Crane (Professor)	John	Medical Expert Witness	Instructed by Harrison Bundy, solicitors on behalf of

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			Janet Alder
Crichton	Kenneth Stuart	Police Staff – Gatehouse Security Queens Gardens Police Station	Humberside Police
Crosby (Dr)	Alan Courtenay	Medical Expert Witness	Instructed by Dibb Lupton Allsop, Solicitors on behalf of Tees, East & North Yorkshire Ambulance Service NHS Trust
Davison	Paul	Detective Chief Inspector	Humberside Police
Dawson	Nigel Thomas	Police Constable	Humberside Police
Dearden (Dr)	Norman Mark	Medical Expert Witness	Instructed by CPS
Dixon	Michael	Police Sergeant	Humberside Police
Drennan	Victoria	Paramedic	Tees, East & North Yorkshire Ambulance Service NHS Trust
Dunn	John Andrew	Police Sergeant	Humberside Police
Dunne	Malcolm Leslie	Police Staff PT Instructor	Humberside Police
Edwards	Paul Andrew	Waterfront Employee	
Ellerington	Mark	Police Constable	Humberside Police
Elliott	Jim	Authority Member	Police Complaints Authority
Enzor	Chris	Solicitor	Crown Prosecution Service
Everett	Andrew	Chief Superintendent	Humberside Police
Feasey	Mark	Waterfront Witness	
Ford	John	Inspector	Humberside Police
Forrest (Professor)	Alexander Robert	Medical Expert Witness (Toxicologist)	Instructed by Dr John Clark
Fountain	John	Detective Constable	Humberside Police
Frankland	David Milner	Porter	Hull Royal Infirmary
Friegoun	Aimun	Waterfront Witness	
French (Dr)	John Peter	Forensic Consultant	Instructed by Humberside Police

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Frost	Victoria	NHS Secretary	
Fyle	Dennis	Race Relations Commissioner	Hull Racial Equality Council
Gallagher	Michael John	SOCO	Humberside Police
Goforth	Neil	Waterfront Employee	
Goode	Ian Alan	Police Constable	Humberside Police
Gosnold (Dr)	John	Consultant	Hull Royal Infirmary
Gray (Dr)	Carl	Medical Expert Witness	Instructed by Williamsons
Grasby	Clive Lawrence	Patient Witness at HRI	
Green	Anthony Christopher	Person In Custody Queens Gardens Police Station	
Greenley	Debra	Person In Custody Queens Gardens Police Station	
Grout (Dr)	Paul	Doctor	Hull Royal Infirmary
Guymer	Joan Sullivan	Person In Custody Queens Gardens Police Station	
Hall (Professor)	Roger	Medical Expert Witness	Instructed by CPS
Harper	Alan	Manager, Hull Royal Infirmary	Hull Royal Infirmary
Hass	Anthony David	Police Constable	Humberside Police
Hawkins	Sally	Authority Member	Police Complaints Authority
Hillyard	Richard Edward	Waterfront Witness	
Holt	John Frank	Detective Superintendent	West Yorkshire Police Force
Hobson	Jennifer Diane	Ex – Girlfriend of Christopher Alder	
Holdsworth	John	Friend of Christopher Alder	
Hoyles	Steven James	Person In Custody	

Appendix 3: List of Names Appearing in Report

		Queens Gardens Police Station	
Hudson	Nicola	Waterfront Witness	
Hunt	David Anthony	Person In Custody Queens Gardens Police Station	
Hutchinson	Darren	Technical Support	Humberside Police
Jalopamo	Olliwasevi	Waterfront Witness	
James (Professor)	Vivian	Medical Expert Witness	Instructed by solicitors for the five officers
Jarvis	Jurgen William	Waterfront Witness	
Johnstone	Phil	Case Worker	Police Complaints Authority
Jones	Gary	Security at Prince's Quay	
Jones	Graeme Neil	Police Constable	Humberside Police
Kane	Steven	Police Constable	West Yorkshire Police
Khan (Dr)	Aamer	Dr on duty at Hull Royal Infirmary	Hull Royal Infirmary
Khan	Adil	Community and Race Relations Officer	Humberside Police
Knox (Dr)	Ann	Forensic Medical Examiner	
Killen	Nicola	Friend of Christopher Alder	
Knapp	Joanne	Waterfront Witness	
Krebs	Stephen Paul	Paramedic	Tees, East & North Yorkshire Ambulance Service NHS Trust
Lawler (Dr)	William	Medical Expert Witness	Instructed by Whittles, solicitors for the officers
Layas	Leon	Waterfront Witness	

Appendix 3: List of Names Appearing in Report

Leak	Gillian	Forensic Scientist	Forensic Science Service
Loose (Dr)	James Halyburton	Examines Jason Paul	Humberside Police Forensic Medical Examiner
Lynch	Ian Livingstone	Waterfront Witness	
Mainland	Alan	Detective Constable	Humberside Police
Malik	Mohammed	Waterfront Witness	
Marsden	Adrian	Police Constable	Humberside Police
Mataix	Phillipe	Waterfront Witness	
Mellors	Christopher James	Police Constable	Humberside Police
Merrills (now Webster)	Pamela Marjorie	Nurse	Hull Royal Infirmary
Mills	Karen	Waterfront Employee	
Moran	Tom	Police Chief Superintendent	West Yorkshire Police
Morris	Paul	Police Inspector	West Yorkshire Police
Murray	Mandy	College Administrator	BWB Training Centre, Hull
Myatt	Paul Anthony	Waterfront Employee	
Naughton-Doe (Dr)	Patrick Edward	Forensic Medical Examiner	Humberside Police
Naylor	Mark Andrew	Detective Constable	Humberside Police
Neal	Jane Amanda	Police Sergeant	Humberside Police
Njie	Patrick	Waterfront Employee	
North	James	Police Constable	Lancashire Constabulary
Ojo	Augustine Ayodele	Waterfront Witness	
Okwesia	David Nnoromele	Waterfront Witness	
Ottaway	Guy	SOCO	Humberside Police
Pandor	Zuber	Waterfront Witness	
Paul	Jason Alexander	Waterfront Witness	
Pokawa	Milton	Waterfront	

Appendix 3: List of Names Appearing in Report

		Witness	
Porter (Dr)	Janet Elizabeth	Medical Expert Witness	Instructed by Hempsons for the NHS Trust and subsequently by Harrison Bundy for Janet Alder
Prince	Michael Thomas	Hospital Manager	Hull Royal Infirmary
Ramm	Jason Peter	Waterfront Witness	
Ravat	Faizal	Waterfront Witness	
Reynolds	Anthony	Police Constable	Humberside Police
Rice (Dr)	Paul	Medical Expert Witness	Instructed by The Coroner
Rix (Dr)	Keith	Medical Expert Witness	Instructed by The Coroner
Robinson	Clare	Friend of Christopher Alder	
Rodgers	Malcolm Terrence	Security Guard	Hull Royal Infirmary
Rogers	Danielle Claire	Police Constable	Humberside Police
Ruddy	Brett	Police Sergeant	Humberside Police
Saggu	Davinder	Waterfront Witness	
Sanderson	John	Chief Superintendent	Humberside Police
Scott	Richard	Police Constable	Humberside Police
Shah	Abbas Ali	Waterfront Witness	
Shepherd (Dr)	Richard	Medical Expert	IPCC
(Ogunley) Smith	Beatrice	Family Liaison Officer, Police Constable	Humberside Police
Smith	Jacqueline Claire	Nurse	Hull Royal Infirmary
Smith	Kevin	Waterfront Employee	
Stainforth		Detective Constable	Humberside Police
Stevenson	Robert	Waterfront Employee	
Taylor	Lisa	Waterfront Witness	

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Taylor	Richard	Waterfront Club Manager	
Thompson	Keith	Police Chief Superintendent	West Yorkshire Police
Timperley (Dr)	Walter	Medical Expert Witness	Instructed by Dr Clark
Todd	Stephen	Waterfront Employee	
Tolan	Keith	Police Inspector	West Yorkshire Police
Townend (now Hudson)	Helen Elizabeth	Nurse	Hull Royal Infirmary
Tweed	Beverley	Radiographer	Hull Royal Infirmary
Varma (Dr)	Medavarm	GP of Christopher Alder	
Wade	Jeff	Detective Constable	Humberside Police
Walker	Carol Margaret	Receptionist	Hull Royal Infirmary
Walkup	Benjamin	Friend of Christopher Alder	
Wallace	June	Switchboard Operator	Humberside Police
Ward	Lindsey	SOCO	Humberside Police
Wheatcroft	Patricia	Ambulance Dispatcher	Tees, East & North Yorkshire Ambulance Service NHS Trust
Wildbore	Darren Paul	Police Constable	Humberside Police
Williams	Sarah	Waterfront Employee	
Wilson	Kelvin	Son of Christopher Alder	
Wilson	Leon	Son of Christopher Alder	
Wilson (now O'Brien)	Nicola	Ex-girlfriend of Christopher Alder, Mother of Leon and Kelvin	
Winkley	Bridget	Custody Suite Matron	Humberside Police
Woodcock	Brian	Detective Constable	Humberside Police

Appendix 4: Doctors involved in the forensic analysis

Professor Jennifer Adgey

MD FRCP FACC FESC,
Honorary Professor of Cardiology, Queens University of Belfast
Consultant Cardiologist, Royal Victoria Hospital, Belfast.
Extensive experience in the diagnosis and management of out-of-hospital cardiac arrests.

Instructed by Harrison Bundy, Solicitors on behalf of ***Ms Janet Alder.***

Dr Nathaniel R. B. Cary

MA MD MB BS FRCPath DMJ (Path)
Consultant Pathologist and Home Office Accredited Pathologist (with specialist experience in cardiothoracic and forensic pathology)

Instructed by ***Dr John Clark****, and by the* ***CPS***

Dr John Chalmers Clark

MBChB FRCPath. DFM.
Registered medical practitioner;
Senior Lecturer in Forensic Pathology at the University of Sheffield, and
Consultant Pathologist to the Home Office

Instructed by ***the Coroner,*** *Mr Geoffrey Saul*

Dr Graham Cook

Director and Consultant employed by the Midkent Healthcare Trust in the Accident & Emergency Department of Maidstone Hospital, Maidstone, Kent
Fellow of the Royal College of Surgeons and
Fellow of the Faculty of Accident & Emergency Medicine.
Force Medical Consultant to the Kent County Constabulary
Specialist lecturer for the South East and London Training Courses in Legal Medicine
.Formerly Medical Adviser to the Police Complaints Authority.
Hon. Medical Adviser to the Uniformed Services University of Health Sciences Bethesda, USA
Former Chairman of the Kent Ambulance Service Paramedic Steering Committee

Instructed by the ***PCA***

Dr Peter Nigel Cooper

B.A: M.B.,B.S; M R.C Path;
Diploma in Medical Jurisprudence in Pathology (D M J Path);
Registered medical practitioner;
Senior Lecturer in Forensic Pathology at the University of Newcastle upon Tyne;
Honorary Consultant at the Royal Victoria Infirmary, Newcastle, and
Home Office Pathologist for the North East of England

Instructed by Harrison Bundy, Solicitors on behalf of ***Ms Janet Alder.***

Professor John Crane

MB BCh; FRCPath; DMJ (Clin and Path.)FFPath RCPI.
State Pathologist for Northern Ireland.
Professor of Forensic Medicine at the Queens University of Belfast and
Consultant in Pathology to the Northern Ireland Health and Social Services Boards

Instructed by Harrison Bundy, Solicitors on behalf of ***Ms Janet Alder.***

Dr Alan Courtney Crosby

MB Ch.B., F.R.C.S. (Ed);F.F.A.E.M
Consultant in Accident and Emergency Medicine, Northern General Hospital, Sheffield
Appointed consultant in Sheffield 1989.
Formerly Clinical Director of the A&E Department at the Royal Hallamshire Hospital, Sheffield (1991-97)
An honorary clinical tutor at the Sheffield Medical School teaching and examining under-graduate students. Teaches accident and emergency medicine to post graduate medical practitioners, dental staff and dental auxiliaries.

Instructed by Dibb Lupton Alsop, Solicitors on behalf of ***the Tees East and North Yorkshire Ambulance Service NHS Trust.***

Dr N. Mark Dearden

BSc. MB ChB. FFARCS.
Consultant Anaesthetist, Leeds General Infirmary
Honorary Senior Lecturer to the Department of Anaesthesia, University of Leeds.

Instructed by the CPS

Dr Alexander Robert Walker Forrest

Chemical Pathologist, Dept of Clinical Chemistry, Royal Hallamshire Hospital, Sheffield
A Registered Medical Practitioner, a Chartered Chemist, a Registered Analytical Chemist and a Registered Toxicologist
Bachelor of Science in Pharmacology.
Bachelor of Medicine.
Bachelor of Surgery
Master of Laws
Diploma in Obstetrics of the Royal College of Obstetricians and Gynaecologists.
A Mastership in Clinical Biochemistry and a Certificate in Contraception and Family Planning.
Fellow of the Royal Colleges of Physicians of London and Edinburgh.
Fellow of the Royal College of Pathologists
Fellow of the Royal Society of Chemistry
Professor of Forensic Toxicology to the University of Sheffield and Honorary Consultant in Clinical Chemistry and Toxicology at Central Sheffield University Hospitals NHS Trust
Visiting Professor of Forensic Toxicology to the University of Bradford.

Instructed by ***Dr John Clark***

Dr Carl Gray

BSc (Anatomy); MBChB; DMJ (Path); FRCPath
Consultant Histopathologist to the Harrogate Health Care NHS Trust, and Consulting Forensic Pathologist.
MAE, MEWI: Member of the Academy of Experts and of the Expert Witness Institute
Registered Medical Practitioner (GMC)
Registered Specialist in Morbid Anatomy and Histopathology
Formerly Senior Lecturer in Pathology at the University of Leeds and Honorary Consultant in Histopathology and Morbid Anatomy to the General Infirmary at Leeds.

Instructed by Williamsons, Solicitors on behalf of ***Mr Jason Paul,*** *and*

By Stamp Jackson and Proctor, Solicitors on behalf of ***the family of Mr Alder***

Professor Roger J. C. Hall

MD., FRCP
Professor of Clinical Cardiology, The Hammersmith Hospital, London

Instructed by the ***CPS***

Professor Vivian James

BSc, PhD , FRCPath, HonMRCP,
Emeritus Professor of Chemical Pathology in the University of London
Cconsultant in clinical biochemistry
From 1952- 1961 Member of the research staff of the National Institute for Medical Research.
From 1956 held various senior academic appointments at St. Mary's Hospital Medical School in the University of London including Professor of Chemical Endocrinology.
1973-1990. Professor and Director of the Department of Chemical Pathology.
Has made a special study of steroids and steroid hormones including anabolic steroids
Has carried out original research in this field and has published over three hundred original papers including studies of the physiological and pharmacological effects of steroids in human subjects.
Editor of a number of books on steroids

Instructed by solicitors for ***the five officers***

Dr William Lawler

M.D., F.R.C.Path
Consultant Pathologist
Home Office Pathologist

Instructed by Whittles, solicitors for ***the officers***

Dr Janet Elizabeth Porter

Qualified in Medicine from Cambridge University (1971).
A Fellow of the Royal College of Surgeons of England (1977)
A Founding Fellow of the Faculty of Accident and Emergency Medicine in 1991
An accredited specialist in Accident and Emergency Medicine
Formerly consultant in charge of the Accident and Emergency Department at Southend Hospital (1984 – 1999).

Instructed by Hempsons, solicitors for the ***Hospital NHS Trust***
and subsequently by Harrison Bundy for ***Ms Janet Alder***

Dr Paul Rice

Bachelor of Medicine (Southampton University Medical School, (1982) and post-graduate training in pathology.
Member of the Royal College of Pathologists (1993)
A registered and accredited toxicologist with the Institute of Biology
A member of the British Society of Toxicological Pathologists, the International Academy of Pathology; the Society of Pathology of Great Britain and Northern Ireland, and the Association of Clinical Pathologists
Employed by the Chemical & Biological Defence Establishment since 1987.
Currently the Technical Manager for Medicine at CBD Porton Down with overall responsibility for skin toxicology and the human volunteer research programme.

Instructed by the ***Coroner***

Appendix 4: List of Doctors

Dr Keith J.B. Rix

MPhil, MD, MEWI, FRCPsych,
Consultant Forensic Psychiatrist, Leeds Community and Mental Health Services Teaching NHS Trust
Senior Clinical Lecturer in Psychiatry, University of Leeds.

Instructed by the Coroner

Dr Walter Timperley

MA. DM; F.R.C.Path,
Consultant Neuropathologist, Department of Neuropathology, Royal Hallamshire Hospital, Sheffield.

Instructed by Dr Clark

Appendix 5: Brief Chronology Of Medical Expert Involvement

1 April 98	Dr John Clark is assigned by the Coroner to perform and initial post mortem (PM) and produces his report on 27th May 98.
6-7 April 98	Dr Alexander Forrest, at the request of Dr Clark, analyses blood samples for drugs and CS gas, finds only alcohol (later he also tests for carbon monoxide)
10 April 98	Dr Carl Gray performs second PM on behalf of Jason Paul and the Alder family
20 May 98	Dr William Lawler performs third PM on behalf of police officers.
21 October 98	Dr Nathaniel Cary reports on the condition of Mr Alder's heart at the request of Dr Clark.
16 Dec 98	Dr Graham Cook, A&E specialist provides advice and later a report to the PCA at the request of Mr Jim Elliott.
13 January 99	Dr Peter Cooper performs fourth PM on behalf of Ms Janet Alder.
15 Feb 99	Dr Cary provides report at request of CPS analysing what is known so far.
1 April 99	Dr Walter Timperley analyses Mr Alder's brain tissue at request of Dr Clark, finds no abnormalities
10 May 99	Dr Mark Dearden, Consultant Anaesthetist, provides a report at request of the CPS regarding the handling of Mr Alder in hospital and immediately after discharge.
19 May 99	Drs Cary, Dearden, Clark and Cook meet with the CPS and provide a Joint Report.
6 July 99	Dr Cary analyses similarities and differences between Dr Cooper's view, and the Joint Report, for the CPS
13 Feb 00	Dr Paul Rice , toxicologist, reports to the Coroner on tests for use of CS gas against Mr Alder. Finds no evidence for it.
22 April 00	Dr Keith Rix, psychiatrist, reports to the Coroner on the subject of Christopher Alder's mental state.

16 June 00	Dr Jane Porter, A&E consultant provides report to solicitors for the hospital NHS Trust on the quality of A&E care provided to Mr Alder.
19 June 00	Dr Alan Crosby, A&E consultant provides report to Ambulance NHS Trust on the quality of care provided by their staff
June 00	Professor John Crane, consultant pathologist, provides a further pathology analysis to Ms Janet Alder's solicitors.
6 July 00	Professor Vivian James, chemical pathologist, provides analysis of the possible effects of anabolic steroids, at the request of the solicitors for the five officers.
21 July 00	Dr Porter provides further report, suggesting alternative reasons for Mr Alder's unconsciousness
3 July 00	Inquest into death of Mr Alder hears evidence from all of the doctors who had reported. Inquest verdict of "*Unlawful Killing*"
27 Feb 01	Professor Hall provides further report at request of the CPS on likely cause of Mr Alder's unconsciousness.
6 March 01	Joint meeting of Drs Cary, Clark, Dearden, Cook, Professor Hall and Professor Crane with CPS to seek consensus.
3 August 01	Professor Jennifer Adgey, a professor of cardiology, produces a report at request of solicitors for Ms Janet Alder. Concludes that lack of care was a contributing factor to death of Mr Alder.
13 Sept 01	Professor Hall writes to CPS, differing on some points with Professor Adgey
5 October 01	Dr Porter writes a statement for the CPS agreeing that lack of care was a contributing factor in Mr Alder's death.
9 October 01	Joint meeting of Dr Cary and Professors Hall, Crane and Adgey with CPS produces joint report. CPS add manslaughter to the indictment
10 April 02	Crown Court trial begins. Evidence given by Doctors Clark; Cooper; Gray; Cary; Cook; Forrest; Timperley; Dearden; Gosnold. Professor Crane; Porter; Professors Adgey and Hall.
14 May 02	Dr Dearden made a further statement varying his views in light of a recent case. Other doctors were asked to comment

	upon it, and gave their analysis, largely agreeing that it was of no relevance.
21 June 02	Trial ends following ruling of Roderick Evans J

Appendix 6: Summary of Medical opinions

Doctor, [Appointed by] & Report	Cause of Unconsciousness	Cause of Death
Clark [Coroner] (1st PM)	Most likely to be Cardiac arrhythmia due to excitable state excited delirium or acute alcohol intoxication. Alcohol alone unlikely, but may contribute to excited state	Intoxication. Inhalation of vomit; postural asphyxia and lack of medical treatment. Cannot assess influence of latter two factors. May have died anyway. **Cause: Undetermined (Multi-Factorial)**
Gray [J Paul & Alder Family] (2nd PM)	Alcohol leading to inhalation of vomit and respiratory depression OR excited state leading to cardiac arrhythmia	Intoxication inhalation of vomit; postural asphyxia and respiratory depression **Cause: Undetermined (Multi-Factorial)**
Lawler [Police Officers] (3rd PM)	Cardiac arrhythmia due to excitable state; inhalation of vomit a possible factor, but not significant	Intoxication; inhalation of vomit leading to respiratory depression and postural asphyxia. Lack of treatment might have contributed, but may have died anyway **Cause: Undetermined (Multi-Factorial)**
Cary [Coroner] 21 Oct'98	Alcohol & sudden drop in glucose levels leading to inhalation of vomit	Inhalation of vomit and postural asphyxia contributed to by lack of care.
Cary 15 Feb 99	Alcohol and possibly hypoglycaemia, together with head injury	Inhalation of vomit and postural asphyxia contributed to by lack of care.
Cooper [Janet Alder] (4th PM)	Alcohol and maybe inhalation of vomit	Intoxication; inhalation of vomit leading to respiratory depression and postural asphyxia. Lack of treatment might have contributed. **Cause: Undetermined (Multi-Factorial)**
Dearden [CPS] 10 May '99	Uncertain, but possibly cardiac arrhythmia, respiratory depression or inhalation of vomit	Upper airway obstruction leading to respiratory depression, contributed to by lack of care. Cannot say that he would not have died anyway
Cook [CPS] 14 May 99		Airway obstruction leading to brain damage and cardiac arrest. Proper care could have prevented this.
JOINT REPORT **Cary, Cook Clark & Dearden**	Most probably a convulsive fit due to head injury. Cardiac arrhythmia possible but unlikely	No conclusion as to cause of death, but cannot exclude possibility that death was inevitable, and so cannot say lack of care must have contributed
Porter [Hospital Trust] 16 June '00	Most likely to be alcohol induced coupled with head injury	Respiratory depression and airway obstruction, exacerbated by lack of care from the police
Crane [Janet Alder] June '00	Possibly a second blow to head; inhalation of vomit or use of neck restraint (possible but no evidence)	Upper airway obstruction due to postural asphyxia; head injury, alcohol and inhalation of blood were factors.

Inquest Evidence

There was no consensus on what caused his unconsciousness, and therefore it was impossible to say whether he would have survived: whatever led to the collapse in the van may already have damaged him enough to make survival impossible. All the experts agreed that the lack of attention was harmful to his respiration, and position he was placed in was bad for him. Although it was uncertain whether he could have been saved, and he might have died anyway, it was still a possibility that early intervention at the station might have saved him.

Professor Crane was sure that he died of upper airway obstruction due to postural asphyxia (PA) and inhalation of blood; Dr Cooper thought PA was a major factor; Drs Cary & Gray both thought it played a part, although Dr Gray was unsure if it was critical; Dr Porter thought it played a role whilst Dr Lawler thought it was marginal.

Dr Clark felt that prompt attention "might well" have saved Mr Alder; Dr Cooper thought early help probably would have saved him; Dr Dearden thought it possible, and Dr Cary thought it likely. Dr Cook was unsure that he would have survived whatever the care, and Dr Lawler felt that there was a good chance that Mr Alder would have died in any event.

Post Inquest Evidence

Doctor & Report	Unconsciousness	Death/Chances of Survival
Hall [CPS] 27 Feb'01	Either ventricular tachycardia (VT) or a convulsive fit. Unsure which	Chances of survival worsened by positioning. If collapse was cardiac, chances of survival less that 50% anyway; if respiratory or due to convulsion, early help would probably have saved
JOINT REPORT **Cary, Clark, Dearden Cook, Hall, Crane** 6 March '01	Uncertain. All except Crane accepted fatal heart disturbance was a possibility	All: Long term survival was uncertain no matter how good the care Crane: Life could have been extended by proper care, but could not say by how long Crane. Positioning and lack of care hastened death, but could not say by how much Cary: No longer sure that it did hasten death
Adgey [Janet Alder] 3 August '01	'Collapse' due to one or more factors: Excess alcohol and inhalation of vomit or epileptic fit or VT. Cardiac disturbance possible but unlikely.	Lack of basic treatment to reinstate breathing
Porter [Janet Alder] 5 Oct '01	Possibly due to epileptic fit, cardiac disturbance or hyperventilation	Proper treatment would have allowed for survival
JOINT REPORT **Cary, Hall,**	Uncertain as to cause: Hall-Cardiac arrhythmia leading to	Hall If VT, chances of survival less than 50%

Crane, Adgey 9 Oct '01	VT. Adgey-Combined factors, but VT alone unlikely. Cary & Crane-VT possible but unlikely All agreed not hyperventilation and that second blow to head would explain it more readily	Cary & Crane-Respiratory failure was cause of death All-If unconsciousness not due to cardiac problem, then care would have afforded better chance of survival. Adgey & Crane-although could not predict ultimate survival, police prevented initial survival and contributed more than minimally to his death Hall & Cary- cannot exclude possibility that he might have died anyway

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APPENDIX 7: Forensic Overview and Recommendations for the IPCC Review into the Death of Christopher Alder

Discrepancies in recording of injuries

1. Dr Khan and Dr Clark worked in very different situations and to very different protocols.

2. Dr Khan would have been concerned with identifying the injuries that he felt would have a significant effect on his patient. He would not have been concerned to document every single injury that may have been present.

3. One of the primary functions of the examination by Dr Clark, a specialist forensic pathologist (Home Office pathologist), was the identification and documentation of every injury to the body no matter how small.

4. Dr Khan was dealing with an aggressive, intoxicated man in Casualty and while he was able to examine Christopher Alder he had to do so whilst being verbally abused and spat at. Photographs are seldom taken in A & E departments and no complete photographic record could possibly have been made in these circumstances. The identification and description of the injuries in these less than perfect circumstances is also very likely to be less than perfect.

5. Dr Clark made his examination in the controlled circumstances of the post mortem room, he had both the time and the experience that would have ensured that he made a thorough examination. His descriptions of the injuries are confirmed by photography and can therefore be seen to be correct and complete.

6. It is very common for a pathologist to identify injuries in the post mortem room that had not been noted by the clinical medical staff.

   Minor Injuries

7. Dr Khan has not described four injuries to the skin which on any basis must be considered to be of a minor nature: these are the injuries to the forehead, right eye, left elbow and left hand. These injuries cannot be considered to have played any part whatsoever in the death of Mr Alder neither can they be considered to be markers of significant trauma

   Head Injury

8. There are minor differences in the detail of the descriptions of the injury to the back of the head, these differences are mainly due to variations in the use of language rather than

a substantial alteration in the actual appearance of the injury. They are not significant differences and cannot be used as the basis for the theory that an additional blow or blows have been struck in this area.

Loss of Tooth

9. One tooth was apparently lost at the scene of the original incident at the Waterfront, a tooth was recovered from a bin but never examined.

10. It is the loss of the second tooth that presents the unresolved problem. There are numerous occasions when, theoretically, this tooth may have become dislodged and lost: in hospital after examination by Dr Khan, outside the hospital, in the police van, during removal from the van, during entry into the police station or during resuscitation.

11. I note that no tooth was found in the police van and the lack of significant blood staining in this small area would be against loss of the tooth. No tooth was reported to have been recovered in the police station but if it was lost during resuscitation it may have been removed from the mouth by the use of suction equipment.

12. It would not be difficult finally to dislodge the displaced tooth that was noted by Dr Khan. Spitting may do so and this is likely to cause the dislodged tooth to pass out of the mouth, alternatively it may be swallowed or inhaled into the stomach or airways respectively.

13. If swallowed or inhaled a dislodged tooth can sometimes be seen quite easily at postmortem. On other occasions the presence of material in the airways or the stomach may obscure identification of the tooth.

14. Dr Clark is an experienced pathologist who has noted the loss of the teeth and who would have been aware of the possibility that they may have been swallowed or inhaled and it is to be expected that he would have searched for the tooth in both the lungs and stomach during his examination.

Lips

15. It is the difference in the descriptions of the injuries to the lips that are of the greatest concern because this discrepancy raises the possibility of a further blow to this area after Christopher Alder left hospital.

16. All agree that there was an injury to the upper lip, although descriptions vary slightly.

17. It is the presence or otherwise of the injury to the lower lip that is crucial. The injury is too severe to have been caused during resuscitation in the police station.

18. It may be that Dr Khan, for the reasons noted above, failed to notice this injury to the lower lip despite it being present at the time of his examination.

19. It may be that there was no injury to the lower lip at the time Dr Khan examined Mr Alder and that his description is completely accurate.

20. The alignment of the injury of the lower lip with the injury to the upper lip would tend to support the suggestion that they were both caused at one and the same time.

Conclusion

21. 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 Christopher Alder.

22. 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.

Cause of death

23. All of the medical experts are agreed that there was a major change in the medical status of Christopher Alder while he was in the police van. Many theories have been put forward to explain this change, ranging from an epileptic fit to an abnormal rhythm of the heart to the direct or indirect effects of alcohol. All of these theories are pure speculation, indeed they cannot be other than speculation.

24. These theories cover all of the reasonable possibilities and it is most likely that one of them is correct but it is not possible to determine which one it is because the medical information that would enable us to do so (for example ECG tracings) is not available and, in these circumstances such as this, never would be available.

25. There are many events that can occur in the body, some of which may be lethal, that simply do not leave a mark or sign that they have occurred, no matter how detailed a subsequent post mortem examination. These events may follow one of five different paths:

    a. they may cause death immediately and instantly.
    b. they may set in train a series of events that will inevitably result in death no matter what is done
    c. they may set in train a series of events that may lead to death unless positive steps are taken to prevent it.
    d. they may cause a temporary disturbance from which the individual will recover spontaneously without any assistance.
    e. they may cause a temporary disturbance from which the individual will recover spontaneously without any assistance but during the recovery period they are vulnerable to other events

26. Since we do not know the nature of the event we cannot determine which of these paths would be followed and whether or not other events or influences may have been relevant.

Position on floor

27. In addition to the alteration in the conscious state of Christopher Alder whilst in the van it is generally agreed that the position into which he was placed on the floor of the custody suite caused obstruction to his breathing. Such obstruction, if not relieved by active steps, may eventually result in asphyxiation, the greater the obstruction the more rapid and serious the effects.

28. Whether or not the position of Christopher Alder on the floor of the custody suite contributed significantly to his death cannot be determined with certainty but whatever the possible medical effects, simple humanity would suggest that no individual should be left in such position.

Nasal Obstruction

29. The suggestion that Christopher Alder could breathe only through his mouth due to nasal obstruction is not borne out by consideration of his medical notes. The medical notes show that the only time that Christopher Alder is reported to have complained of nasal obstruction to a doctor was in 1981, 17 years before his death.

30. He has not complained of nasal obstruction to either his earlier GP, Dr Keiran, (whose list he joined on 11th April 1986) or to his latest GP, Dr Varma, who saw him as a new patient on 10th August 1992.

31. An undated, self-completed "patient questionnaire", possibly related to joining Dr Keiran's practice as it bears an address in Kingston upon Hull, does not mention nasal obstruction or any difficulty in breathing.

32. When he was examined in 1981 the obstruction was described by the consultant ENT surgeon who saw him as being both intermittent and alternating between sides.

33. That he was a described as a "constant mouth breather" when he was seen by the consultant ENT Surgeon in 1981 does not mean that he could not, at any time, breath through his nose.

34. Neither the ambulance crew, the nursing staff nor Dr Khan mention any difficulty in breathing during their various examinations of Christopher Alder at the scene or in hospital.

35. There is no positive evidence to suggest that Christopher Alder was suffering from any significant nasal obstruction due to a medical cause at the time of his death.

Conclusion

36. Despite the consideration of the events, the clinical history, viewing the events in the police station and the subsequent resuscitation on the CCTV, together with the post mortem examination and the microscopic examination of the organs and specialist opinions on the heart and brain and having had the opportunity to review and discuss the postmortem findings the group of experts could not agree on a mechanism for the collapse in the van nor the exact effect of leaving Christopher Alder face down on the floor. They could not agree on a cause of death nor on the mechanisms that led up to it.

37. This failure to reach agreement is in fact a very common amongst medical professionals in complex cases such as this where there is no incontrovertible cause of death (e.g. gun shot wound to the head). This is particularly so where there are gaps in the medical evidence that might have been of value.

Post mortem examination and Expert Committee

Postmortem examination

38. The initial postmortem examination performed by Dr Clark was a full and thorough examination where all of the relevant macroscopic features of the injuries and the internal organs were recorded and the all of the necessary medical samples and exhibits for the criminal justice system were retained.

39. The subsequent examination of the medical samples with referral to additional specialists to examine the heart and brain was exemplary.

Expert Committee

40. The use of a committee or a group of experts is to be applauded and although they were unable to reach a unanimous decision it is possible to state that they had considered all of the available options with skill and in depth. The advice that they were able to give to the Police and to the CPS enabled these authorities to make their decisions from a certain knowledge base.

41. In these complex and difficult cases the use of a committee or group of experts will not only prevent the potential bias that the use of a single experts may produce but they will provide significant depth and breadth of information and advice.

42. Medical opinion is diverse and there will always be an expert to offer another point of view. There will always be a proponent of some additional test which, had it been performed, would have resolved an issue if not the whole problem.

43. The difficulty faced by those charged with investigating these deaths and those charged with preparing a prosecuting is that doctors, in circumstances such as these where there is incomplete medical evidence, will tend to speculate on the conclusion.

44. These are indeed fascinating medical conundrums, they form an excellent basis for academic medical discussions but for the same reasons they are legal minefields because, in the current state of knowledge, there will never be a final conclusion that is accepted by all. In some cases there may not even be an overall majority in favour of one of the possibilities.

45. It is possible that conclusions can be reached that will satisfy the majority of relevant medical experts to the lower level of proof - "the balance of probabilities". Sufficient to enable a jury at an Inquest to reach a verdict.

46. The possibility that conclusions can be reached that will satisfy the majority of relevant medical experts to criminal standard of proof "beyond all reasonable doubt" and which can be defended with confidence in the higher courts is nigh on impossible.

47. The discrepancy in the required levels of proof and the inability of the relevant medical experts to reach the higher standard of proof in their conclusions following deaths of this sort has been shown by the number of Unlawful Killing verdicts reached in the Coroner's Courts which were then followed by failed prosecutions in the higher courts.

Conclusions

48. The postmortem examination, the subsequent additional investigations and the work of the expert committee all appear to be of the highest standard.

49. It has to be accepted that it is most unlikely that expert medical opinion will achieve the higher level of proof required for a successful prosecution in complex deaths such as this and it is unlikely that any foreseeable advance in medical science will alter this.

50. Coronial Courts will continue to return verdicts of Unlawful Killing based on the same evidence but using the lower standard of proof. This apparent discrepancy rightly causes confusion and considerable disquiet.

Recommendations

1. Investigation of deaths in Police custody
   a. Many of the deaths that occur "in custody" do not pose any significant medical problems although they may raise serious issues about care and procedure (for example, hanging in a police or prison cell)
   b. 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), A& E consultant and they should be able to co-opt individuals with additional skills as they see necessary.
   c. This team would be available to provide guidance to the original pathologist, the Coroner, Police and the CPS throughout the investigations.

2. Confidential Inquiry
   a. In a number of areas of medicine (maternal deaths, post operative deaths etc) it has been found that the establishment of 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.

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01 December 2005

The Healthcare Commission

The Healthcare Commission exists to promote improvements in the quality of healthcare and public health in England. We are committed to making a real difference to the delivery of healthcare and to promoting continuous improvement for the benefit of patients and the public. The Healthcare Commission's full name is the Commission for Healthcare Audit and Inspection.

The Healthcare Commission was created under the Health and Social Care (Community Health and Standards) Act 2003. The organisation has a range of new functions and took over some responsibilities from other Commissions. It:

- replaces the Commission for Health Improvement (CHI), which ceased to exist on March 31st 2004
- takes over responsibility for the independent healthcare functions previously carried out by the National Care Standards Commission, which also ceased to exist on March 31st 2004
- carries out the elements of the Audit Commission's work relating to the efficiency, effectiveness and economy of healthcare

We have a statutory duty to assess the performance of healthcare organisations in the NHS and award annual ratings of performance, to coordinate inspections and reviews of healthcare organisations carried out by others, and register organisations providing healthcare in the independent sector on an annual basis.

We have created an entirely new approach to assessing and reporting on the performance of healthcare organisations - our annual health check – which will examine a much broader range of factors enabling us to focus on what really matters to patients and the public.

Executive summary

Background

In April 1998, Christopher Alder died in police custody after he was assaulted outside the Waterfront nightclub in Hull. As a result of the assault he was assessed and treated by ambulance crew at the Waterfront nightclub in Hull, by hospital staff in the accident and emergency department (A&E) at Hull Royal Infirmary and again by the same ambulance crew at the Queen's Garden Police Station.

The inquest into the death of Christopher Alder was held in August 2000 and returned a verdict of unlawful killing. The jury at the inquest concluded that his death was caused by multifactorial events leading to a level of unconsciousness, which resulted in a life threatening condition in which oxygen is prevented from reaching the tissues by obstruction or damage to any part of the respiratory system (upper airway obstruction and positional asphyxia), and returned a verdict of unlawful killing. More detailed information about the coroner's inquiry, the internal and external investigations undertaken by the police, and the subsequent criminal proceedings are available in the Independent Police Complaints Commission's (IPCC) review of the death of Christopher Alder.

Neither the Humberside Ambulance Service nor the Hull Royal Hospitals NHS Trust (which includes Hull Royal Infirmary) conducted detailed investigations of the incidents surrounding Christopher Alder's death, and an initial coroner's inquiry that was held in August 2000 highlighted some discrepancies in the views expressed by clinical experts.

Why investigate?

On April 20th 2004, the Home Secretary wrote to the IPCC requiring it to undertake a review into the death of Christopher Alder. In December 2004, the IPCC asked the Healthcare Commission to assist.

The Healthcare Commission decided that although this investigation related to a single incident, it was probable that there were underlying issues around the systems in place and significant lessons to be learnt by the three agencies at a local level, as well as national lessons to be learnt. This case illustrates the tensions for healthcare staff in managing patients who display aggressive or violent behaviour towards them, whilst ensuring that they receive appropriate care and treatment. It also highlights the role of the police in such cases and the clear need for proper safeguards, such as robust joint working protocols and a clear understanding between healthcare staff and the police of their mutual roles and functions, to protect both the health and liberty of patients and the safety of staff. The Healthcare Commission was also aware of general

concerns about the number of deaths occurring in custody with a link to healthcare. We were also aware of the national debate surrounding the use of hospitals and police stations as places of safety.

The Healthcare Commission was also asked to look specifically at the interface between Hull Royal Hospitals NHS Trust (now Hull and East Yorkshire Hospitals NHS Trust), Humberside Ambulance Service (now Tees, East and North Yorkshire Ambulance Service NHS Trust) and the Humberside police.

The investigation

The purpose of the Healthcare Commission's investigation was to determine the lessons to be learnt from the death of Christopher Alder and make recommendations where necessary to improve the links between police and healthcare agencies, thereby improving the care of patients.

During our investigation, we looked at the care given by the ambulance crew outside the Waterfront nightclub, on the subsequent journey to Hull Royal Infirmary, and at Queens Garden Police Station. We also considered the appropriateness of the care given to Christopher Alder at Hull Royal Infirmary, and the decision to discharge him from hospital. The adequacy of the policies and working practices of these bodies, and the interface between the ambulance service, Hull Royal Infirmary and the police, were also reviewed.

Staff from the Healthcare Commission worked with a team of clinical advisors with specialist knowledge of A&E and ambulance services. We looked at various materials including witness statements, medical reports, inquest transcripts, CCTV footage, local and national polices and working practices. Clinical records relating to Christopher Alder's medical history were also reviewed, along with patient record forms, and triage, assessment and observation recording forms. The investigation team also interviewed a total of 18 NHS staff, including past employees.

The Healthcare Commission is aware of the difficulties when relying upon interview evidence gathered seven years after events. Therefore we have put greater reliance on more contemporaneous accounts and records. The Healthcare Commission's interviews also concentrated on clarifying areas of uncertainty and eliciting explanations of terms used within those accounts.

The trust

In 1998, Royal Hull Hospitals NHS Trust operated from four hospital sites within the city of Hull: Hull Royal Infirmary, Kingston General Hospital, The Princess Royal Hospital and Hull Maternity Hospital. The trust served a population of over half a million people in Hull and East Riding of Yorkshire, and employed 4,200 staff.

Since 1998, both trusts have undergone mergers. Humberside Ambulance Service is now part of Tees, East and North Yorkshire Ambulance Service NHS Trust and Royal Hull Hospitals NHS Trust became Hull and East Yorkshire Hospitals NHS Trust.

The events leading up to the death of Christopher Alder

On the evening of March 31st 1998, Christopher Alder attended the Waterfront nightclub in Hull. As he was walking home, he was involved in a fight with another man with whom he had an altercation earlier at the nightclub. During the fight, Christopher Alder was punched in the face, and fell to the ground, hitting the back of his head on the street.

An ambulance was called and paramedics arrived. They carried out an initial assessment of Christopher Alder before taking him to Hull Royal Infirmary.

Attempts to treat Christopher Alder in A&E were made, but his behaviour was described by healthcare staff as aggressive. He was later discharged from hospital into the custody of the police for a breach of the peace.

Christopher Alder was driven to Queen's Gardens Police Station. He travelled alone in the back of the van for approximately five minutes and when they arrived, Christopher Alder was slumped in his seat.

Police officers moved him from the van into custody believing he was asleep. However, he did not rouse. An ambulance was called, and the paramedics who had treated Christopher Alder earlier at the nightclub arrived on the scene. The ambulance crew tried to revive Christopher Alder, but he died shortly afterwards. A detailed account of the events leading up to the death of Christopher Alder can be found in the Healthcare Commission's full report.

What went wrong and why?

Here we highlight the key findings from the investigation. The detailed findings can be found in the full investigation report, which is available on the Healthcare Commission's website: www.healthcarecommission.org.uk.

In drawing our conclusions about the actions and decisions of individuals, the Healthcare Commission has assessed the extent to which they were in accordance with reasonable practice at the time (April 1st 1998). While the Commission rightly criticises aspects of the healthcare provided, we also recognise that there were more serious failings on the part of the police. More information about the actions of the police officers can be found in the review by the Independent Police Complaints Commission.

Throughout the evening Christopher Alder's behaviour was difficult to manage. The nursing, medical and ambulance staff made several attempts to reason with him and calm him down despite provocation. However, from their first contact with Christopher Alder following the assault at the Waterfront nightclub, his treatment in A&E and finally the attempts to resuscitate him at the Queen's Garden Police Station, NHS staff failed to obtain or pass on key information to assist them in making appropriate decisions about his care and treatment.

There was a failure by the police to clarify their role in the A&E department and in relation to removing Christopher Alder from the department. The police also failed to recognise significant signs of deterioration in Christopher Alder. This resulted in a delay in alerting the ambulance service and therefore denied Christopher Alder an increased chance of survival. Both the NHS staff and the police failed to obtain factual information and their decisions were informed by a number of assumptions and misunderstandings.

While it is acknowledged that Christopher Alder's behaviour was described as aggressive and staff made every effort to reason with him despite provocation, 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 to admit him for observation, x-ray his skull and refer him to a maxillo-facial surgeon. Despite this he decided to discharge him without seeking advice from a senior colleague. A senior doctor (specialist registrar) was on call in the hospital, and a consultant was available on call from home to provide such advice.

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 with 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 into the care of the police. In hindsight the decision to discharge Christopher Alder can be seen as flawed but at the time, the situation was confused due in part to the presence of the police.

This confusion about the role of the police in relation to the care of Christopher Alder continued from when Christopher Alder entered the A&E department through to when he died in police custody. There was a lack of clarity between the doctor and the police about expectations once the police removed Christopher Alder from the hospital. The doctor discharged Christopher 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 Christopher Alder go home by himself.

There was a lack of understanding by nursing and medical staff about the implications of letting the police take Christopher 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 circumstances the police station was used inappropriately as a place of safety.

By the time Christopher Alder reached the police station his condition had deteriorated. He was unresponsive when the police removed him from the van, but the police failed to recognise the signs of deterioration and so did not treat him accordingly. The police officers wrongly assumed that Christopher Alder was feigning unconsciousness and the custody sergeant did not challenge this.

This inability to recognise Christopher Alder's condition delayed their call to the ambulance service. They also failed to provide the ambulance crew with sufficient details about the change in Christopher Alder's condition. The crew were unaware that he had been unconscious since his arrival at the police station, approximately 20 minutes earlier.

This failure between the police and paramedics to share the appropriate information about Christopher Alder's condition meant that they did not provide effective care, or work as a team. The paramedics did not take the appropriate equipment with them when they first arrived, a decision affected by their lack of detailed knowledge of his condition.

The decision to remain at the police station was also flawed. Christopher Alder should have been taken back to the A&E department, as it was a relatively short journey of five minutes, and would have provided access to senior medical advice. This decision was caused by a lack of training, and therefore inexpert use of clinical judgement.

Staff were undoubtedly influenced by the circumstances of Christopher Alder's injuries. He was a fit, muscular man who had been drinking and had been involved in a fight at a nightclub, albeit a victim of assault. This, together with the fact that he had a head injury and was displaying agitated and fluctuating behaviour understandably raised apprehension, although the description of him as violent and aggressive fuelled the assumptions made by hospital staff and subsequently by police officers. Similarly, the fact that the doctor thought it was appropriate to discharge Christopher Alder to the police may have caused the police to believe that Christopher Alder's condition was not serious, although they were aware that he had to return for further treatment.

Although the Healthcare Commission is critical of some of the decisions and actions of the healthcare staff we recognise that there were more serious failings by the police once Christopher Alder was taken into police custody. The police wrongly assumed that Christopher Alder's apparent lack of consciousness was fake and the custody sergeant, who did not call a forensic examiner, did not challenge this. If clear instructions about what to look for in the case of a head injury had been given to the police, it may have resulted in them treating Christopher Alder's lack of consciousness seriously. However, the fact that Christopher Alder did not respond when he was dragged from the police van to the police station, and did not move or speak while he was lying face down on the floor should have alerted the police officers that a significant change in his condition had occurred and that they should have sought the appropriate assistance. The consequence of this insufficient attention was that Christopher Alder died as officers stood around him discussing how they might legitimately hold him in custody.

More information about the actions of the police officers can be found in the Independent Police Complaints Commission's review of the death of Christopher Alder.

Trust policies

Both trusts had a range of policies in place in 1998 for both clinical care (for example the management of head injuries and working practices) and management, but staff did not fully adhere to them. With the emergence of clinical governance (the framework through which NHS organisations continually review and improve the quality of care for patients) many of these policies and working practices have been strengthened and developed. However, some policies such as zero tolerance and discharge/transfer of care should be adapted to meet the needs of A&E departments.

It was, and still is, normal practice for staff at the trust to seek assistance from the police in managing difficult and aggressive patients. There are, however, no written protocols in place about when to call the police, the consequence of such a call or their respective roles in A&E.

In relation to managing risk, incident forms were available in both trusts, but were not used. It would have been good practice for both trusts to have undertaken a review, or joint review, to determine if the care provided to Christopher Alder was appropriate. This could have also identified any learning from the incident or changes that needed to be implemented.

Clinical guidelines for the management of patients with head injuries, including discharge information, were available in the department. Staff also had access to senior medical staff for advice, yet they did not seek their advice. Similarly, the ambulance staff had access to protocols for assessing and treating (including resuscitating) patients, which they did not adhere to.

Apart from an information sharing protocol, there was a complete absence of polices and guidelines governing working arrangements between Hull and East Yorkshire Hospitals NHS Trust, Humberside Police Force and Tees, East and North Yorkshire Ambulance Service NHS Trust.

What has already been done?

As the incident took place in 1998, there are some policies and procedures that have already changed and some new ones have been introduced, which address some of the concerns and issues relating to the death of Christopher Alder. Here we highlight some of those changes, with a view to understanding what still needs to be done. A detailed look at these changes can be found in the full investigation report.

1. Systems for the management of risk in place in Hull Royal Hospitals NHS Trust have now been implemented in the merged Hull and East Yorkshire Hospitals NHS Trust and a trust manager for risk is in place, supported by a risk information officer.

2. All clinical departments have a designated lead for risk and A&E has a group that considers risk issues. Training on risk is now available for staff and the number of incidents reported has increased year on year. Tees, East and North Yorkshire Ambulance Service NHS Trust have developed the systems for risk management

there is now a risk management strategy, risk register and incident reporting system in place and a risk manager, responsible for coordinating risk activity.

3. Both trusts have achieved level one of the clinical negligence scheme for trusts, which are the standards assessing the standard of managing risk relating to patient care.
4. Formal inductions for locum doctors are now in place and where possible they are recruited to provide cover for a relatively long period of time to ensure continuity of care. Medical cover has also improved and there is now another senior house officer available, as well as a middle grade and staff grade doctors.
5. The discharge/transfer of care policy was updated in 2004 including an explicit recognition of confidence that a patient is fit to discharge. The decision as to whether a patient is fit to be discharged, is made by the senior doctor prior to removal from the department.
6. Hull and East Yorkshire Hospitals NHS Trust has adopted the National Institute for Health and Clinical Excellence (NICE) guidance on the management of head injuries. A&E nurses now have a five day triage training programme, including information on the management of patients with a head injury - there is also an academic post registration course they can undertake.
7. Academic programmes of education, and professional registration relating to pre hospital care, have been introduced for paramedics and technicians administering care to patients. Also team nursing and team leaders for each area have been introduced and training for staff nurses working in A&E is more thorough to ensure nurses will not treat patients if the nurses have not met the relevant criteria.
8. Security staff have now been increased and their role now includes covering A&E and maintaining a safe environment for staff and patients. Training is also provided on issues such as managing conflict and protecting people and property. Hull and East Yorkshire Hospitals NHS Trust introduced a policy in January 2001 for dealing with violence at work.

What happens next?

As well as the progress already listed, the Healthcare Commission, in conjunction with the Independent Police Complaints Commission, has a series of key recommendations, which the trusts and other relevant organisations need to put into action. Both organisations will advise and assist the trusts and other relevant organisations in the preparation of a new action plan to incorporate these recommendations. The Healthcare Commission expects the trusts to consider all aspects of this report. The strategic health authority and the Healthcare Commission will monitor the implementation of the action plan for the healthcare providers, and the outcomes.

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 patient 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.

Action for 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 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 upon 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 appropriate reviews are undertaken.

- A regular audit of record keeping and documentation should be conducted to assist staff 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 and in particular 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 that the person is fit 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 the rights of patients. There should be a section covering the A&E department and local police forces should be consulted about this.

Appendix 9: Glossary of Medical Terms

TERM	EXPLANATION
Abrasion	Superficial injury to the skin or other body tissue caused by rubbing or scraping
Agonal	Relating to the process of dying or the moment of death
Aorta	The largest artery in the body which takes oxygenated blood from the heart to the rest of the circulation
Asphyxia	Condition caused by inadequate intake of oxygen. Fatal if prolonged or severe
Asystole	Cardiac standstill or arrest, absence of a heartbeat
Cardiac, Cardiology	To do with the heart, concerned with the heart and its diseases
Cardiac Arrest	The heart stops pumping due to asystole (qv) or ventricular fibrillation or another dysrhythmia. Universally fatal without treatment
Cardiac Arrhythmia	A disturbance with the electrical activity of the heart that manifests as an abnormality in the heart rate or heart rhythm
Cardiac Dysrhythmia	Any abnormality in the rate, regularity or sequence of cardiac activation
Cardiopulmonary Resuscitation (CPR)	Attempting to resuscitate a patient who has collapsed with underlying cause being cardiac arrest or breathing failure.

	by external cardiac massage and artificial ventilation
Cardiovascular	About or connected to the heart and blood vessels
Cerebral Hypoxia	A lack of oxygen to the brain
Clinical	Strictly relating to healthcare delivered at the bedside by a healthcare professional or clinician. Term is used more widely to cover the delivery of care in other non-bedside situations
Consultant	Fully trained specialist in a branch of medicine who accepts total responsibility for specialist patient care
Dislocation of the shoulder	Displacement of the shoulder from its normal position, common in sports injuries but can also result from other forms of trauma. The shoulder is restored to its normal position by manipulation under local or general anaesthetic. The procedure can also be described as reduction of dislocated shoulder.
Defibrillator	Equipment that sends an electric current through the heart to restore the normal heart rhythm when ventricular fibrillation or some other dysrhythmia is present.
Excited Delirium	Rare form of severe mania sometimes considered part of the spectrum of manic-depressive psychosis and chronic schizophrenia
Glasgow Coma Scale (GCS)	A scale that assesses the degree of coma in patients with brain injuries, also assesses brain function, brain damage and patient progress
Haematology	The study of the blood and blood forming

	tissues and their diseases
Haematoma	A localised collection of blood, usually clotted, in an organ space or tissue, due to a break in the walls of blood vessels
Haemorrhage	The escape of blood from the vessels, bleeding
Histology	The study of cells and tissue on the microscopic level
Hyperadrenalism	Excessive secretion of the adrenal cortex
Hyperventilation	Excessive breathing rate such that there is reduction of carbon dioxide levels in the blood
Hypoglycaemia	An abnormally low concentration of glucose in the blood
Laceration	A cut to the skin often used when torn or jagged
Metabolites	Metabolism is the sum of all the chemical and physical changes that take place within the body and enable its continued growth and functioning. Metabolites are either produced during metabolism or are constituents of food taken into the body.
Neuropathology	Pathology of the nervous system
Oesophagus	A long hollow muscular tube that connects the pharynx to the stomach, often referred to as the gullet
Pathologist	Doctor who specialises in the diagnosis of disease by examining blood, fluids, cells or tissues taken from the living by

	sampling or surgery or at the time of post mortem examination
Pathology	The work of a pathologist. Includes biochemistry, haematology & microbiology as subspecialties
Petechiae	Small red spots on the skin caused by small leakages of blood from vessels that may be due to a low platelet count or asphyxia
Petechial Haemorrhage	Bleeding from the capillaries (which are the smallest tissues in the body) into the skin that forms petechiae
Pleura	The covering of the lungs (visceral pleura) and lining of the inner aspect of the chest cavity.
Pleural Cavities	The potential space between the two layers of the pleura.
Postural Asphyxia	Inadequate intake of oxygen caused by the position of the body
Radiographer	Healthcare professional who produces images of the body to diagnose injuries and disease eg X-rays, CT & MRI scans. These images are interpreted by a radiologist who is a doctor with further specialist training
Senior House Officer (SHO)	Position gained by doctors after their registration by the General Medical Council. Second tier of trainee doctor in the hospital
Specialist Registrar (SpR)	Specialist training post in a field of medicine, more senior than other training posts
Toxicology	The scientific study of the chemistry,

	effects and treatment of poisonous substances
Trauma	Any injury to the body eg fracture, laceration, haematoma
Triage	Focused assessment of patients, usually when they first arrive in A&E, in order to prioritise urgency of treatment needs
Ventricle	The main pumping chambers of the heart. The right ventricle pumps blood into the lungs to pick up oxygen and the left pumps the oxygenated blood around the body
Ventricular Fibrillation	A disorganised, chaotic contraction of the ventricles so that pumping ceases. A type of cardiac arrest that is fatal if not treated by defibrillation
Ventricular Hypertrophy	The enlargement or overgrowth of the ventricle due to an increase in size of its constituent cells
Ventricular Tachycardia	Abnormally fast ventricular rhythm with a usual rate of 150-200 beats per minute. If untreated may progress to ventricular fibrillation (qv)

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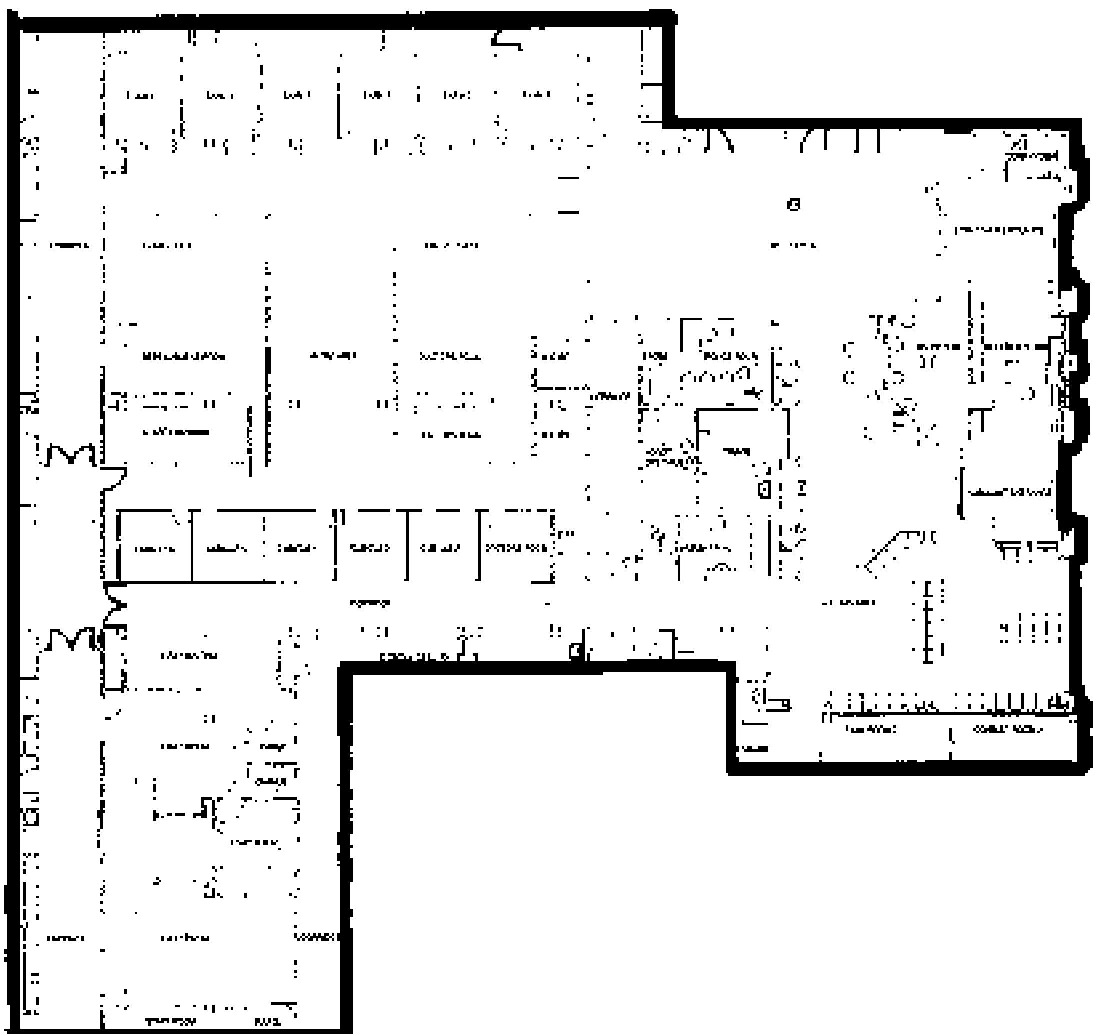
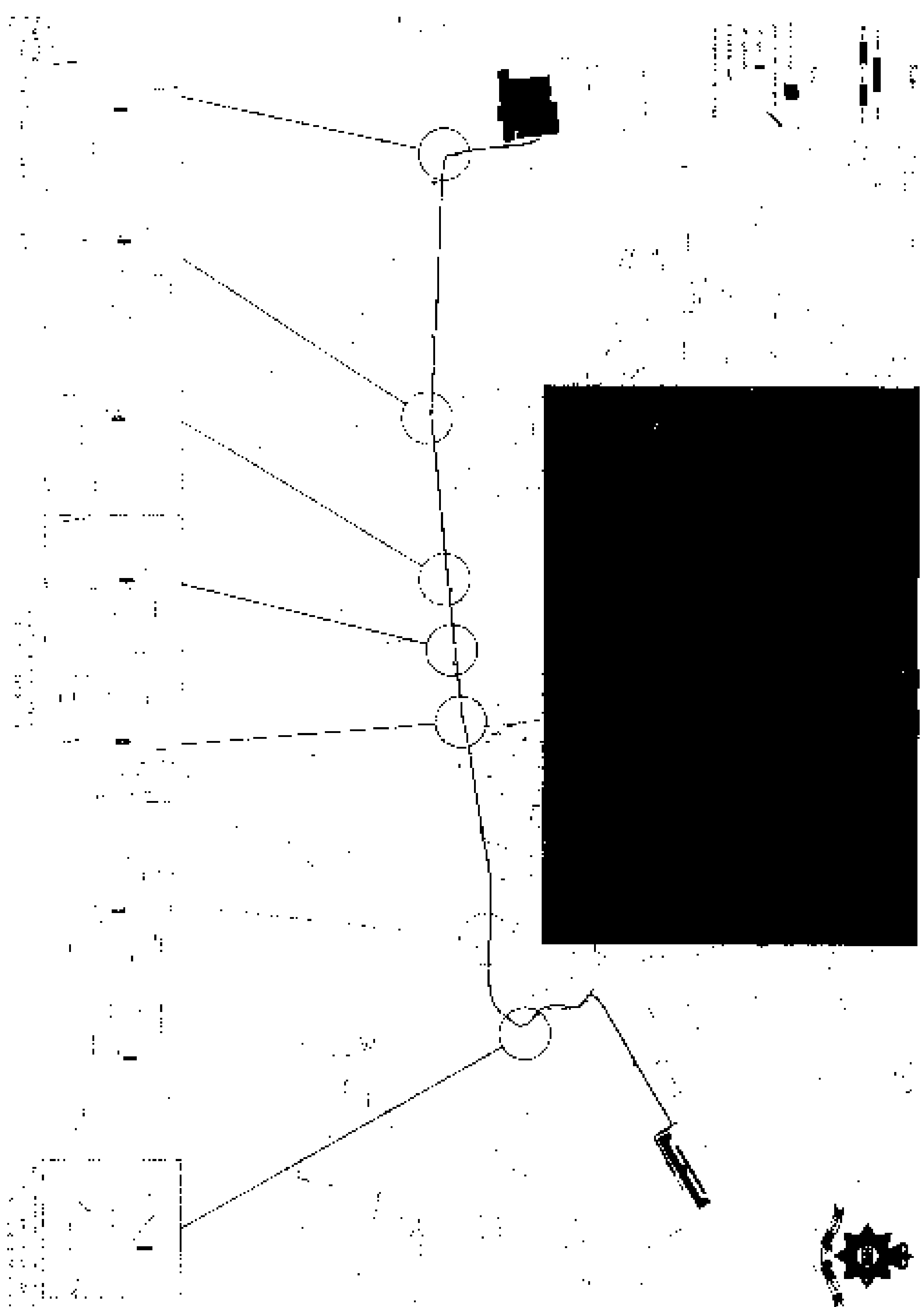


Accident & Emergency Dept
Ground Floor Hull Royal Infirmary

NOTES

Hull and East Yorkshire Hospitals NHS
NHS Trust
Estates Development Department



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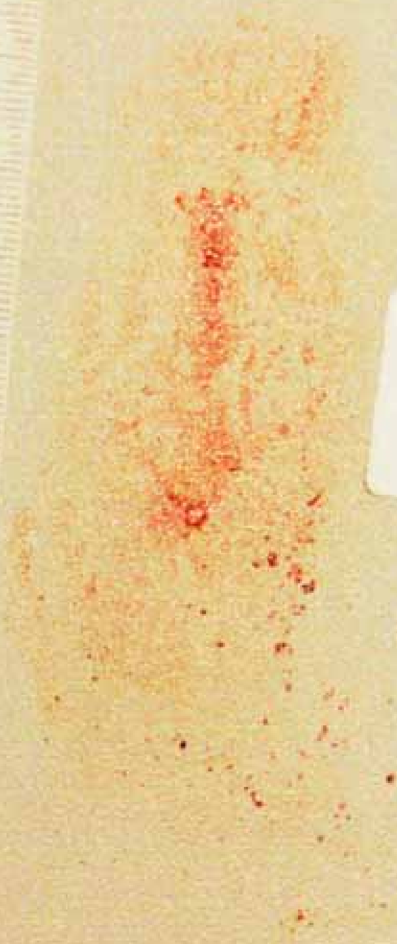

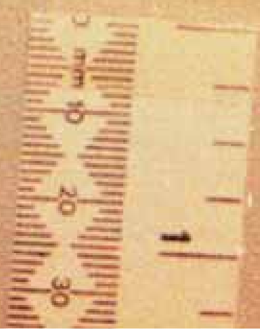

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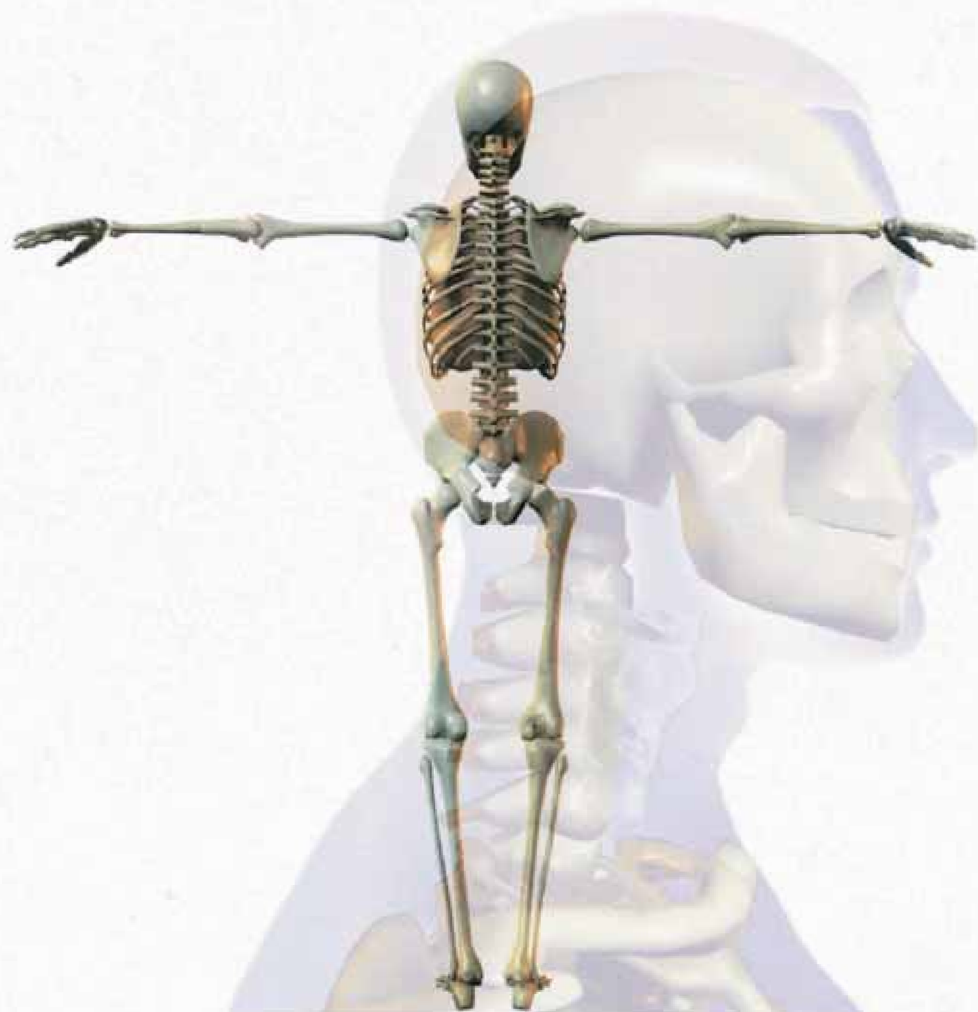
ALDER INQUIRY
INJURY MODELLING GRAPHICS



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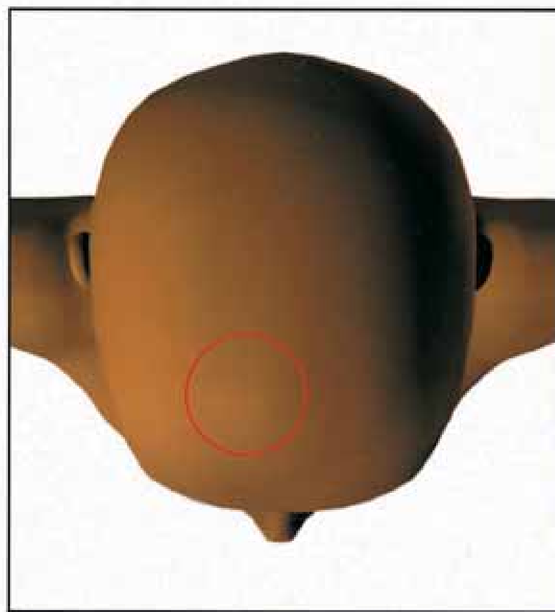
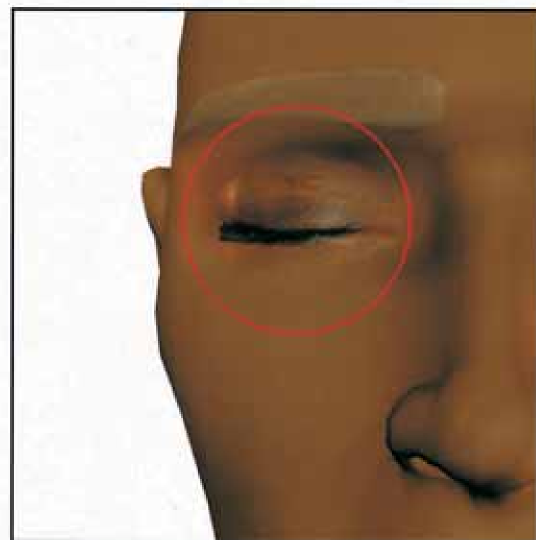
Injury Modelling - Christopher ALDER



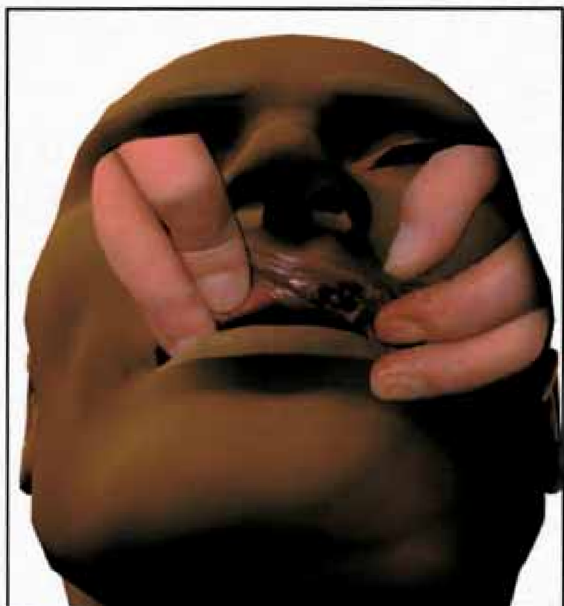


Head And Neck

1. Short, very fine diagonal laceration, 1cm in length, at the front of the head in the midline with the lower end to the left.

2. Superficial grazed abrasion, 1cm in diameter, on the middle part of the upper lid of the right eye.

Injury Modelling - Christopher ALDER



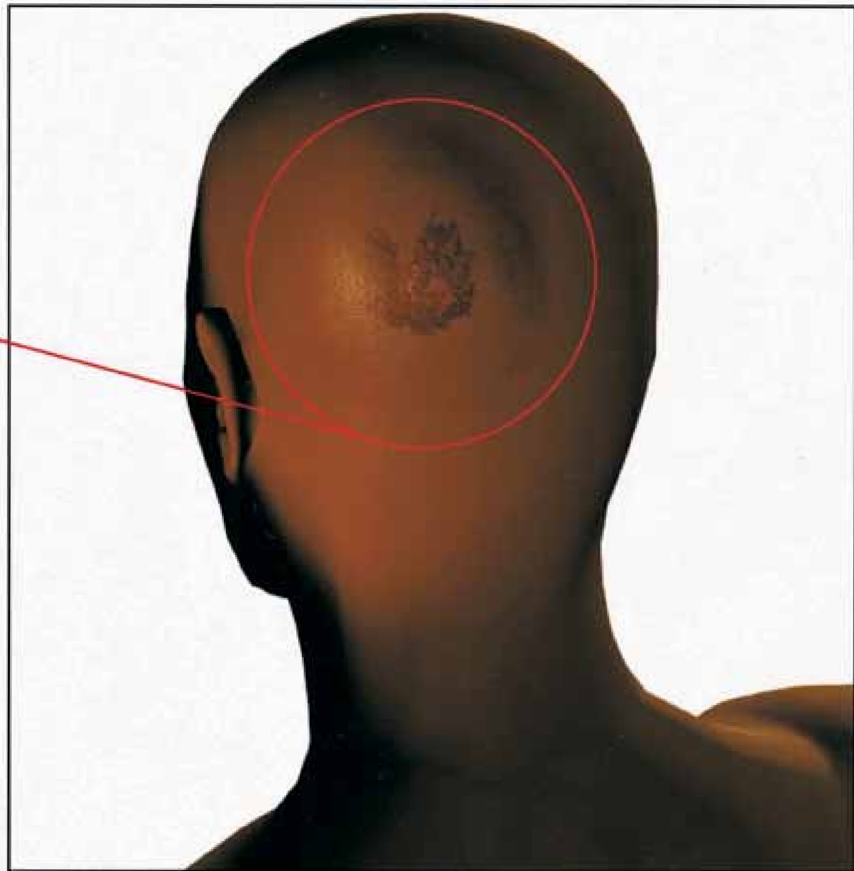
3. In the mouth:

   i) Ragged, deep vertical laceration, 1.5cm 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, 0.8cm in diameter.

   ii) Tiny bruise on the inner surface of the upper lip to the right of the midline.

   iii) Left upper 1st and 2nd teeth dislodged and missing, with bleeding from both sockets.

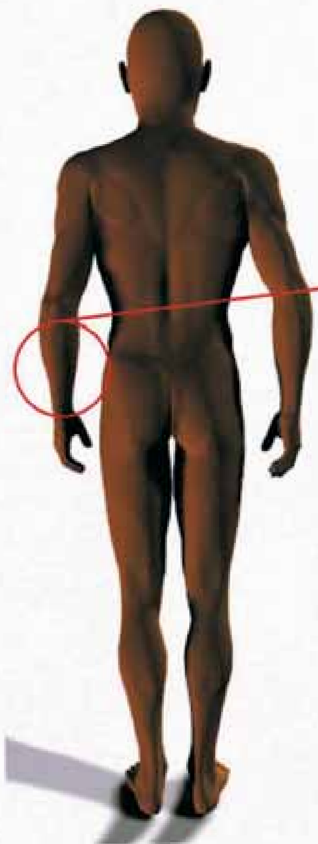
   iv) Full thickness ragged laceration on the left side of the lower lip near the midline, measuring 0.5cm in length on the outer surface and 2cm in length on the inner surface.

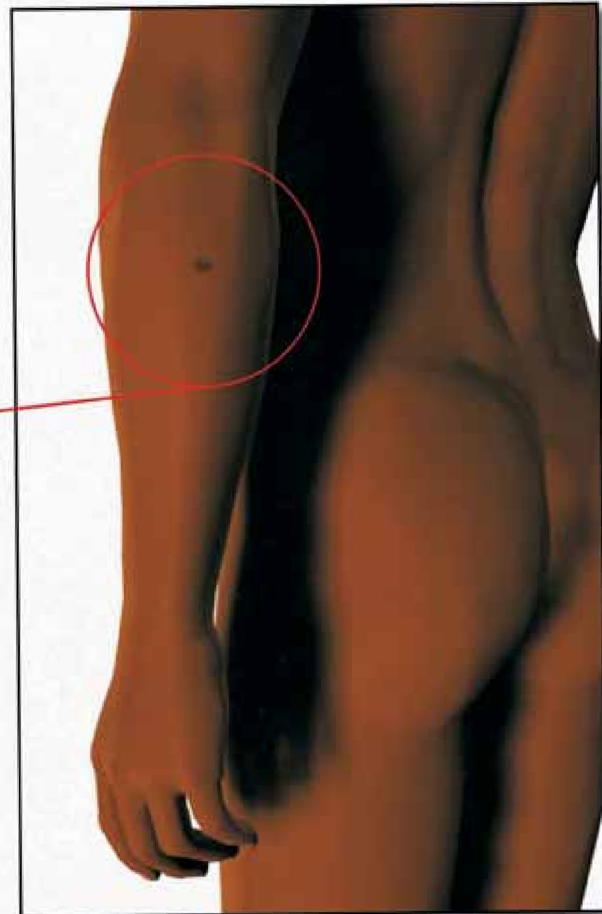


HEAD AND NECK

4. At the back of the head, 1cm to the left of the midline and level with the upper part of the ear, a circular superficial abrasion, 3cm in diameter, with an overlying ragged superficial vertical laceration, 1cm in length, which was oozing blood. There was a large underlying bruise, 8cm in diameter.

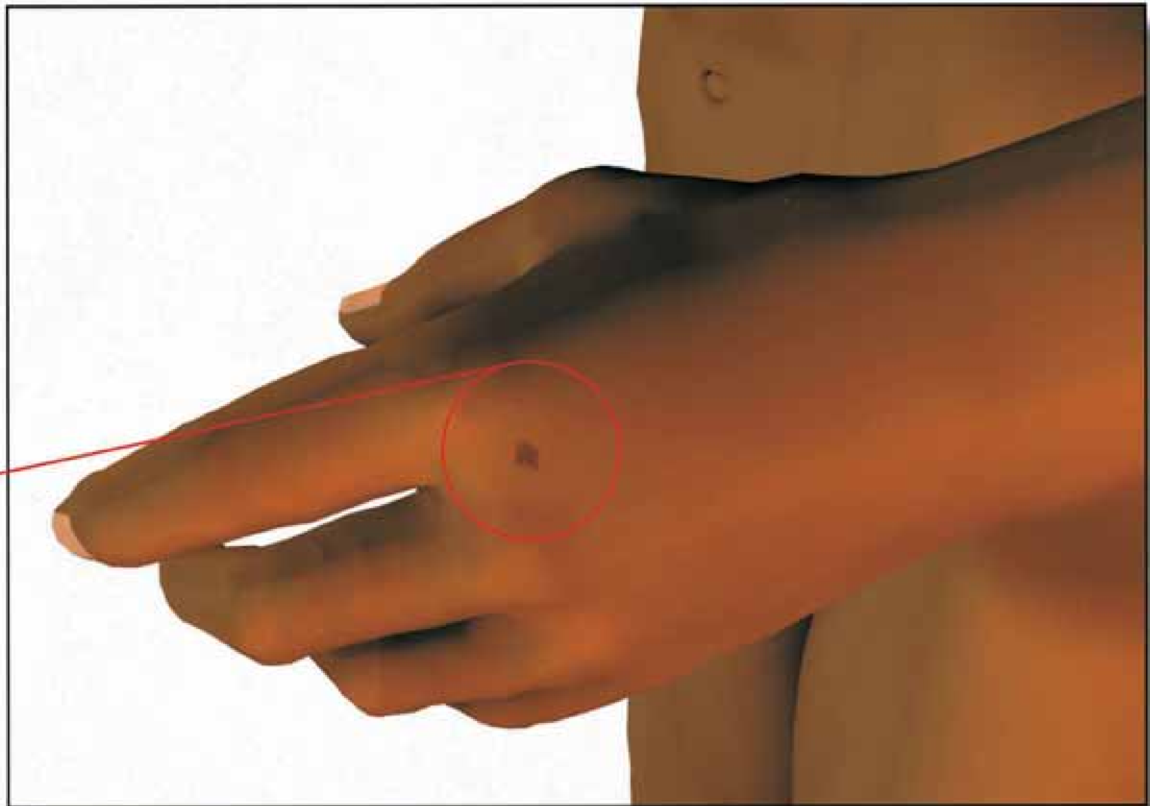
Injury Modelling - Christopher ALDER





ARMS

5. Abrasion, 1cm in diameter, on the outer aspect of the left arm below the elbow.



ARMS

6. Tiny abrasion, 0.2cm in diameter, on the back of the left hand between the base of the index and middle fingers.

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ALDER INQUIRY

MODELLING - INTERIOR OF VAN

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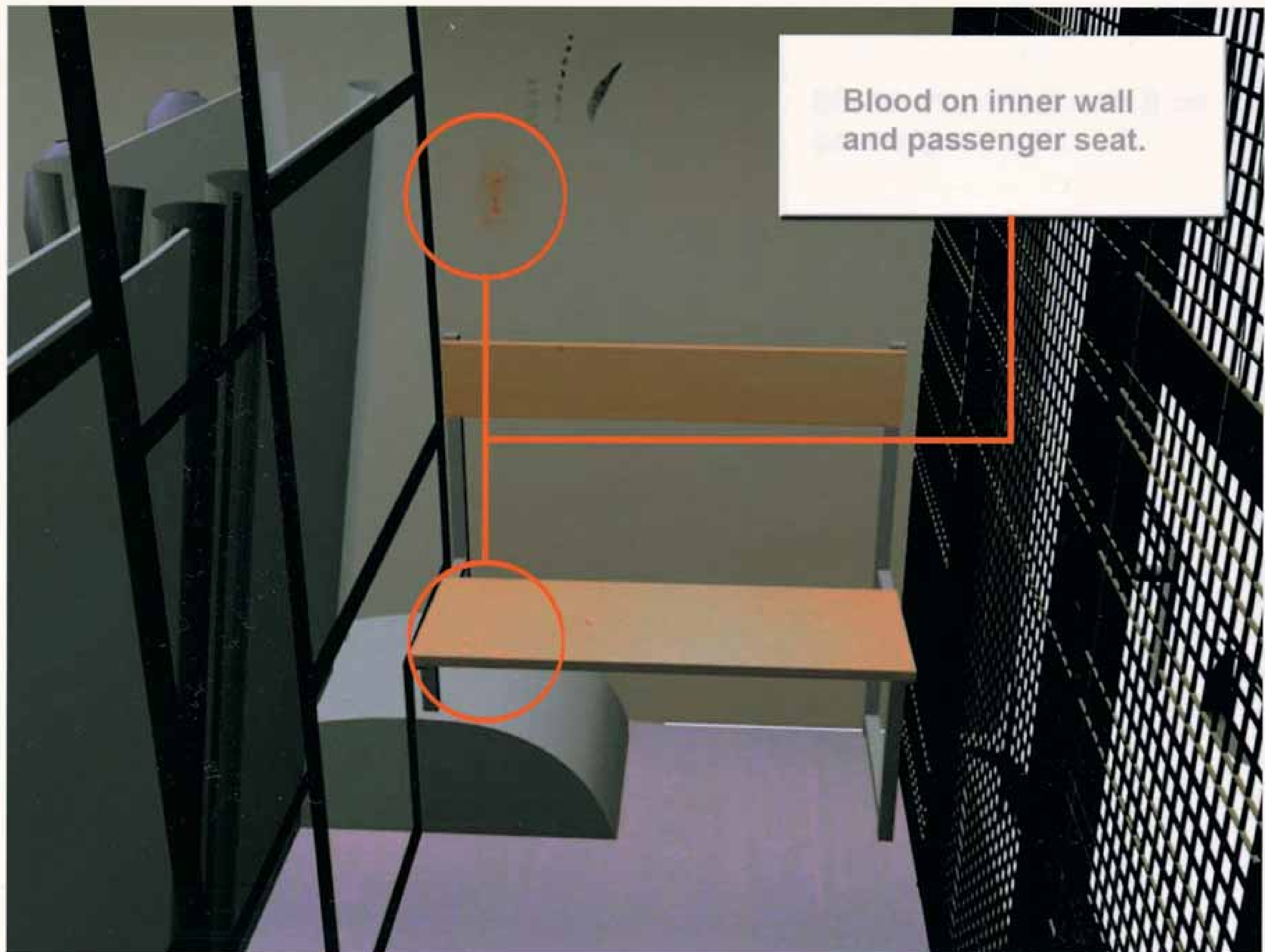
Blood found inside van...



Blood found inside van...

Blood found inside van...

Blood on inner wall
and passenger seat.

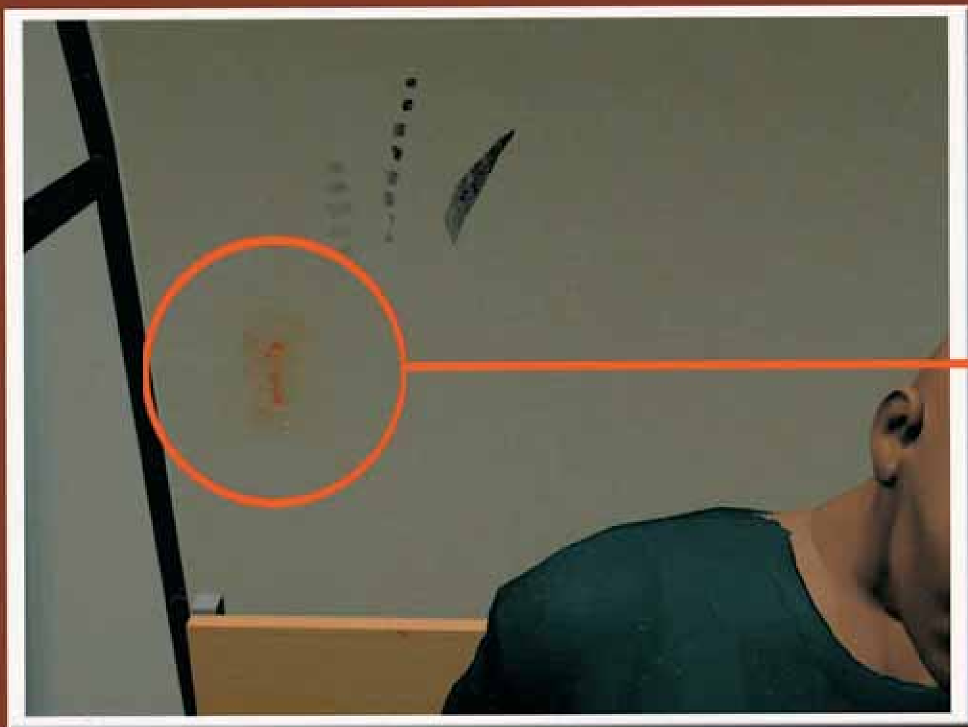
Blood on inner wall and
passenger seat.

Blood found inside van...

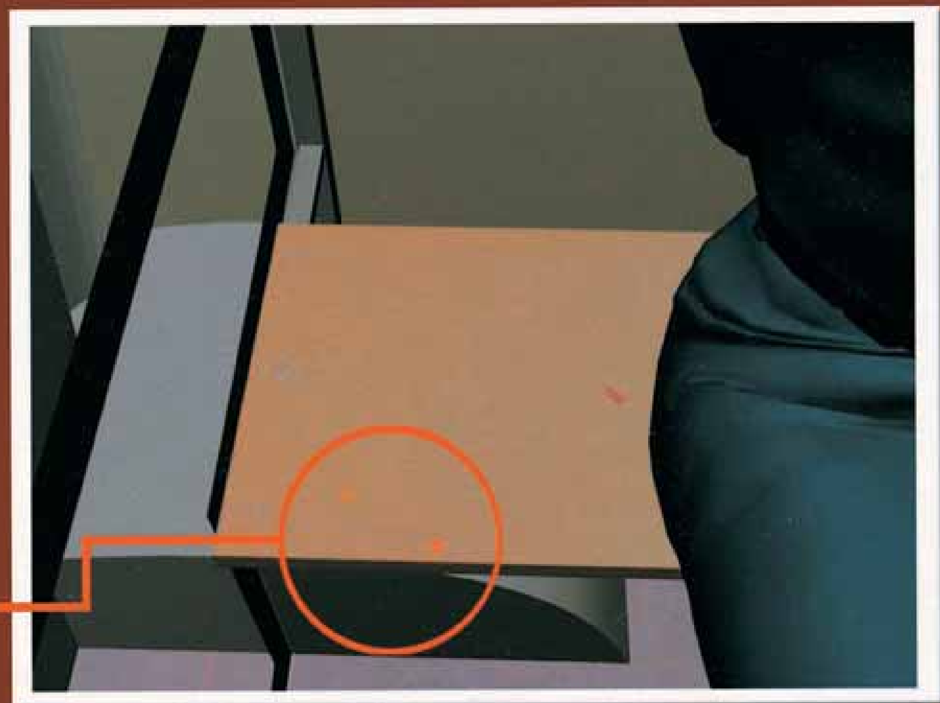
View showing blood A on the passenger seat.

View showing blood B on the passenger seat.

Close up of Blood found inside van...

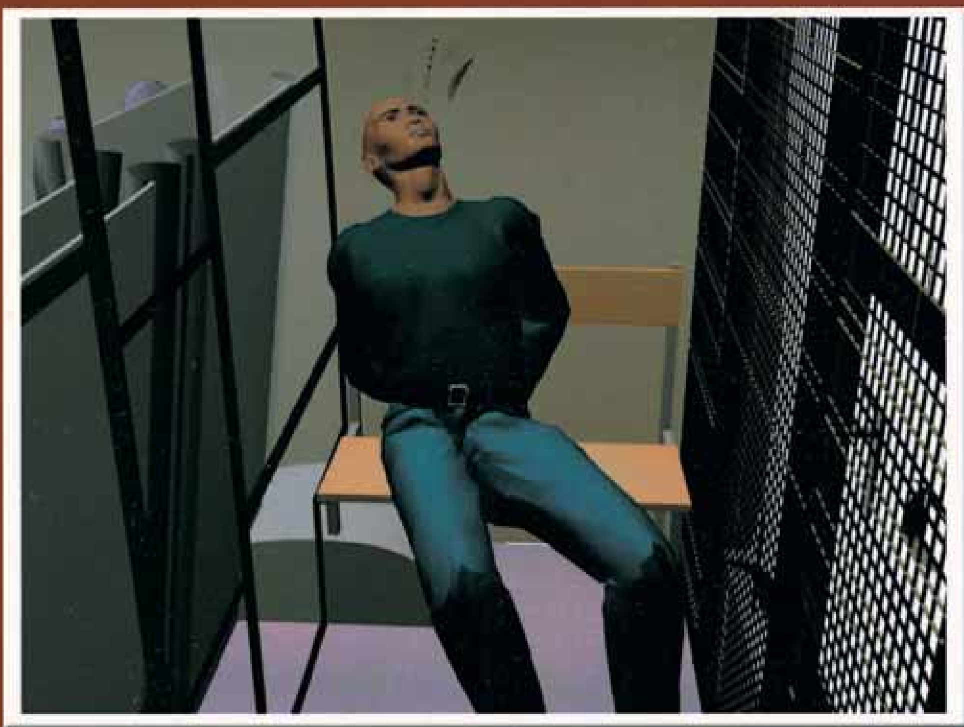


Close up of the blood to the inner wall.

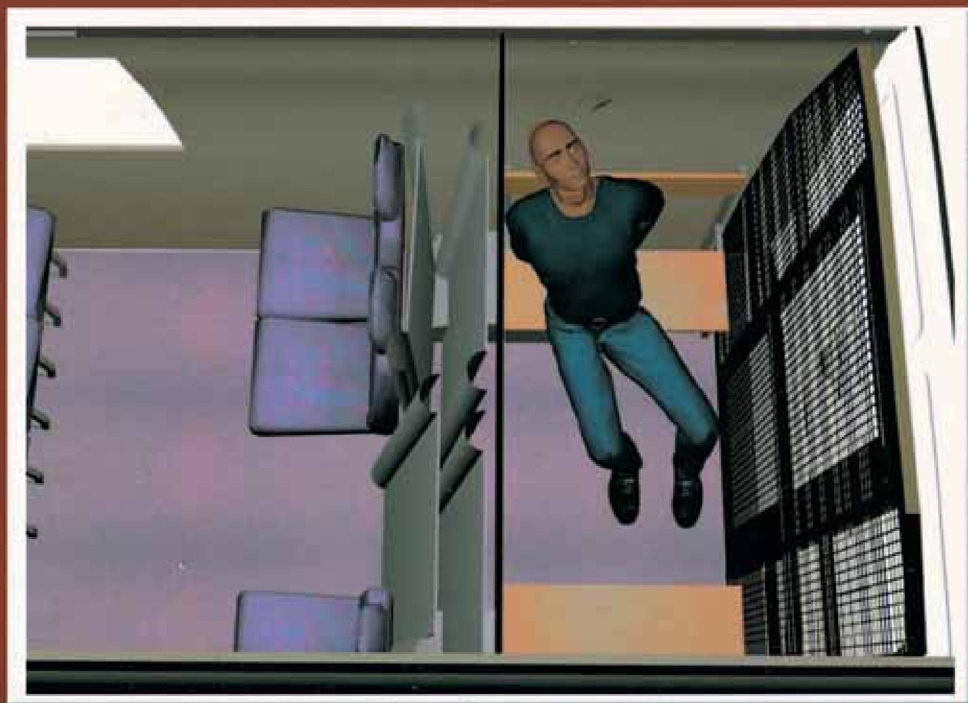


Blood on passenger's seat.

Possible position for Alder to be in...

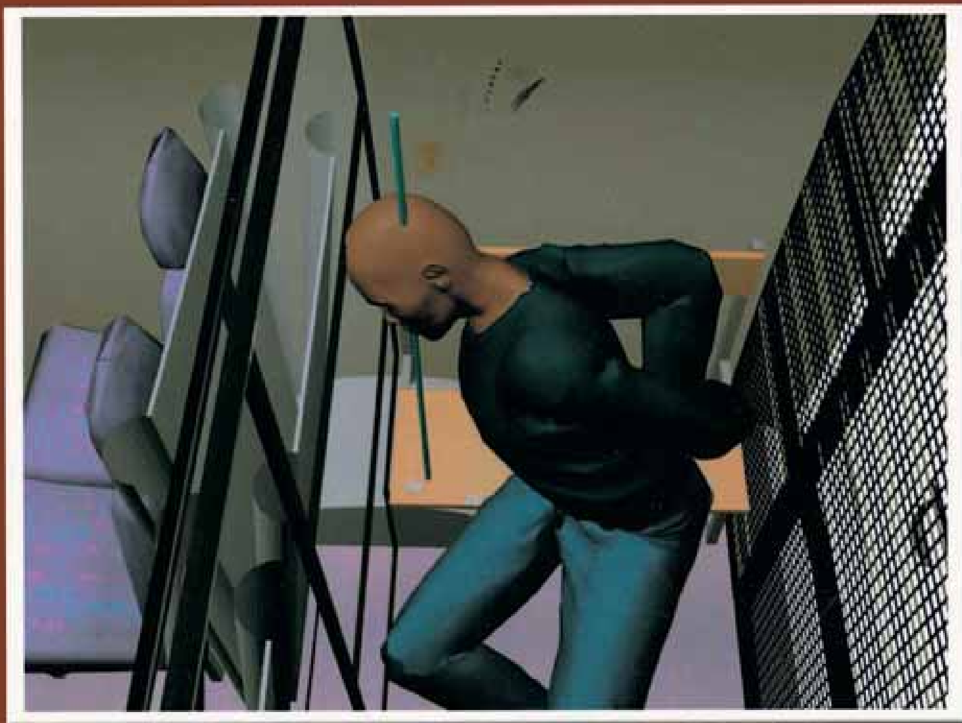


View showing Alder's
head up against
blood to inner wall.



View showing Alder's
head up against
blood to inner wall.

Possible position for Alder to be in...



Possible position of Alder to produce blood A on passenger seat.

Possible position of Alder to produce blood A on passenger seat.

Possible position for Alder to be in...

Possible position of Alder to produce blood B on passenger seat.

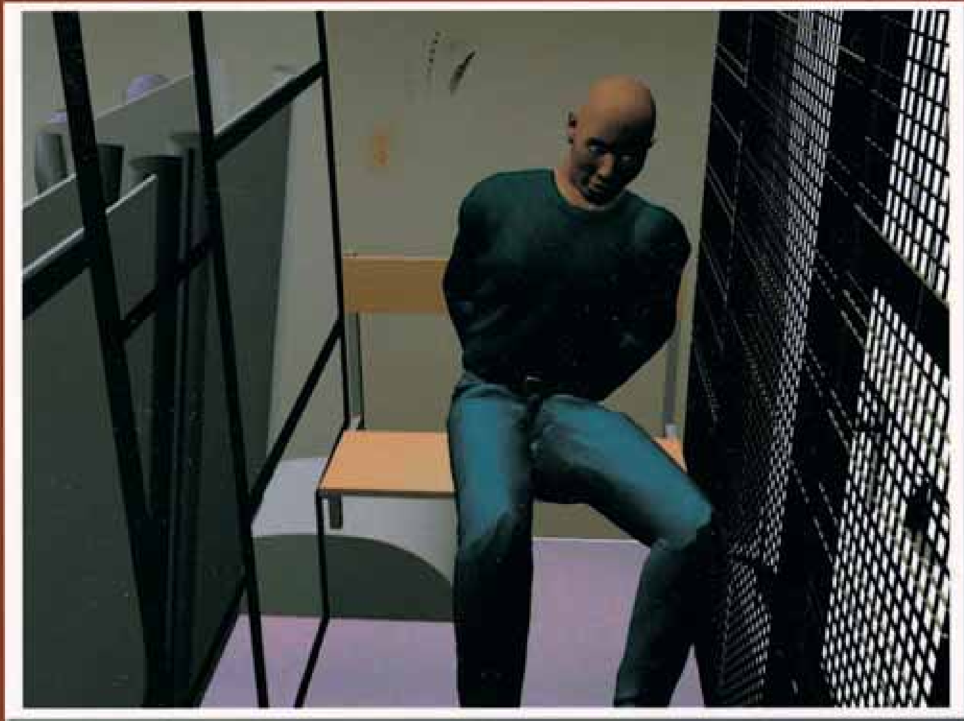
Possible position of Alder to produce blood B on passenger seat.

Possible position for Alder to be in...

Possible position of Alder to produce blood B on passenger seat.

Possible position of Alder to produce blood B on passenger seat.

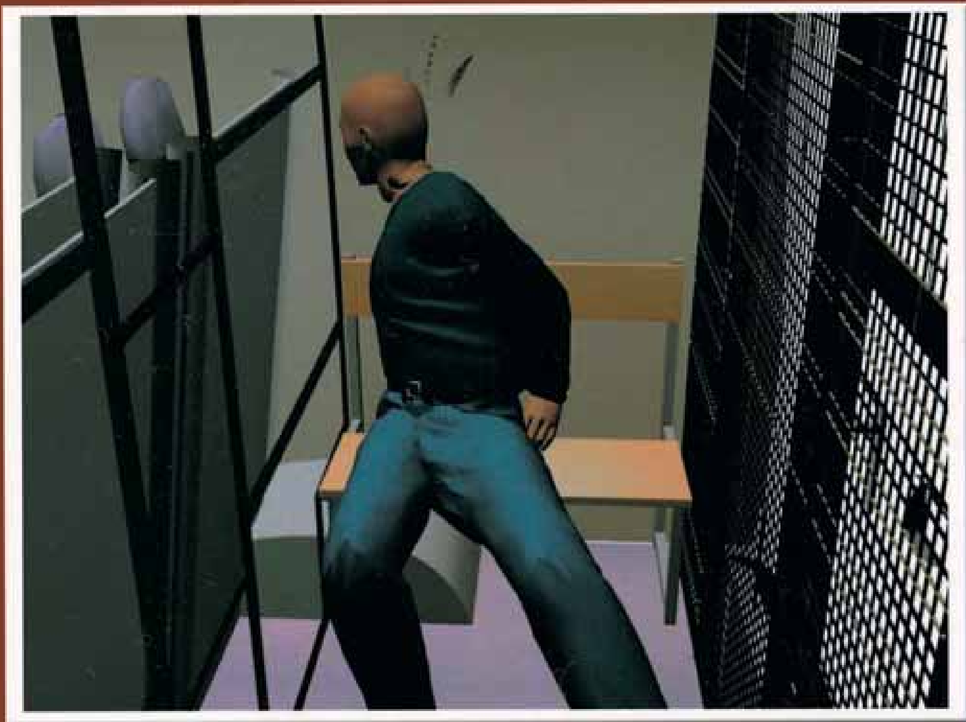
Alder seated correctly inside van...



View showing Alder in a seated position.

View showing Alder in a seated position.

Possible position for Alder to be in...



View showing Alder's face (mouth) up against blood on inner wall.

View showing Alder's face (mouth) up against blood to inner wall.

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ALDER INQUIRY
MODELLING - POSSIBLE FALL SEQUENCE

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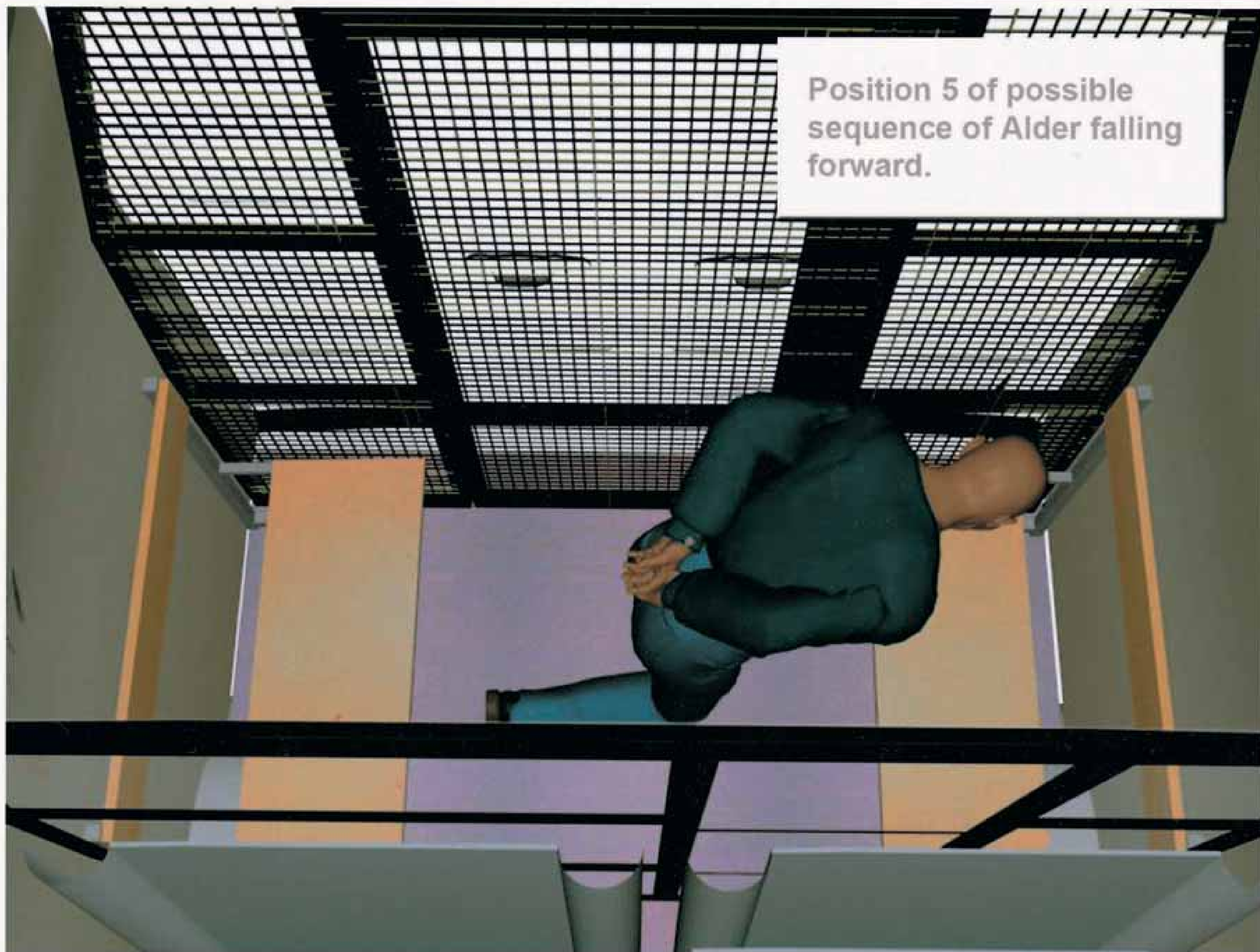
Alder possible fall sequence scenario...

Alder possible fall sequence scenario...

Alder possible fall sequence scenario...

Alder possible fall sequence scenario...

Alder possible fall sequence scenario...



Alder possible fall sequence scenario...

Alder possible fall sequence scenario...

Alder possible fall sequence scenario...

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