

# Investigation into the care and treatment given to Christopher Alder by Hull Royal Infirmary and Humberside Ambulance Service NHS Trust prior to his death

November 2005

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## 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 31<sup>st</sup> 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 31<sup>st</sup> 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 20<sup>th</sup> 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 policies 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 31<sup>st</sup> 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](http://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 1<sup>st</sup> 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 maxilla-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 inexperienced 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 policies 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.

# 1 Introduction

## Why investigate?

On April 20<sup>th</sup> 2004, the Home Secretary wrote to the Independent Police Complaints Commission (IPCC) asking it to undertake a review into the events leading up to and following the death of Christopher Alder (under the powers of the Police Act 1996 s79 (1)). Christopher Alder died in police custody in April 1<sup>st</sup> 1998. In the early hours of that morning, he had been assaulted outside the Waterfront nightclub in Hull and as a result was assessed and treated by ambulance crew at the Waterfront nightclub, by hospital staff in A&E at Hull Royal Infirmary and again by the same ambulance crew at the Queen's Garden Police Station. For a chronology of the events on April 1<sup>st</sup> 1998 please refer to appendix 1.

In December 2004, the IPCC asked the Healthcare Commission to assist them by investigating the care and treatment provided to Christopher Alder by healthcare staff on April 1<sup>st</sup> 1998. The Commission was also asked to look at the links between the two healthcare organisations and Humberside police.

At the time of Christopher Alder's death in 1998, the police conducted a local investigation, which focused largely on the actions of the other person involved in the assault. As a result, it appeared that not all the available information had been collected and preserved.

A coroner's inquiry was held in August 2000, and there were some discrepancies in the views expressed by clinical experts. The jury concluded that death was caused by multifactorial events leading to a level of unconsciousness, which resulted in upper airway obstruction and positional asphyxia (a life threatening condition in which oxygen is prevented from reaching the tissues by obstruction or damage to any part of the respiratory system), and returned a verdict of unlawful killing. For more detailed information about the coroner's inquiry, the internal and external investigations undertaken by the police, and the subsequent criminal proceedings, please refer to the Independent Police Complaints Commission's (IPCC) review of the death of Christopher Alder.

Following the death of Christopher Alder, staff from both healthcare organisations confirmed that they had not completed incident forms despite the fact that systems for the reporting of incidents were in place and despite the sudden and unusual circumstance in which Christopher Alder died. There are no records of any internal reviews or meetings to discuss and/or review the care provided to Christopher Alder.

Neither Humberside Ambulance Service NHS Trust nor Hull Royal Hospitals NHS Trust (which includes Hull Royal Infirmary) conducted detailed investigations.

Staff from both healthcare organisations submitted statements to the police, and gave evidence at the inquest into the death of Christopher Alder.

The Healthcare Commission decided that although this investigation is related to a single incident that occurred seven years ago, it was likely that there were underlying problems in the systems in place to deal with a case like Christopher Alder's and there were significant lessons to be learnt for all involved at a local and national level in relation to how the police and healthcare services work together. 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 function, 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 where there has been some involvement with healthcare and of the national debate surrounding the use of hospitals and police stations as places of safety (Section 136 of the Mental Health Act 1983 enables a police officer to remove someone who appears to have a mental health disorder from a public place to a place of safety for assessment). Although Christopher Alder was not suffering from a mental health disorder and was not detained under the Mental Health Act, this case bears similarity to the concerns expressed in relation to the exercise of that power, that police stations do not have the facilities to receive and observe people who may be excited and restless due to a mental health disorder or who may be unpredictably suicidal. Equally, accident and emergency (A&E) departments are also rarely equipped to deal with patients detained under Section 136 of the Mental Health Act 1983 and psychiatric units may also have problems in providing a suitable place of safety due to inadequate staffing levels.

The European Court of Justice has stated that, as the right to life is the most fundamental of all human rights, a death in custody must always arouse concern (Jordan v United Kingdom (2003) 37 EHRR 2). It is important when this does occur that the actions of the agents of the State, and the surrounding circumstances are carefully considered. In particular, where the events lie wholly, or in large part (as with a death in custody), within the exclusive knowledge of the authorities, strong presumptions of fact are said to arise (Jordan v United Kingdom (2003) 37 EHRR 2, para 103). Accordingly, the Healthcare Commission considered it important that it contributed to the IPCC's investigation by examining the circumstances surrounding the death of Christopher Alder in terms of the healthcare provided to him and the inter-relationship between the various agencies.

The Healthcare Commission agreed to investigate the care and treatment provided to Christopher Alder by healthcare staff and to investigate the working relationships between the police, ambulance and hospital services. The purpose of the 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.

The Healthcare Commission has full responsibility for this report and for ensuring that an action plan is published by the trusts involved. The Commission will make the action plan available through its website.

## Terms of reference

The Independent Police Complaints Commission (IPCC) was asked to undertake a review into the events leading up to and following the death of Christopher Alder in custody on April 1<sup>st</sup> 1998, in particular to identify the lessons to be learned. The terms of reference for the IPCC's review include:

- to identify and take account of the concerns of the family over this tragic death
- to consider circumstances surrounding Christopher Alder's 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
- to include any recommendations in the report for the benefit of policing that arise from the review

The Healthcare Commission agreed to assist by carrying out an investigation into the care and treatment given to Christopher Alder by NHS organisations prior to his death and to make recommendations where necessary for changes to relevant policies and working practices for the benefit of healthcare generally. The terms of reference for the investigation were that the Healthcare Commission would examine:

- the care given to Christopher Alder by the ambulance crew outside the Waterfront nightclub, on the subsequent journey to the Hull Royal Infirmary, and at Queen's Garden Police Station
- the appropriateness of the care/treatment given to Christopher Alder at the Hull Royal Infirmary, and the decision to discharge him, including the circumstances of the discharge
- the adequacy of the policies and working practices of these bodies

The joint terms of reference for the IPCC and the Healthcare Commission required them jointly to consider:

- the interface between the ambulance service, Hull Royal Infirmary, and the police and, where appropriate, to make recommendations for changes to the interface between the police and healthcare agencies

## What was our approach?

Staff from the Healthcare Commission worked with a team of clinical advisors with specialist knowledge of A&E and ambulance services, and with staff from the



Independent Police Complaints Commission. See appendix B for further details of the investigation team.

The investigation team reviewed 184 documents including transcripts of evidence given at the inquest, previous statements written by the staff involved, previous medical reports and policies supplied by the trusts, as well as reviewing CCTV footage supplied by Humberside police. Where relevant, the Healthcare Commission also took account of the absence of information and records, where we would reasonably expect such records to exist.

The investigation team interviewed 18 NHS staff including past employees. Two members of staff, a staff nurse and a member of the security staff, who were working at Hull Royal Infirmary at the time Christopher Alder was admitted but are no longer working in the NHS, were invited to meet with the Healthcare Commission but did not respond.

Christopher Alder's sister was also invited to meet with the Healthcare Commission but did not respond to the invitation. The IPCC review contains information about the concerns of Christopher Alder's family.

The investigation team reviewed clinical records relating to Christopher Alder's past medical history, along with record forms completed by the ambulance crew who attended to Christopher Alder, and the triage, assessment and observation recording forms completed by staff at Hull Royal Infirmary. Other documents reviewed included previous medical reports on the care provided to Christopher Alder and statements made by staff following his death. The investigation team also referred to national and local policies that were in place in 1998 for example, the management of patients with head injuries and discharging patients, and discussed the rationale with staff during interviews for the decisions made on the night in question.

The Healthcare Commission has considered relevant legislation and guidance in place at the time of the events in 1998, and has considered whether current policies and guidance are sufficient to prevent a similar death happening today or if further change is required. There are a number of acts of Parliament that have a bearing on this case including legislation on human rights. Further details about these can be found in appendix C.

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 1<sup>st</sup> 1998). In making our recommendations we have considered what changes might be required to reduce the risk of a similar tragedy happening today.

It is the responsibility of the IPCC, not the Healthcare Commission, to assess the actions of the police. However, this report contains some reference to the actions of the police in terms of the care provided to Christopher Alder in order to place the contribution made by healthcare staff in context and because, as a general principle,

the standard of care for detainees should be equal to that provided by the NHS.<sup>1</sup> Please refer to the IPCC's review of the death of Christopher Alder for more information about the actions of the police both on the April 1<sup>st</sup> 1998 and subsequently.

The Commission is aware that difficulties clearly exist in relying upon interview evidence gathered through interviews taken seven years after the events. Therefore, greater reliance has been placed on more contemporaneous accounts and records, and the Healthcare Commission's interviews concentrated on clarifying areas of uncertainty and eliciting explanations of terms used in those accounts.

The IPCC has written a full review covering the events leading up to the assault of Christopher Alder, the actions of the police and subsequent investigations since Christopher Alder died in 1998. The Healthcare Commission's report on the actions of healthcare staff is incorporated into the IPCC's report. The Healthcare Commission's executive summary of this report is included as an annex in the IPCC report. The IPCC report was presented to the Home Secretary to decide on any further action to be taken.

Although individuals are named in the IPCC's report (and their names are already in the public domain by virtue of the coroner's inquiry) the Healthcare Commission has decided not to name them in order to ensure that the focus of attention is directed on improvement. The overarching purpose of this report is to determine the lessons and changes required to safeguard patients and to improve their quality of care, rather than to focus on the actions of individuals.

## Acknowledgements

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- Elizabeth Thomas, Hull and East Yorkshire Hospitals NHS Trust Coordinator for the investigation
- Jayne Barnes OBE, Chief Executive Tees, East and North Yorkshire Ambulance Service NHS Trust
- Dr Angela Brown, Tees, East and North Yorkshire Ambulance Service NHS Trust Coordinator for the investigation

1 *Healthcare of detainees in police stations* (second edition) British Medical Association and Association of Forensic Physicians 2004

## 2 National and local context

### Managing aggressive behaviour in the A&E department

The British Crime Survey report *Violence at work – findings from the British Crime Survey* showed that in England and Wales 275,000 workers were assaulted in 1997 and 395,000 were threatened. The report was funded by the Health and Safety Executive and published jointly with the Home Office. The report highlights that violence is a significant issue for nurses, healthcare professionals and social workers, and that high risk groups were found to be primarily staff who came into direct contact with the public and who worked during the evening or night.

Reasons why patients and visitors may become violent and aggressive in a hospital setting include stress and concern about their own injury or that of a relative, or they may be confused or disorientated because of their physical or mental condition. They may also be under the influence of drugs or alcohol or frustrated at having to wait to see the medical staff. Known violent behaviour has traditionally been a problem for staff in accident and emergency departments.

In 2000, the Government launched a national 'zero tolerance' campaign to protect the health and safety of healthcare staff. Guidelines produced by the Department of Health state that:

"In some NHS trusts the threat of violence and intimidation by patients and visitors is so serious that it has proven necessary, as a last resort, to withhold treatment from some patients. The withholding of treatment raises difficult dilemmas for clinicians and managers...However, where such policies and procedures have been introduced, there is clear evidence that they act as a deterrent..."

The Department of Health recommends that all trusts have local policies, which cover both the need to withhold treatment, and the decision to provide treatment or care to violent and aggressive patients, including procedures for involving a trust's security staff and the police.

Some A&E departments are now working more closely with the local police force to prevent and manage violent and aggressive incidents. This is done either through a visible police presence or a hotline to police stations. Despite the development of this working relationship between the police and healthcare staff, there are no national guidelines setting out the respective duties and responsibilities of hospital and community staff and police, where the former call the police for assistance in the management of a violent or aggressive patient. In the case of Christopher Alder, local protocols did not exist in 1998, and there are none in place in today.

## Deaths in custody

Between 1990 and 2001, 627 people died in police custody (Liberty 2003). Between 1999 and 2000, 70 people died (Home Office 2000). Giles and Sandrin (1992) reported that 86% of deaths in police custody were linked to recent alcohol consumption or chronic alcohol abuse. In 81% of deaths in police custody that related to head injury, the deceased was suspected of intoxication (Leigh et al, 1998).<sup>2</sup>

Between April 2003 and March 2004, there were 38 deaths in police custody in England and Wales, of which seven were in police stations, 22 were in hospital and the remainder were at the scene of arrest or following arrest.<sup>3</sup> Use of restraint did not feature in any of the deaths at police stations although six of those who died in hospital had been restrained by police shortly before their death.

A study by the Police Complaints Authority illustrated the extreme vulnerability of those who die in police custody. They found that between 1998 and 2003, of those who died, a higher proportion were from minority ethnic backgrounds (17.6% were non-white compared to 9% of the general population and 13% of people arrested). The study also found that the use of restraint was higher in the deaths involving non-white individuals (21.7%) than among white individuals (12.3%).

There are also very high rates of drug and alcohol dependency, and mental illness, amongst those held in police custody, and those who die there. Between 1998 and 2003, of 153 deaths in police custody, 43.8% had consumed alcohol prior to arrest, 17.6% cocaine, 12.4% heroin, 20.3% benzodiazepines, 8.5% ecstasy and 13.7% cannabis. Over half of those who died had prior indications of mental health problems and three of those (out of 60) had been brought to the police station as a place of safety.

There have been a number of initiatives to address problems related to deaths in police custody. The Standing Committee on Learning the Lessons from Adverse Incidents was established by the Home Office in 2002. It reviews adverse incidents and makes recommendations arising from its reviews. The National Custody Forum, together with the National Centre for Policing Excellence, is working towards developing practice to ensure safer detention in police cells. The Metropolitan Police Service has established a Deaths in Custody Group dedicated to the reduction and ultimately the prevention of death following police contact.

However, the standing committee (2002) commented that these initiatives appeared to be limited, to some extent, by the decentralised policing system and by the wide variation in practice between police forces.

2 Dr D Best, Amakai Kefas *The role of alcohol in police-related deaths, Analysis of deaths in custody (category 3) between 2000 and 2001*. Police Complaints Authority. 20004 p.9.

3 House of Lords House of Commons s Joint Committee on Human Rights *Deaths in Custody Third report of Session 2004-05* Vol.1.8 December 2004

The Mental Health Act Commission has also expressed continuing concern about the use of police stations as places of safety for people detained under section 136 of the Mental Health Act 1983.<sup>4</sup> The British Medical Association (BMA) has stated that a place of safety should ideally be a hospital.<sup>5</sup>

## Healthcare of detainees

Inadequate provision of medical care for detainees may constitute inhuman treatment under Article 3 of the Human Rights Act 1998. The level of failure that may trigger a violation of Article 3 is relative and will depend on the circumstances of the case, and can include taking account of the characteristics of the prisoner.

The BMA has produced guidelines on Healthcare of detainees in police stations (2004)<sup>6</sup>, which states that the standards of healthcare for detainees should be equal to those treated in the NHS. The guidelines set out the duties and responsibilities of forensic physicians and custody officers and highlight the requirements of the Human Rights Act 1998, in particular the right to life, liberty and human dignity (Article 2 and Article 5 respectively).<sup>7</sup> For instance, custody officers are required to call immediately a healthcare professional where a detainee appears to be suffering from physical illness, is injured or in need of medical attention.<sup>8</sup>

The guidelines acknowledge that conditions in police stations may be inappropriate for people with head injuries and such cases, particularly in conjunction with alcohol consumption, are potentially dangerous to manage in police stations and are a common cause of death in police custody. Where head injury is suspected, the guidelines require that a person should be referred immediately to hospital, irrespective of alcohol consumption. Where section 136 of the Mental Health Act is engaged, often a police station will not be an appropriate 'place of safety' as referred to in that section.<sup>9</sup>

The BMA has expressed concern about some cases where referral to hospital for investigation or diagnosis has been delayed because the detainee is intoxicated or smelling of alcohol. The BMA point out that a person who appears to be drunk or behaving abnormally may be suffering from an illness or may have sustained a head

4 Mental Health Act Commission 8<sup>th</sup> Biennial report 1997-1999. The Mental Health Act Commission 9<sup>th</sup> Biennial report 1999-2001

5 *Healthcare of detainees in police stations* (second edition), British Medical Association and Association of Forensic Physicians 2004. The first edition was withdrawn in 1996 and the guidance was not enforced after this.

6 Ibid

7 Ibid (1.1.1), (3.1)

8 Ibid (3.2.1)

9 The Mental Health Act Commission 8<sup>th</sup> Biennial Report 1997-1998

injury. The Police and Criminal Evidence Codes of Practice advise that where there is doubt, an appropriate health professional or an ambulance should be called urgently.

An analysis of deaths in custody between 2000 and 2001 found that a significant proportion of custody sergeants, who are responsible for the health and welfare of detainees, had not received adequate training, particularly in relation to drugs, alcohol and mental health. There was also concern that detainees were not checked and roused as prescribed under PACE.<sup>10</sup> It found that the police did not accurately diagnose or respond to alcohol consumption and were not best placed to make decisions about the need for treatment. Overall, it concluded that vulnerable populations are not cared for adequately in police custody and that where a medical crisis occurs in this population, police officers do not have the support, resources, skills or training to provide the emergency interventions required.

Furthermore, healthcare professionals also need to be conscious that police may be relying on them for careful diagnosis, particularly where there is a need to distinguish between those factors, which might be attributed to a head injury and those to alcohol, in order to assist the police in terms of appropriate use of their custodial powers.

## Local context

Since 1998, both Hull Royal Infirmary and Humberside Ambulance Service NHS Trust have undergone mergers with other local NHS organisations. In 1999, the Hull Royal Infirmary, which formed part of Royal Hull Hospitals NHS Trust merged with East Yorkshire Hospitals NHS Trust to form the Hull and East Yorkshire Hospitals NHS Trust.<sup>11</sup> For the purpose of this report it will be referred to as Hull Royal Infirmary.

Humberside Ambulance Service NHS Trust merged in 1999, with Cleveland and North Yorkshire Ambulance Service to form Tees, East and North Yorkshire Ambulance Service NHS Trust.<sup>12</sup> For the purpose of this report it will be referred to as Humberside Ambulance Service NHS Trust.

In 1998, Royal Hull Hospitals NHS Trust, which includes Hull Royal Infirmary operated from four hospital sites. The trust served a population of over half a million people in Hull and East Riding of Yorkshire, and employed 4,200 staff.<sup>13</sup>

Humberside Ambulance Service NHS Trust was established on April 1<sup>st</sup> 1993. The service operated from 12 ambulance stations providing accident and emergency

10 Dr D Best, Amakai Kefas, *The role of alcohol in police-related deaths. Analysis of deaths in custody (Category 3) between 2000 and 2001*. Police Complaints Authority 2004 p.8.

11 CHI Clinical Governance Review Report Hull and East Yorkshire NHS Trust 2001

12 CHI Clinical Governance Review Report Tees, East and North Yorkshire Ambulance Service NHS Trust 2003

13 Royal Hull Hospitals NHS Trust Annual Report 1998/1999

services and non-emergency transport services for Hull and East Riding of Yorkshire. The ambulance service covered an area of 965 square miles with a population of 600,000. In 1998 the trust employed 359 staff.<sup>14</sup>

Humberside Ambulance Service NHS Trust merged in 1999 to become Tees, East and North Yorkshire Ambulance Service NHS Trust, which now provides emergency services and non-emergency patient transport services to a local population of two million. They have a collaborative arrangement with West Yorkshire Metropolitan Ambulance Service NHS Trust, and some executives have responsibilities in both organisations.<sup>15</sup> Both trusts report to the North and East Yorkshire and Lincolnshire Strategic Health Authority.

The local population for whom both trusts provide services has a low number of people from minority ethnic communities compared to the national average.

14 Humberside Ambulance Service NHS Trust Annual Report 1996/1997, 1997/1998 and The Right Response ( a consultation document on the proposed merger)

15 CHI Clinical Governance Review Report Tees East and North Yorkshire Ambulance Service NHS Trust 2003

### 3 Clinical factors and clinical records

In conducting its investigation, the Healthcare Commission reviewed the clinical records completed by nursing, medical and ambulance staff who treated Christopher Alder.

The Commission also reviewed previous medical reports prepared for previous inquiries into the death of Christopher Alder.

Four post mortems were carried out on Christopher Alder and the Commission has reviewed the post mortem reports. The post mortems were unable to establish a definitive cause of death, although they agreed that several factors contributed to his death including: alcoholic intoxication, assault and postural asphyxia.

The Healthcare Commission appointed three clinical advisers: a former senior manager in the ambulance service who worked as a paramedic and has extensive experience in training paramedics; a senior nurse with over 20 years' experience working in accident and emergency and a consultant in A&E medicine who is the leading clinician for the management of head injuries, chairman of a paramedic liaison committee and is involved in training, examining and recruiting paramedics. The comments and conclusions of the clinical advisers are incorporated into the findings and conclusions of the Healthcare Commission.

During the assault outside the Waterfront nightclub, Christopher Alder hit his head on the ground resulting in a laceration to the back of his head. He also sustained a laceration to his lower lip and one of his teeth fell out. Prior to the assault, he had been at the Waterfront nightclub where he had been drinking alcohol. The table on the following page sets out the typical signs and symptoms of a person suffering a head injury and the behaviour that a person who has ingested alcohol may exhibit.

As indicated in the table there are some similarities in the condition of someone suffering from a head injury and someone who has ingested alcohol. As a result, it may be difficult to distinguish between the two. If a person attends A&E with a possible head injury and has also ingested alcohol, it is extremely difficult to apportion changes in behaviour to one or the other.

Christopher Alder's behaviour was described as being aggressive, confused and agitated. It was also unclear if he had lost consciousness for a period of time. Based on the information in the table, his behaviour could have been attributed to trauma or alcohol consumption.



Clinical features of brain injury	Clinical features of alcohol intoxication
History of trauma	History of alcohol consumption
<p><b>1. Features of cerebral irritation, which can be grouped together as follows:</b></p> <ul style="list-style-type: none"> <li>a. disturbance of level of consciousness</li> <li>b. disturbance in speech</li> <li>c. disturbance in ability to perform simple motor function</li> <li>d. eye changes/capillary changes</li> <li>e. localising stroke signs of paralysis</li> <li>f. photo-phobia and neck stiffness</li> </ul> <p><b>2. Changes in behaviour:</b></p> <ul style="list-style-type: none"> <li>a. no response</li> <li>b. vomiting</li> <li>c. aggressive behaviour</li> <li>d. inappropriate behaviour</li> </ul>	<p><b>1. Obvious confirmation of intake of alcohol either from smell or breath.</b></p> <ul style="list-style-type: none"> <li>a. vomiting</li> <li>b. abnormal behaviour ranging from confused, irritable, aggressive and belligerent</li> <li>c. impairment of speech ranging from slurred speech to inappropriate words</li> </ul> <p><b>2. Impairment of function ranging from normal gait, to various abnormalities of gait, to loss of balance</b></p>

Source: Mr Sambasiven Shankar – Consultant in accident and emergency medicine, Clinical Adviser to the Healthcare Commission, May 2005

## 4 Care at the Waterfront nightclub (including the journey to and arrival at A&E)

On the evening of March 31<sup>st</sup> 1998, Christopher Alder, a 37 year old man born in Hull (of Nigerian parents) attended the Waterfront nightclub, where, during the evening, he drank alcohol. He was approximately 5.6 feet tall with a muscular physique.

During the evening, Christopher Alder and another man had a slight altercation, which resulted in the other man being asked to leave the club. Christopher Alder later left the club just after 2am and was walking to his home, when he was intercepted by a man who had earlier been in the nightclub. Christopher Alder and the man discussed the incident that had occurred earlier in the nightclub and shook hands. However, other people intervened and a fight broke out. Christopher Alder is shown on CCTV footage taken outside the nightclub removing his jumper leaving him naked from the waist up.

Christopher Alder was punched in the face, and fell to the ground, hitting the back of his head on the cobbled street. He is believed to have been unconscious for a short period of time, although accounts of witnesses vary in the length of time from not at all to a couple of minutes. Staff at the nightclub called for an ambulance. For more detailed information about the events leading up to the assault of Christopher Alder please refer to the IPCC's review into the death of Christopher Alder.

Ambulance person 1, who is a qualified ambulance technician, recorded in an undated 'aide memoire' written shortly after the death of Christopher Alder, that she and another paramedic, ambulance person 2, received an emergency call to an assault outside the Waterfront nightclub. Ambulance person 1 was driving and ambulance person 2 attended. They arrived at the scene at 2.29am and found Christopher Alder lying on the ground surrounded by security staff from the club and onlookers. Ambulance person 2 (a qualified paramedic) said in his statement dated April 4<sup>th</sup> 1998, that he saw a group of eight or nine people surrounding a "coloured"(sic) male lying on his right side on the ground about 10 to 12 feet from the club's premises. As he approached he could see blood on the ground and around the mouth of the patient. Ambulance person 2 spoke to Christopher Alder who replied "my teeth". Ambulance person 2 observed that Christopher Alder had a large lump or swelling to the back of his head just below the crown and the skin appeared to be broken. Ambulance person 1 said that it was the size of a "boiled egg, about 3x4cm" and that Christopher Alder kept spitting out a mixture of blood and saliva. In his supplemental statement of July 7<sup>th</sup> 2000, ambulance person 2 recalled that someone at the scene told him that Christopher Alder had been unconscious, but he was conscious by the time ambulance person 2 reached him. Ambulance person 2 said that he recorded "unconscious ? time" in the trauma column of the patient record form because he did not know the length of time Christopher Alder had been unconscious.

Ambulance person 2 explained during his interview with the Healthcare Commission that he had been concerned to get Christopher Alder into the ambulance as swiftly as possible to remove him from any further risk of harm. He understood that Christopher Alder had been assaulted and was concerned that the perpetrator might still be present. He did not ask for any additional information from bystanders as he felt he was unlikely to receive a coherent or consistent account from people who had clearly been drinking.

Christopher Alder said that he was not in pain and was able to stand. He was assisted to his feet by ambulance person 2 and ambulance person 1 who then escorted him to the ambulance. Ambulance person 2 said that Christopher Alder walked slowly and normally. Ambulance person 1 said that he was unsteady as he got to his feet. As they got to the rear of the ambulance, Christopher Alder turned to address the club staff and said, "what the fucking hell's happened". Someone replied that he had been hit. Christopher Alder's exchanges were described as slightly heated.

Ambulance person 2 records that Christopher Alder began to get a bit aggressive, raising his voice and flaying his arms in a gesticulating manner. Ambulance person 1 records that he seemed confused and that when they tried to ascertain his medical history he seemed bewildered and disorientated and did not seem to know what had happened. His mood seemed to swing from accepting help from the ambulance staff to resisting their help. Christopher Alder kept walking away from the ambulance towards the crowd but the ambulance staff persuaded him to remain. As Christopher Alder stepped up into the ambulance his right leg buckled, causing him to stumble. At one point his arm moved backwards. Ambulance person 1 described it as having lashed out as it caught ambulance person 1 across her chest knocking her backwards. Both ambulance person 2 and ambulance person 1 agreed at the coroner's inquest and during their interview with the Healthcare Commission that they did not think it had been done deliberately.

Ambulance person 1 said that Christopher Alder remained uncooperative and refused oxygen therapy. He smelt of alcohol and his speech was impaired, although that might have been due to his oral injuries. The ambulance crew persuaded him to lie on a stretcher, where he remained until he reached the hospital. The ambulance left the Waterfront nightclub at 2.37am.

Ambulance person 1 said that ambulance person 2 stayed in the back of the ambulance but did not conduct any further observations "due to his [Christopher Alder's] aggressive demeanour and we did not want to agitate or antagonise him in any way". Ambulance person 1 watched Christopher Alder through her rear mirror "due to Chris' violent nature". The patient told ambulance person 2 his surname and seemed to develop a rapport with ambulance person 2 as they discussed having both served in the army.

Ambulance person 2 recorded on the patient report form that they had been unable to record any observations or give any treatment to Christopher Alder because of his "violent nature" yet in his interview with the police on April 4<sup>th</sup> 1998, ambulance person 2 said that "at no point in my company at the scene was the patient abusive, uncooperative or violent towards anyone".

Ambulance person 2 said that he placed an oxygen mask on Christopher Alder's face. Ambulance person 1 said that he refused oxygen therapy and that is recorded on the patient record sheet. Ambulance person 2 explained during his interview with the Healthcare Commission that Christopher Alder had accepted the mask initially, but later removed it from his face. It remained just below his chin and so continued to increase the flow of oxygen to Christopher Alder. At one point Christopher Alder "grabbed hold" of both of ambulance person 2's hands and ambulance person 2 believed he did that "for assurance and comfort".

The ambulance arrived at Hull Royal Infirmary at 2.44am. Ambulance person 2 removed the oxygen mask and took Christopher Alder, who was still lying on the stretcher, out of the ambulance. Ambulance person 2 and ambulance person 1 wheeled the patient into the handover area in A&E. Ambulance person 2 asked Christopher Alder, in the presence of a hospital porter, to move across to another trolley. Christopher Alder became agitated. He did not refuse to move across but he raised his voice at those around him. He said loudly, "where am I?" and "what's happened?" and appeared confused. He was persuaded to move across to another trolley and then calmed down. He was then wheeled into a hospital bay. Ambulance person 1 said in her statement of April 4<sup>th</sup> 1998 that she was near the reception desk and asked a female police officer who was there on unrelated business to go to the medical bay as Christopher Alder was "being unruly, aggressive and uncooperative as [she] was concerned for the medical staff". Prior to leaving the hospital, ambulance person 1 observed two male uniformed police officers, whom she had seen earlier at the Waterfront nightclub, and a male security officer going to the treatment area where Christopher Alder was being treated.

Ambulance person 2 said in his statement of April 4<sup>th</sup> 1998, that he went to the work area to hand the patient over to the hospital staff and at that point could no longer see Christopher Alder. After a short while, he could hear Christopher Alder's raised voice and advised staff that perhaps another nurse should attend in case he became aggressive.

Ambulance person 2 went to get a drink and about 10 minutes later, rejoined ambulance person 1. They left the hospital at 3.15am.

At a recent interview with the Healthcare Commission, ambulance person 2 stated that if he had been told that Christopher Alder had been unconscious for any period, he would have treated him differently. He would have used a stretcher to transfer him to the ambulance. He also acknowledged that although he told the nursing staff all the relevant information, he did not maintain adequate records of his assessment, care and treatment. When invited to reflect whether any improvements might have been made ambulance person 1 said that she was fully satisfied with the quality of care provided at the time and would not do anything differently now. She acknowledged it would have been better to have used a spinal board or a neck collar.<sup>16</sup>

16 Ambulance person 1 did not think they had a spinal board at the time and ambulance person 2 was uncertain if they did. Ambulance person 1 thought it would have been difficult to use the collar on an uncooperative patient.

At the coroner's inquest, ambulance person 2 explained that the term "violent" was open-ended and that Christopher Alder had not been violent towards him or ambulance person 1. Ambulance person 2 explained during his interview with the Healthcare Commission that it was Christopher Alder's potential to be violent which concerned him, as experience had taught him that people with head injuries and those who had been drinking alcohol could become aggressive. Ambulance person 2 was concerned for the safety of the staff in A&E who were predominantly female and felt bound to protect them. Therefore, he told them to be careful as a precaution rather than because Christopher Alder had been violent. Both ambulance person 2 and ambulance person 1 agreed that they involved the police simply because the police happened to have been there and they would not have called them otherwise.

During her interview with the Healthcare Commission, ambulance person 1 said that she would now describe Christopher Alder's behaviour as uncooperative, rather than violent. At the coroner's inquest she said that when she told staff Christopher Alder had been "unruly and uncooperative", she meant that she observed him spitting on the floor in the hospital rather than using a bowl and "aggression" referred to his angry demeanour. She said at the inquest that she had suggested the police assist, because she knew that Christopher Alder was angry and was concerned that he might want to find the person responsible for assaulting him and "sort it out".

## **Summary conclusions on the care provided by the ambulance crew at the Waterfront nightclub**

Ambulance crews are trained to treat and respond on the assumption that the patient's condition was as bad as it could be. Whilst acknowledging the crew's desire to move Christopher Alder to a safe place quickly, it is concluded that the crew did not obtain sufficient information about the history of events at the Waterfront nightclub, or conduct a detailed examination and that this was not in accordance with the protocols that they were working under.

The crew should have taken the necessary equipment with them when they left the ambulance in readiness to treat Christopher Alder. For example they should have been able to administer oxygen immediately. If they had adhered to their protocols this would have led them to actively assess if it was appropriate to use a spinal board and collar to immobilise Christopher Alder and therefore the need to move him to the ambulance via a stretcher. The Health Commission's advisers are critical of the ambulance staff's failure to maintain adequate written records of the care and treatment they provided to Christopher Alder.

## 5 Care and treatment at Hull Royal Infirmary

Christopher Alder was received by staff at the A&E department at approximately 2.45am on April 1<sup>st</sup> 1998.

Two senior house officers were on duty on April 1<sup>st</sup> 1998, Doctor A and Doctor B. Doctor A was a locum senior house officer who had previously worked in the A&E department at Hull Royal Infirmary. There was also a specialist registrar on call in the hospital and a consultant on call from home. Three staff nurses were on duty: staff nurse A, staff nurse B and staff nurse C. Staff nurse C was the nurse in charge of the shift.

There were two police officers in the department when Christopher Alder arrived, but they were there on an unrelated matter.

The A&E department is divided into two areas: one dealing with major incidents and one dealing with minor incidents. Patients brought in by ambulance are normally admitted to the majors area, and patients who walk into the department are normally allocated to the minors areas. Allocations to the two areas are not fixed and following assessment by nursing or medical staff or a change in their condition, patients can be transferred between areas. On the night that Christopher Alder was brought into A&E staff nurse B described the department as being "fairly quiet". There were four patients with non-serious injuries, which was an unusually low number for the A&E department.

### Handover

The ambulance crew entered the A&E department via the doors to the left of the reception area and staff nurse B observed the crew trying to persuade Christopher Alder to move from the stretcher to the trolley. The ambulance crew experienced some difficulty transferring Christopher Alder and staff nurse B believed this was because he appeared confused and didn't understand why they wanted him to move.

Ambulance person 2 describes Christopher Alder as being confused and he was asking "where am I?" and "what's happened?". In his interview with the Healthcare Commission, ambulance person 2 describes Christopher Alder as being "agitated" and said that he tried to calm him down. Once on the trolley, Christopher Alder began swearing, and asking "where am I?, what am I doing?".

Staff nurse B greeted the ambulance crew and went into the cubicle area with Christopher Alder.

Ambulance person 2 told staff nurse B the patient's name was Christopher Alder, that he had been assaulted outside the Waterfront nightclub and had a swelling at the back of his head. It is unclear if he told her that they were unsure if Christopher Alder had

lost consciousness, as this is not recorded on the triage form. Staff nurse B also observed that Christopher Alder had a laceration to his upper lip, an upper tooth was missing and an adjacent tooth was pushed forward. Christopher Alder began to spit blood and saliva on the floor, so staff nurse B gave him a bowl to use. Although staff nurse B observed the injuries, in the section titled 'Injuries' on the triage form she has written "head face", there is no description of the injuries. The triage form contains very little information about the assault, the only other detailed information is that Christopher Alder was transferred from the Waterfront nightclub.

Staff nurse A went to assist staff nurse B, and received details of the injury from ambulance person 2, while staff nurse B attended to Christopher Alder. This handover took place in the corridor outside the cubicle.

Staff nurse B recalls ambulance person 2 saying "Christopher was assaulted outside the Waterfront and he hit his head on the ground". In her statement of April 9<sup>th</sup> 1998, staff nurse A said that she went to cubicle eight to see if she could help but it does not say if she passed on any information to staff nurse B.

During her interview with the Healthcare Commission staff nurse C, who was the nurse in charge of the shift when Christopher Alder was admitted, said that at the beginning of each shift nursing staff are allocated different responsibilities but as the department was quiet they assisted as required.

Although ambulance person 2 gave the details of Christopher Alder's injuries to staff nurse A, he states in his statement on April 4<sup>th</sup> 1998 that he formally handed over responsibility for Christopher Alder to staff nurse C.

## Triage

Ambulance person 2 told staff nurse A that he "believed the patient had been assaulted" and she recorded this on the triage form. There is nothing recorded on the triage form about whether or not Christopher Alder lost consciousness. The patient report from the ambulance (a copy of which is always given to A&E) included information about Christopher Alder's head injury, and indicated that the ambulance crew were unsure if he had lost consciousness. Staff nurse A did not allocate a triage category, although in this case it was irrelevant as Christopher Alder was seen almost immediately and taken to the majors area because of his head injury.

## Assessment by nurses

Staff nurse B attempted to help Christopher Alder to put a hospital gown on, but she describes him as being uncooperative, and was only able to help him remove his jumper. He sat up on the trolley and this enabled her to observe the haematoma (lump) at the back of his head.

Staff nurse B intended to carry out an initial assessment of Christopher Alder, including recording his blood pressure, pulse, respiratory rate, temperature, blood sugar and alcohol level and neurological observations. While she was explaining this

to him Christopher Alder threw the bowl on the floor, spat in her direction and began to swear and tell her to leave him alone. Staff nurse B returned the bowl to Christopher Alder who threw it at her again, hitting her leg. At this stage staff nurse B became concerned about her safety and informed staff nurse C of her concerns and asked for her assistance.

Staff nurse C went into the cubicle and took over the care of Christopher Alder. Staff nurse B did not enter the cubicle again but could hear Christopher Alder swearing at staff nurse C. During her interview with the Healthcare Commission staff nurse B told us that she felt fearful of Christopher Alder, and was unable to calm him down. This was why she passed his care over to staff nurse C. She also said that Christopher Alder did not want to stay in the department.

Staff nurse C's first impression of Christopher Alder was that he was "drunk and aggressive", and that he was spitting blood and saliva over the side of the trolley. During her interview with the Healthcare Commission, staff nurse C said that she was told by a member of the nursing staff that he had been assaulted, that she was unable to remember which member of staff it was, but did not get the history of the assault and is unsure if she was told that he hit his head on the ground. Staff nurse C observed that Christopher Alder had facial injuries and a haematoma (lump) at the back of his head.

Staff nurse C explained they were there to help him. Christopher Alder started to talk about a (previous) injury to his shoulder, but staff nurse C was unable to get him to elaborate on this.

Staff nurse C did not ask for a history of Christopher Alder's injuries from the ambulance crew, but ambulance person 2 took her to one side and told her that Christopher Alder had been abusive while he was in the ambulance. While he was doing this, ambulance person 1 alerted the police officers (who were already present in the department for unrelated reasons) and they went into the cubicle. They were joined by a security guard, security person A, and remained in the background while staff nurse C carried out an assessment of Christopher Alder's injuries. The security guard developed a rapport with Christopher Alder, who then became calm. The police officers left the cubicle.

Once the police had left the cubicle Christopher Alder began to swear, and spit blood, refusing to use a bowl. He also complained that his head hurt and said that he was tired. The security guard offered to help, and staff nurse C was able to obtain recordings of Christopher Alder's blood pressure, pulse and assess that both pupils were equal and reacting to light. Staff nurse C also completed the neurological observation chart, recording that his eyes were open spontaneously, his verbal responses were confused and that he was obeying commands i.e. able to move his arms and legs. These recordings were collated and Christopher Alder was assessed as having a Glasgow coma scale of 14 (the scale for assessing level of consciousness. A score of 14 is one score down from the maximum level of consciousness).

Staff nurse C described his behaviour as becoming "more aggressive" and she was unable to carry out the alcometer test (blood alcohol recording). During her interview



with the Healthcare Commission, staff nurse C said that at this stage it would be difficult to say if Christopher Alder's behaviour could be attributed to drink. She said that she thought that she could smell alcohol although they had been unable to carry out the alcometer test (blood alcohol recording). Staff nurse C acknowledged that Christopher Alder's head injury could have been a factor contributing to his behaviour.

## Medical assessment

Doctor A was in the general work area of the A&E department and answered a telephone call for staff nurse C, who was in Christopher Alder's cubicle. He went to inform her of the telephone call and took the opportunity to treat Christopher Alder.

Patients are normally seen in the order in which they arrive in A&E, unless the nursing staff request the attention of a doctor for complex or serious cases.

Doctor A returned to the work station and obtained Christopher Alder's A&E card, triage document and ambulance patient report form. Recorded on the A&E card were the observations taken by staff nurse C and the information, which included that he had possibly suffered a period of unconsciousness, from the ambulance crew who transferred him from the Waterfront nightclub.

In her interview with the Healthcare Commission, staff nurse C said she could not remember who handed responsibility over to doctor A, although she feels she would have had some discussion with him about Christopher Alder's history. She was unable to be more specific.

Doctor A's impression of Christopher Alder was that he was drunk, had suffered facial and head injuries and was being abusive. In his interview with the Healthcare Commission, doctor A said he reached the conclusion that Christopher Alder was drunk because he could "smell alcohol on his breath, his behaviour, the time of night and where the assault took place".

Doctor A approached Christopher Alder and began to ask him about what had happened to him. Christopher Alder began to swear and spit at him, so doctor A gave him some gauze to spit into and introduced himself. Doctor A persevered in asking Christopher Alder questions despite his abuse. Christopher Alder told doctor A his name and that he had been assaulted. He confirmed that he had been drinking but denied taking any drugs such as cocaine or heroin. Doctor A asked Christopher Alder if he could remember "everything before and after the assault" and Christopher Alder replied "yes". Doctor A also asked Christopher Alder if he had lost consciousness, to which he said "I can't remember". Doctor A said that Christopher Alder was concerned about his teeth and the lump at the back of his head. Christopher Alder also said this had happened to him before and he knew who had done it.

Doctor A decided that Christopher Alder had a good recollection of events except for whether or not he had lost consciousness. In view of this, and because he had consumed alcohol, doctor A felt Christopher Alder should have a skull x-ray. Because

of Christopher Alder's aggressive demeanour, doctor A refrained from making notes while he questioned him. His usual practice is to record the responses of patients as they answer his questions.

Christopher Alder agreed to doctor A's examining him. Doctor A examined his eyes, forehead, skull, face, mouth, abdomen and limbs and listened to chest sounds. He noted that Christopher Alder had the following injuries:

- haematoma (a collection of blood within tissues that clots to form a solid swelling) at the rear of his head caused by impact but not consistent with a direct blow
- localised swelling to the area of the left side of his upper lip
- two wounds to the left side of his upper lip which were not bleeding
- front left canine tooth was knocked out and the tooth adjacent to it upon the left upper side was pushed into his mouth
- minimal bleeding from the tooth that was knocked out

Throughout the examination, doctor A explained to Christopher Alder what he was doing. In his statement on April 1<sup>st</sup> 1998, doctor A said "there was some doubt in his history as to whether or not he had lost consciousness, at least that is what he told me".

Doctor A told Christopher Alder that he did not think his injuries appeared serious and that they would refer him to a maxillo-facial surgeon regarding the injury to his teeth and that he needed a skull x-ray. By this stage doctor A had developed a rapport with Christopher Alder who continued to swear, but had calmed down.

Doctor A left the cubicle and recorded the examination and treatment plan on the casualty card. In the patient assessment form doctor A has recorded that Christopher Alder was "possibly assaulted" and "possibly lost consciousness". He also documents a plan of care for Christopher Alder including: skull x-ray, mandible x-ray, sutures to his mouth wound and admission to the short stay ward. Doctor A also generated a computer x-ray request form.

During this time, two police officers (not the same police officers who were initially in A&E) who had been at the Waterfront nightclub entered the cubicle to give Christopher Alder a log number to use should he wish to file a complaint in relation to the assault that had taken place. Staff nurse C asked them to wait while she attempted to carry out the alcometer test on Christopher Alder. Christopher Alder agreed to the test and staff nurse C obtained a reading of 190 mg/dl, which is high (approximately twice the normal drink/drive level). This reading was then converted into a blood/alcohol reading.

Staff nurse C believed that one of the police officers witnessed the reading. When asked about this in her interview with the Healthcare Commission, she said that the alcometer reading would not have been shared with the police, as staff have to go to a different area to convert the reading to a blood alcohol level. However on the basis of interviews with the police it seems likely that this information was shared with them.

Although the police and security guard were in the cubicle, they stayed in the background in order to keep the atmosphere calm.

When doctor A returned to the cubicle Christopher Alder had climbed off the trolley and was swearing and spitting. Doctor A managed to persuade him to get back on the trolley, although Christopher Alder continued to say that he didn't want to stay, he wanted to go home.

Staff nurse C said that it was not unusual to have police present in A&E. If they needed help they would radio up to the control room to summon them, or, if they were required urgently, nursing staff would ring 999. When Christopher Alder was first admitted staff nurse C felt that his behaviour did not warrant them calling the police. However, she felt they would have called them subsequently, as his behaviour became more aggressive. Staff nurse C is not aware of any guidelines about the role of the police in the A&E department.

Doctor A believed Christopher Alder was under arrest because two police officers were present when he first met him. During his interview with the Healthcare Commission, doctor A said that he did not seek to clarify why the police officers were in the cubicle as it would not have affected the care Christopher Alder received from him.

Doctor A felt he had developed a good rapport with Christopher Alder and he did not feel threatened by him.

## Assessment/treatment by the radiographer

Transferring patients to and from the x-ray department is normally done by the porters, but in this instance doctor A decided he would escort Christopher Alder to have his x-ray to maintain continuity of care and he was anxious "that another face would not have benefited his treatment".

Staff nurse C assisted doctor A with pushing the trolley round to the x-ray department. Doctor A asked the police and security guard to follow but to remain at a distance.

As he was being wheeled to the x-ray department Christopher Alder was quiet. However on arrival at the x-ray department he began to swear again and said he did not want to be there. Doctor A thought the abuse was directed towards staff nurse C. Christopher Alder momentarily settled and apologised to staff nurse C.

Radiographer A was the radiographer on duty on April 1<sup>st</sup> 1998. Doctor A entered the office of x-ray room one and gave radiographer A the x-ray form, saying he intended to stay because he thought she may need some assistance.

Radiographer A knew that Christopher Alder had a head injury (this was indicated on the x-ray request form) and that he had been at the Waterfront nightclub. She said that he could have been drunk because he had been at the nightclub and it was in the early hours of the morning.

Radiographer A and doctor A went into the x-ray area and radiographer A observed that Christopher Alder was lying on his right side, while staff nurse C was explaining the procedure to him. The police officers waited outside.

Doctor A had requested an x-ray of Christopher Alder's skull and jaw, and in order for the x-rays to be taken, Christopher Alder had to lie on his back and remain still. Staff nurse C, radiographer A and doctor A all asked him to do this and he responded by swearing at them. At one point he did lie on his back, but as soon as radiographer A said "lets do the x-rays" he turned and lay on his front.

Christopher Alder was asked to lie on his back again and he refused. At this point he knelt on the trolley (the safety rails were in place) and threw the blanket on the floor. He also indicated that he wanted to urinate.

Doctor A felt that Christopher Alder was becoming more uncooperative and he began to feel uncomfortable as Christopher Alder moved across the trolley and began to point at doctor A's face.

Staff nurse C also said that when Christopher Alder knelt on the trolley, "he was towering over them", which made him seem quite threatening.

Radiographer A said that Christopher Alder stared at her "menacingly" and she stepped away from him. He began to swing his arms around and spat on the trolley and at doctor A. Doctor A asked him to stop spitting.

At this point radiographer A felt that Christopher Alder was too uncooperative for them to obtain the x-rays and suggested that he return later when he was calmer. She asked if he was going to the short stay ward and doctor A said he felt he was too aggressive to be managed there and that he would probably go with the police as all attempts to treat Christopher Alder had failed.

They agreed that Christopher Alder should be taken back to A&E so that he could go to the toilet. On being told this by doctor A, Christopher Alder said he wanted to go to the toilet and got off the trolley.

Christopher Alder walked into the corridor outside the x-ray room. Before he left, doctor A made one last attempt to try and persuade him to have the x-rays.

Staff nurse C left the room to get a urine bottle for Christopher Alder and when she returned he had left the room and was standing by the service lift (approximately 20 feet away) with the police officers either side of him. They agreed to escort him to the toilet and staff nurse C showed them the way. As he walked to the toilets, Christopher Alder was swearing and the police officers asked him to calm down and threatened to use CS spray. Doctor A also said that he could hear Christopher Alder being abusive as he was being escorted to the toilets by the police. Doctor A followed them to the toilets and saw the police officers waiting outside while Christopher Alder was inside. He could see Christopher Alder urinating on the floor. Doctor A recalls Christopher Alder threatening the police, saying "he would take them on" and he heard the police mention the possibility of using CS spray to control his behaviour.

When asked if the police thought they could use CS spray in A&E, staff nurse C said she assumed they believed they could use it, but if they had attempted to, she would have prevented it.

## Decision to discharge

Doctor A was joined by staff nurse C in the corridor and they discussed Christopher Alder's medical management. The initial plan of care was to admit him to the short stay ward for observation, "Needs admission to SSW" is recorded on the casualty card. Both doctor A and staff nurse C agreed that, although they would have preferred him to stay in the short stay ward, "this was highly unlikely in the circumstance due to his drunk and disorderly manner". Although doctor A had some concerns about discharging Christopher Alder "in view of his injuries which could have been quite severe", he felt it was better for the police to take him away because he was being "abusive and dangerous to staff".

During his interview with the Healthcare Commission, doctor A said it was not unusual to admit patients like Christopher Alder to the short stay ward and nurse them in a side room. There were beds available on the short stay ward but they did not pursue this option because Christopher Alder's behaviour became more difficult to manage.

Staff nurse C, in her interview with the Healthcare Commission, said it would have been difficult to keep Christopher Alder safe on the short stay ward, and although the department was quiet, if a seriously ill patient came in they would not have been able to cope with Christopher Alder. Staff would have struggled to keep Christopher Alder safe on the short stay ward without such facilities as a padded cell and although the department was quiet at the time, the workload in A&E is unpredictable. Ideally, doctor A said that he would have liked to have x-rayed Christopher Alder's skull and sutured his wounds before he left the department.

When the decision to discharge Christopher Alder to the police was discussed with doctor A during his interview, he agreed that he could have sought advice from the specialist registrar who was on call. However, he didn't contact the on call specialist registrar because he didn't really consider that he was discharging Christopher Alder. He also assumed the police would bring him back once he had calmed down. Doctor A believed the police would have been aware of the signs of deterioration to look for in a patient with a head injury. He was not aware of any guidance in relation to handing patients, who still required treatment, over to the police.

Staff nurse C told the Healthcare Commission that she reached a joint decision with doctor A that they were unable to treat Christopher Alder in his present condition and she agreed with doctor A that he should be taken into police custody. They were unhappy about him going home alone, and believed that handing him over to the police was a safer option.

This decision was explored with staff nurse C in her interview with the Healthcare Commission, and she said that they were effectively using the police as a place of safety and expected Christopher Alder to return for treatment for his head and lip injuries. Their understanding was that the police were taking Christopher Alder into custody to calm him down. Staff nurse C also said that with hindsight, perhaps they should have contacted the specialist registrar on call.

Doctor A made one more attempt to reason with Christopher Alder, asking him to calm down and allow them to treat him. Christopher Alder refused saying he did not need their help. Doctor A told him that the police were going to take him away, but once he had calmed down the A&E staff would be willing to treat him. Doctor A documented in the patient assessment form that they were unable to perform the x-ray due to Christopher Alder being “abusive” and “spitting”. Doctor A also documented that he told Christopher Alder to come back “when sober for treatment” and that he was “discharged care of police and TR when ready admit”.

The police officers expressed some concerns about taking Christopher Alder away not knowing if he had a fractured skull. Doctor A explained to them that although Christopher Alder had a haematoma (lump) at the back of his head, he did not think he had a fractured skull.

It is best practice to give cards with head injury advice, detailing signs of deterioration and what to do in the event of deterioration, to patients or family members when a patient is discharged following a head injury. Head injury advice cards were available. Staff nurse C confirmed that no written information about head injury was given to the police.

In his interview, doctor A said he believed the police were given some form of advice, but that he felt the police would know what signs to look for. Doctor C, Consultant in charge of the A&E department in 1998 told the Healthcare Commission that he expected the police officers would have known what signs to look for and would have brought Christopher Alder back to hospital if his condition had deteriorated.

During interviews, senior police officers from Humberside police said that it would be unlikely that police officers would know what signs of deterioration to look for in patients with head injuries and they would not have had any guidelines in the police station.

Christopher Alder was sitting on the floor in the A&E department complaining about what was happening to him, and staff nurse C gave him his jumper. The police then dragged him backwards by his arms out of the department.

Doctor A was under the impression that the police were taking Christopher Alder to the police station, but their subsequent actions indicate that they intended to release him. Once they were outside the A&E department, Christopher Alder stood up and began abusing the police officers. The police officers told him to go, but he refused. The police officers then approached him and put handcuffs on him, which he did not resist. A police van was called and Christopher Alder walked into the van. The police officers said he was under arrest for breach of the peace.

Christopher Alder climbed into the back of a police van and was driven to Queen’s Gardens Police Station. According to police statements, he travelled alone in the back of the van. The van was driven by a police officer and the two police officers who had been present throughout this time followed the van in a marked police car.

During his interview with the Healthcare Commission, doctor A said he would have been unhappy if he had known the police were going to let Christopher Alder go home by himself, as he did not think it was safe. That was why he had discharged him to the police.

At approximately 5.10am staff nurse C was notified by the police that Christopher Alder had died.

The senior nurse on duty notified doctor C, A&E consultant on call, of Christopher Alder's death. Doctor C went into the department and asked staff to document their memory of what had happened and advised them not to alter their notes. In his interview with the Healthcare Commission, doctor C, A&E consultant in 1998, said that no incident form was completed and a review of the care provided to Christopher Alder was not carried out, although doctor C believes that the staff were well supported following Christopher Alder's death. Staff nurse C believed that the senior team reviewed Christopher Alder's notes and that a meeting was held but she was not involved and she does not believe that there are any records of the meeting.

Following the death of Christopher Alder, one of his sisters met doctor C to express her concerns about his discharge. This was not documented as a formal complaint and it is unclear if she was informed about the complaints procedure. Staff have indicated that no complaint was recorded and there is no record that any senior managers met his sister to discuss her concerns.

## Summary conclusions on the care and treatment provided at Hull Royal Infirmary

Christopher Alder was difficult to manage in view of his unpredictable and erratic behaviour both on arrival and during his stay in the A&E. The nursing and medical staff tried to manage his behaviour despite frequent provocations. In addition, there was some confusion amongst the A&E staff about the reasons for the presence of the police in the A&E department. The A&E staff were also unsure about what powers the police could exercise in the A&E department and the police never sought to offer an explanation of why they were there or what powers they could exercise. However, there are a number of occasions on which their practice fell below the expected professional standards.

Having reviewed the written records both of the paramedics and nursing staff, it is agreed that both groups failed to make a comprehensive record of their assessment of Christopher Alder and the history of his assault. This resulted in the failure of key information being disseminated to all members of the multidisciplinary team.

There is very little information recorded on the triage form completed by staff nurse A and the form is not dated or signed. The patient report form completed by ambulance person 2 was incomplete and staff nurse A should have recorded the history of the injury and asked ambulance person 2 how, when and where the injury took place to establish the history of the injury. She should then have documented the response.

Three nurses were involved in the care of Christopher Alder resulting in a fragmented approach to his initial admission and assessment. It is unclear what information about Christopher Alder was shared verbally between the three nurses, as this was not

documented at the time. The documentation of the nursing management of Christopher Alder falls below the expected professional standards in place in 1998.<sup>17</sup>

There is no doubt that it was difficult to examine Christopher Alder, and doctor A managed the situation very well. However, he discharged him without having made a diagnosis and while he still required treatment.

Prior to discharge, it would have been good practice to record a set of observations (blood pressure, pulse, respirations, neurological recordings), although this may have been difficult due to Christopher Alder's behaviour.

Doctor A and staff nurse C jointly decided to discharge Christopher Alder. Doctor A was a locum doctor and staff nurse C in her role as senior nurse, and more experienced in working in the department, should have challenged this decision, advising him to contact the on call specialist registrar. Whether the on call specialist registrar would have agreed or disagreed to discharge Christopher Alder is another matter.

Doctor A was unsure whether Christopher Alder was under arrest and did not seek to clarify this. He discharged Christopher Alder into the care of the police, and although the police voiced some concern about this they agreed to take him knowing that, at this stage, there were no clear grounds for arresting him.

Although the police were often present in the A&E department, the absence of a joint working protocol resulted in staff being unclear about their role and function and what powers they were able to exercise. The fact that the police threatened to use CS spray in the A&E department demonstrates that they too, were unclear about their role and the extent of their powers in the A&E department.

17 Standards for Record Keeping, United Kingdom Central Council for Nursing, Midwifery and Health Visiting April 1993



## 6 Christopher Alder's collapse at Queen's Garden Police Station

The journey from Hull Royal Infirmary to the Queen's Garden Police Station took approximately five minutes. CCTV footage and the statements of police officers record that Christopher Alder reached the police station at 3.46am. On opening the van doors the police officers found Christopher Alder slumped in his seat. He did not move when they lifted him out and dragged him, face downwards, with his legs behind him and his arms handcuffed behind his back into the police station. He was laid face down on the floor, with his head turned to one side. His trousers and pants were down around his knees, exposing his bottom.

Christopher Alder made periodic, very loud, rasping sounds, which gradually slowed, with longer and longer periods between each sound. Police officers later explained that they thought he was asleep when they got him out of the back of the van and that the sounds were Christopher Alder snoring.

The custody officer expressed alarm about Christopher Alder's condition and questioned whether he should be returned to the hospital. The custody officer suggested that Christopher Alder should be placed in the recovery position, but no one did this.

The police officers told the custody officer that Christopher Alder was "acting" and that he had been fine when they left the hospital. They said that the hospital "would not have him" and explained the circumstances of his detention: that he had been aggressive toward hospital staff and towards them and that they had arrested him for a breach of the peace as he had refused to leave the hospital and go home. Statements of the police officers record that once Christopher Alder was outside the hospital, he asked to go back in but was prevented from doing so by the police.

A discussion then ensued about the possible justification for holding him, as any breach of peace had clearly passed. They occasionally glanced in Christopher Alder's direction. A police officer walked over to him to remove his handcuffs. Christopher Alder's arms remained in the same position, folded across his back. No effort was made to speak to Christopher Alder or to try to rouse him.

At no point did Christopher Alder make any movement other than breathing. At 3.56am the noises emitted by Christopher Alder stopped.

Shortly afterwards a police officer walked over to Christopher Alder, checked the pulse in his neck and with alarm announced that he was not breathing. Officers rolled Christopher Alder over, placing him in the recovery position, moved him again, and then commenced chest compressions. They brought a mask but did not successfully establish an airway. (The officer using the mask did not know initially which way up to hold it but was instructed by a female warden). An ambulance was called.

Previous clinical advisers' reports (prepared for the police, Christopher Alder's family and the coroner) generally agree to various extents that the police did not provide effective resuscitation. A senior police officer later confirmed, that at the time of the events, it was unlikely the police officers had received proper training in first aid and resuscitation. It is clear from the actions of the officers involved, which was recorded on CCTV footage, that they had some knowledge of the required procedures.

## Care provided at the police station

At 4.02am ambulance person 2 and ambulance person 1, the ambulance crew who had treated Christopher Alder at the Waterfront nightclub, received an emergency call to attend the Queen's Gardens Police Station. The information recorded on the terrafix system (a system for communicating with ambulance staff using data technology instead of voice technology) was "breathing difficulty", "patient query stopped breathing".

During his interview with the Healthcare Commission, ambulance person 2 explained that although the words "breathing difficulty" were relayed to them at the time, he said to ambulance person 1 "that it would probably be someone trying to pull a sickie to get out of appearing in court in the morning". Ambulance person 2 said that he regularly attended the police station and had only ever attended for minor incidents.

According to the ambulance service's records they arrived at 4.04am. Ambulance person 2 drove into the police yard through open gates to the rear of the custody room.

Ambulance person 2 parked close to the door and did not observe any vehicles blocking his path. An officer was standing in the corridor at the rear door waiting for them.

At approximately 4.05am ambulance person 1 went into the custody room, carrying a bag and mask (a rugby ball shaped inflatable bag which is attached to a face mask, it fits over the nose and mouth of a patient and is used for artificial ventilation). Ambulance person 2 followed her, but was not carrying any equipment. A police officer told ambulance person 1 that the patient was not breathing, had no pulse, and that resuscitation was in progress.

Ambulance person 1 was "very surprised" to see that the patient was Christopher Alder. She observed that Christopher Alder's pupils were fixed and dilated, he had no pulse and was not breathing.

CCTV footage recorded that Christopher Alder was lying in the custody room on his back, with his face upwards. He was wearing a jumper, but his trousers and underpants were down around his knees, exposing his genitals. Witnesses have provided no definitive reason for his trousers being down. It has been suggested that the action of dragging him along the corridor may have caused them to be pulled down. His pants were soiled and there has been no explanation provided as to why the police had not covered him. Ambulance person 1 told the Healthcare Commission that she thought it unusual but it was not her main concern.

Ambulance person 1 observed a male police officer with clasped hands, kneeling over Christopher Alder apparently performing chest compressions. No one was performing

artificial respiration (breathing into his mouth whilst holding his nose closed so that air entered his lungs, allowing oxygen from the chest compressions to reach his brain). She saw a blood stained resuscitation mask on the desk. Ambulance person 1 immediately exclaimed "it's Chris" and recalled that "he had been assaulted outside the Waterfront".

The ambulance crew tried to revive Christopher Alder for almost 40 minutes but were unable to do so (at the subsequent inquest it was recorded that Mr Alder died between 3:41am and 4am on 1<sup>st</sup> April 1998). Ambulance person 1 commented in her statement that protocols permitted them to cease resuscitation after 10 minutes but in the circumstances, they chose to continue trying.<sup>18</sup> Once all attempts at resuscitation had ceased, ambulance person 1 was instructed to leave things as they were as the police declared the area a crime scene.

When interviewed by the Healthcare Commission, ambulance person 2 provided the following explanations. Asked whether the fact that he entered the police station without carrying equipment was in line with protocol, he replied that crews would assess the situation and decide what equipment they needed. They would base their decisions on experience.

When he saw Christopher Alder being given chest compressions he returned to collect equipment from the ambulance, which was 40 seconds away. He said he had been "shocked" to see someone collapsed inside a police station who, an hour and a half earlier, had been taken to hospital. It was an unusual coincidence to treat the same patient twice in one night.

Ambulance person 2 confirmed that he was content with the cardiopulmonary resuscitation (CPR) being provided by the police officer and ambulance person 1. He had tried to intubate Christopher Alder but found it hard (this is recorded on the patient report form). However, he was satisfied that "the basics" were being covered, i.e. CPR.

The electrocardiogram reading initially showed an asystolic reading (no electrical rhythm which is required for the heart to pump blood around the body) but then changed to an EMD (electro-mechanical dissociation which is the presence of an electrical rhythm but no mechanical cardiac output i.e. the heart is not pumping blood around the body)<sup>18</sup>. He acknowledged that this condition is more likely to be reversible. The Healthcare Commission has been unable to obtain a copy of the print out from the cardiac monitor and when asked at interview, ambulance person 2 was unable to tell the Healthcare Commission what has happened to the print out from the cardiac monitor. Ambulance person 2 explained that he had decided to stay and provide treatment at the scene, rather than quickly transporting Christopher Alder to hospital. This was because he knew that Christopher Alder's airway was not secure and did not think they would have been able to maintain adequate CPR whilst carrying him out to the ambulance. Due to the layout of the police station (with which he was familiar) they would have had to use a wheelchair, rather than a trolley. He agreed that he was required by the resuscitation protocol to consider transport but he felt it would have taken too long. Ambulance person 2 believed that he provided treatment in accordance with the relevant protocols.

18 This is in line with the protocol for asystole (no electrical rhythm in the heart), however the protocol for electro mechanical disassociation states that they should consider transferring the patient to hospital.

Ambulance person 2 also said that although it was not a conscious decision, he had not included details of his first attendance on Christopher Alder on the second patient report form because he knew the case would go to the coroner's court following the death of the patient and "that both incidents were separate and had been documented as such".

He confirmed that no member of the ambulance trust approached him about the incident (there was no internal investigation) but knowing that the coroner would be involved, he and ambulance person 1 made handwritten notes as soon as was practical.

Ambulance person 2 explained that the same clinical procedures that he employed then were still used within the ambulance trust. Each call is assessed on its own merits and the decision to 'load and go or stay and play' is assessed in the same way. He was aware that the trust was planning to implement the Joint Royal Colleges Ambulance Liaison Committee's guidelines in April 2005.

During his interview with the Healthcare Commission, ambulance person 2 was reminded that the CCTV footage shows the ambulance crew being told when they arrived at the police station that Christopher Alder had been down for five minutes. Ambulance person 2 said that if he had known that Christopher Alder had collapsed 20 minutes earlier at the police station, he would have approached the case differently. Different questions would have been asked on arrival at the police station and different protocols followed.

Ambulance person 1 said that she did not know why Christopher Alder was on the floor and did not make any assumptions. The police did not give them any relevant information. They treated what they saw.

Ambulance person 1 thought the "job had gone smoothly" and was content with the way that they had approached the resuscitation. She confirmed that it was the responsibility of ambulance person 2 as the senior member of staff to lead and decide whether to stay or go to the hospital.

## **Summary conclusions on the care and treatment provided by the ambulance crew at Queen's Garden Police Station**

The Healthcare Commission, whilst fully satisfied that the decisions and actions of ambulance person 2 were made in good faith and with integrity, have concluded that they were flawed. From the information obtained during interviews, it is clear that ambulance person 2 did not expect events to be so serious and that he was not prepared for the situation he found at the police station. There were a number of significant factors known to the ambulance crew (and some which should have been ascertained) that dictated the absolute need to return Christopher Alder immediately to hospital for further and more senior medical intervention. The ambulance crew asked relatively few questions and did not ascertain a sufficient history or make adequate clinical links with events earlier that day. Although they were two separate incidents, the events of the first incident should not have been treated in isolation. The ambulance crew should have linked together all the available clinical information to

aid in the treatment and decision making with regard to Christopher Alder. During the interview, ambulance person 2 did not demonstrate that he had linked the two episodes together.

In addition, the ambulance staff did not perform strongly as a team in terms of their clinical treatment or in deciding the most appropriate course of action. Had the crew asked more questions and elicited the relevant information, which should have been made available to them about the timing and manner of Christopher Alder's collapse, it is likely that it would have altered their decisions.

Although the Healthcare Commission is critical of the failures on the part of the ambulance crew, there are also a number of contributory systemic failures. In 1998 most training for ambulance crews was directed towards delivery of care by protocol. This meant that ambulance crews delivered care in a prescriptive manner. Ambulance crews who considered themselves more experienced would anecdotally add experience and clinical judgement to their decision making processes. While this was appropriate, it was not underpinned by knowledge and education and on occasions led to erroneous decisions. This unsupported approach to clinical care inevitably introduced a high degree of clinical risk, which was not always well managed.

While it is important to acknowledge that any paramedic facing a full resuscitation outside a hospital setting has a lot to consider and does not benefit from a five or six person team as in an A&E department, in this instance they did not make the most appropriate decision, which was to transfer Christopher Alder back to the A&E department for more senior medical attention.

## 7 The adequacy of policies and working practices

In this section, the Healthcare Commission considers the policies and working practices that were in place in 1998, and also highlights any changes or improvements since 1998.

Following the introduction of clinical governance<sup>19</sup> in 1999, all NHS trusts should now have a range of policies and systems in place to ensure the safety of staff and patients, and enable staff to provide effective high quality care. This is now known as clinical governance.

The policies and practices relevant to Christopher Alder's care include the management of risk, arrangements for locum doctors, policies for discharging patients, managing violent and aggressive patients, the training of staff and clinical guidelines. The Healthcare Commission has examined the adequacy of the systems that were in place in 1998 and those that are now in place.

### Management of risk

The systems for the management of risk that were in place in Hull Royal Hospitals NHS Trust (which includes Hull Royal Infirmary) in 1998, have now been adapted and further developed by the trust (which following a merger is now Hull and East Yorkshire Hospitals NHS Trust).

In 1998, Hull Royal Infirmary had a system in place for the reporting of incidents. There was a health and safety manager in post but the trust did not have a manager with responsibility for managing risk. Although staff reported incidents, they were mainly related to health and safety, and not clinical care.

Following the trust's merger, the systems for managing risk were further developed and strengthened. The trust now employs a manager responsible for analysing and coordinating work related to risk who is supported by an information officer. All clinical departments have a person who is designated to take the lead on risk and the A&E department has a group that considers issues of risk. Training on risk is available for staff and the number of incidents reported has increased year on year, including an increase in the number of clinical incidents being reported.

Humberside Ambulance Service NHS Trust had a system in place for reporting incidents in 1998 and following the merger in 1999, Tees, East and North Yorkshire Ambulance Service NHS Trust have further developed the systems for managing risk.

19 Clinical governance is the systems of steps and procedures adopted by the NHS to ensure that users of services receive the highest possible quality of care, ensuring high standards of care, safety and improvement in services for patients CHI 1999.

Training in managing risk is available for staff, a register of risks and systems for reporting incidents (including serious untoward incidents) are in place. There is also a manager with responsibility for risk who is responsible for analysing and coordinating work related to risk.

The clinical negligence scheme for trusts (CNST) includes general clinical standards for managing risks that apply to all NHS trusts. These standards assess an organisation's standard of managing risk relating to the care of patients covering factors such as systems for reporting incidents, induction and training programmes for staff and policies and systems for the control of infection. There are three levels of achievement, one to three (three being the most advanced). Both trusts have achieved level one of the clinical negligence scheme for trusts.

## Complaints

Since 1996, all trusts have been required to have systems in place for managing complaints. In 1998, Hull Royal Infirmary did have a complaints manager in post, yet the Health Commission was told that his sister was not given any information about how to take her concerns forward. Information should have included the right to ask the trust to conduct an investigation and to appeal to the Health Service Ombudsman if she remained dissatisfied with the response to her complaint.

## Confidentiality

All nursing and medical staff are bound by their professional codes of practice to maintain the confidentiality of patients. Following the Caldicott review in 1997, all trusts were required to adhere to six principles of practice and implement the recommendations. Adherence to the principles reassures patients and those treating them that confidentiality is safeguarded.<sup>20</sup> Hull and East Yorkshire Hospitals NHS Trust (which includes Hull Royal Infirmary) has a Caldicott guardian and training in Caldicott principles is available for staff. Training in data protection is also now mandatory for all staff.

## Arrangements for locum doctors

In 1998, induction programmes for locum doctors were variable and depended on how locum doctors were recruited. For example, if they were recruited at short notice they would only receive a short briefing about the department and would be expected to rely on the senior nurse for information on procedures to follow. Doctor A told the Healthcare Commission that he had received an induction to the department, which involved being shown around the department and given information about policies and procedures and the on call roster. Doctor A had previous experience of working in A&E in a similar environment.

20 The Caldicott Committee: Report on the review of patient identifiable information – December 1997  
Department of Health

There is now a formal induction for locum doctors and, where possible, the trust recruits locum doctors to provide cover for a relatively long period of time for example, three months to ensure continuity of care for patients.

## The cover provided by medical staff

The medical cover in the A&E department has improved since 1998. In 1998, the medical cover in A&E at night consisted of two senior house officers and a registrar available until midnight. From midnight, the registrar remained in the hospital but was available on an on call basis. There was also a consultant on call from home. Medical cover has since improved, and there are now three senior house officers, plus middle grade and staff grade doctors available.

## The policy for discharging patients

In 1998, the trust's policy for discharging patients included a section on discharging patients over the age of 70 from A&E, but there is no information about discharging patients into police custody. The policy in place in 1998 also included a section on principles for good practice, which states that patients and carers should be fully informed about discharge and continuing needs for healthcare.

An updated policy for the discharge or transfer of patients was introduced in 2004. This policy applies to all patients, with accepted variations from the policy for designated groups (which includes the accident and emergency department). It does not, however, specify the variations and there is no specific policy for discharging patients from A&E to home or for discharging patients to police custody.

Changes in practice since 1998 include an explicit recognition that when considering the discharge of a patient from A&E, staff have to be confident that the patient is fit for discharge. If staff have any concerns about the fitness of a patient they should admit them to the short stay ward. In an interview with a current A&E consultant, the Healthcare Commission was told that compared with 1998, there is now more discussion between senior and junior medical staff when deciding whether to admit or discharge a patient.

## Operational policy for the short stay ward

The short stay ward has nine beds and takes patients from A&E for observation and further care. The A&E consultants are responsible for the patients on the short stay ward.

In the operational policy (undated) for the ward, the criteria for admission includes intoxicated patients. Staff indicated that patients who were aggressive or intoxicated but required observation or further treatment could have been admitted to the short stay ward in 1998.



## Clinical guidelines

In 1998, local guidelines for the management of head injury were available, along with instructions for patients with a head injury following discharge. Hull and East Yorkshire Hospitals NHS Trust (which included Hull Royal Infirmary) has since adopted the guidance of the National Institute for Health and Clinical Excellence (NICE) on the management of head injuries, which was introduced in 2003. The guidance divides head injuries into three categories — mild, moderate and severe — and includes specific treatment for each category. It also includes information on how to assess a patient who presents with a head injury and on the investigation in A&E. According to the current guidance, Christopher Alder would have had a CT scan and would possibly have been admitted to the short stay ward.

In 1998, the Humberside Ambulance Service NHS Trust had policies and procedures on the care of patients prior to care in hospital. The standards were adopted from those developed by Essex Ambulance Service and include standards on head injury, management of the patient and scene, neurological assessment and asystole and elector-mechanical disassociation (cardiac arrhythmias).

In 2002, the Joint Royal Colleges' Ambulance Liaison Committee published its first set of pre-hospital clinical guidelines with the intention of them being introduced into the ambulance service as evidence-based guidelines on best practice. Tees, East and North Yorkshire Ambulance Service were only in a position to introduce the Committee's guidelines from April 2005. This version of the guidelines should include a package of educational material that helps paramedics understand more broadly their application of the guidelines and their accountability for delivering care. It also educates ambulance staff more broadly about the ethical decisions they make, including the documentation of decisions, both those that they have made and those they have actively chosen not to make.

A national triage scale was used in A&E at the time of Christopher Alder's admission. This scale had five categories which patients could be allocated to following initial assessment. Dependent on the initial assessment, patients were transferred to either the majors or minors area of the department.

Since 1998, training in triage has been further developed. In 2003, the trust produced a document called *Introduction to triage for staff working in A&E*. Additional training documents, which included the levels of skills required by staff, were developed in 2004.

## Training for staff

At the time of Christopher Alder's death, most training for ambulance crews was directed towards the delivery of care according to a protocol. There was a risk-averse approach, which meant that less experienced paramedics and technicians administered care to patients in a predefined and prescriptive manner.

In recent years, there has been a shift away from this with pre-hospital care being recognised as a science. The introduction of clinical governance has also played a significant role in this.

In 1998, A&E employed a part time training manager and organised a training programme for staff nurses new to working in the department. The programme included training on triage. Nursing staff had to have 18 months experience working in A&E and be employed at the relevant grade before they were permitted to triage patients. However, sometimes staff allocated to work in the majors area may have had to triage patients even though they did not meet these criteria. This has now changed through the introduction of team nursing and team leaders for each area.

For nurses working in A&E, there is now a five day triage training programme which includes information on the management of patients with a head injury. There is also an academic post-registration course they can take.

For junior doctors, there is a weekly training programme that locum medical staff can also attend. The programme covers both clinical and administrative procedures but does not include information about the powers of police, or the management of violent or aggressive patients.

Security staff were employed by the trust at the time of Christopher Alder's death but their role was to patrol and protect the building. They would, unofficially, provide support to the staff in A&E but it was not their responsibility to manage violent and aggressive patients. Security staff are now employed to work in A&E and their role has been expanded to include maintaining a safe environment for staff and patients.

In 1998, training for security guards was provided on the job apart from mandatory training i.e. fire training and moving and handling (training in how to handle objects and people to reduce the risk of injury). All security staff now receive a range of training including conflict management, communication in a stressful environment (run by Humberside police), and health and safety regulation. A new training programme is being developed which will include elements of law and of protecting people and property.

## Managing violence and aggression

In line with national guidance, Hull and East Yorkshire Hospitals NHS Trust (including Hull Royal Infirmary) introduced a policy for managing violence at work (including procedures for staff working alone) in January 2001. In August 2004, a policy on the control of violence and aggression at work was introduced and A&E has adopted a zero tolerance policy. However, although the policy includes a section about training for staff with a range of training being available for staff, there is no specific section relating to A&E, for example how to ensure that patients who are aggressive or violent are assessed as fit for discharge or how they should be managed.

## Working arrangements between Humberside police and Hull and East Yorkshire Hospitals NHS Trust (which includes Hull Royal Infirmary)

During their interviews with the Healthcare Commission, hospital staff indicated that there has always been a close working relationship with Humberside police. The police are often called to assist with violent and aggressive patients and it is not unusual to see them in A&E.

Since April 2004, the trust has funded a police liaison officer on a part time basis whose role is to act as the link between the police and the trust.

Despite the fact that the police are often called to assist in A&E and that a police liaison officer has been in post since April 2004, there are no written protocols or guidelines about when trust staff should call the police for help or about the role of the police in A&E. (There were 154 reported calls between March 1<sup>st</sup> and April 30<sup>th</sup> 1998 and 123 reported calls between March 1<sup>st</sup> 2004 and April 30<sup>th</sup> 2004).<sup>21</sup> Staff told the Healthcare Commission that the police are expected to work under the direction of the trust's staff, although there is no policy that states this. Police officers are expected only to observe, and the patient remains under the care of the trust unless the police are asked to intervene.

21 Information provided by Hull and East Yorkshire NHS Trust

## 8 The interface between Hull Royal Infirmary, Humberside Ambulance Service NHS Trust and Humberside police

This section looks at the interface between the three organisations involved with Christopher Alder on the night he died. The focus is mainly on the interface between Hull Royal Infirmary and Humberside police.

### The relationship between Hull Royal Infirmary and Humberside police

Humberside police has longstanding links with Hull Royal Infirmary through the community action team. Following the disbanding of the community action team, a police officer was assigned to continue to work on special projects such as liaison with Hull Royal Infirmary. In April 2004, Hull and East Yorkshire Hospitals NHS Trust (which includes Hull Royal Infirmary) were concerned that this liaison may be discontinued and took steps to secure a permanent part time liaison officer by agreeing to pay half of the salary of the officer.

The current incumbent, sergeant A, acts as a link between Humberside police and Hull and East Yorkshire Hospitals NHS Trust. If there are any problems in the working relationship between the trust staff and police officers, sergeant A is the first point of contact to try to resolve them.

In 1998, it was generally agreed that there was a good working relationship between the police and the trust.

In 1998, there were no permanent security staff in A&E and the police were often called to provide assistance with patients who became violent and aggressive. If a patient was drunk and difficult it was felt that it was more the responsibility of the police to deal with them and staff would hand them over to the police. Staff believe that this is less likely to happen today, as there is more discussion about how to manage such patients. If there are concerns about discharging a patient to police custody, the charge officer and A&E consultant are required jointly to agree the best course of action for the patient. Charge officers are also more likely to refuse to accept a patient if they have concerns about the patient's injuries. Sergeant A believes that A&E staff are also less likely to ask a patient to leave if the patient is aggressive but still requires treatment. They would instead explore the options available and involve the police in the discussion.

Although security staff are now based in A&E, the police are still called to manage patients who for example are drunk and aggressive, or when fights break out between victims and assailants (when they meet in A&E). The police also bring prisoners who are in custody to A&E for treatment. The police are called to A&E on average three to four times a week in Hull and East Yorkshire NHS Trust. At times, there have been up to 12 police officers in A&E.

Despite the appointment of a liaison officer, there are still no protocols in place about the role and powers of the police in A&E. Police officers in 1998, and now, work under the direction of the nursing and medical staff. The only formal agreement in place relates to time taken to respond to requests. Hull Royal Infirmary has been made an 'eck'. This denotes the highest level of priority for attendance. If the police do not give the appropriate response they have to explain their actions to the hospital.

## The relationship between Humberside Ambulance Service NHS Trust and Humberside police

There was no guidance governing the working arrangements between Humberside Ambulance Service NHS Trust and Humberside police in 1998.

## Sharing information between agencies in Kingston upon Hull and the East Riding of Yorkshire

All three organisations involved in the care and treatment of Christopher Alder are signed up to the general protocol for sharing information between agencies in Kingston Upon Hull and the East Riding of Yorkshire (March 2003). The protocol, which is a multi-agency document, makes reference to the Human Rights Act (1998), the Crime & Disorder Act (1998), Data Protection Act (1998) and the common law duty of confidentiality. It also included sections on principles governing the sharing of information and procedures for the disclosure of personal information.

Other than this protocol, there is nothing in writing governing the relationships between the three organisations.

## 9 Conclusions and recommendations

These conclusions relate to the actions and decisions taken by staff in relation to this specific incident and the protocols and working practice that were in operation in 1998.

The nursing, medical and ambulance staff made several attempts to reason with Christopher Alder and to calm him down. 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 to relate and assimilate 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.

The ambulance crew did not spend enough time at the Waterfront nightclub gathering information about the assault or trying to establish whether Christopher Alder was rendered unconscious and, if so, for how long. Accordingly, the ambulance crew were unable to provide the hospital staff with a detailed history of Christopher Alder's condition after the assault and his level of consciousness. There is always a healthy tension between needing to get a patient into a place of safety, while still making enough of a clinical assessment to ensure that the onward journey to the hospital and subsequent treatment of the patient are conducted in the best interests of the patient. On this occasion, because the ambulance crew gained minimal information, there was a lack of clinical information and shortfalls in the documentation of their medical assessment and actions at the time of handover to hospital staff.

The failure to obtain detailed information about the assault continued once Christopher Alder arrived in A&E. Three nurses were involved in the care of Christopher Alder. Although they all spoke to the ambulance crew at differing times, they failed to obtain a detailed history of the events. They did not ask the ambulance crew to expand on any of the information they provided. Both nursing staff and ambulance crew documented very little information about the assault, their assessment of Christopher Alder and the decisions they made. This meant that the patient's notes available to doctor A were limited.

The ambulance crew seemed more concerned with alerting the nursing staff about Christopher Alder's abusive and uncooperative behaviour than with providing information about the assault and his injuries. They have said that they were concerned about their safety and the safety of other NHS staff. However in interviews with the

Healthcare Commission, ambulance person 2 and ambulance person 1 indicated that they did not regard being seriously threatened by Christopher Alder's actions. Ambulance person 1's actions to alert the police in the A&E were taken out of care and concern for her colleagues, not because they thought Christopher Alder posed a real threat. Their use of terms such as "violent" and "aggressive" rather than objectively describing his actual behaviour raised apprehension and resulted in assumptions being made about the level of aggression Christopher Alder was actually exhibiting.

The fact that Christopher Alder had ingested alcohol and sustained a head injury should have resulted in the nursing and medical staff being more cautious in their assessment and decision-making. It was unclear what was causing his behaviour. It is best practice in such circumstances to consider the 'worst case scenario', eliminating all reasonable possibilities before concluding that the behaviour of a patient is solely the result of alcohol.

There was a lack of clarity among the nursing staff about who was responsible for the care being provided to Christopher Alder. It is not documented in any of the medical records or statements made after the death of Christopher Alder what information was shared between the nursing staff, or between the nursing staff and the doctor.

It is acknowledged that Christopher Alder's behaviour was described as aggressive and the staff made every effort to reason with him despite provocation. However, at the time of discharge, doctor A 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. A senior doctor (specialist registrar) was on call in the hospital, and a consultant was available on call from home to provide such advice. 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.

It is also unclear if doctor A thought Christopher Alder was already in police custody as there is conflicting information in earlier statements. When doctor A first went to assess Christopher Alder, the police were already present in the cubicle. Doctor A did not seek to clarify why they were there and the police did not offer an explanation. In his interview with the Healthcare Commission, doctor A 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 in police custody and that in discharging him, he was discharging him to the care 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.

Once the police had removed Christopher Alder from the A&E department, doctor A expected them to take him into custody, as he did not consider it safe for Christopher Alder to go home by himself. However, once outside the hospital the police were initially going to let Christopher Alder go home by himself.

The hospital staff, while expecting the police to care for Christopher Alder until he returned for further treatment, did not provide them with any written or verbal information about the signs of deterioration in a patient with a head injury. This information was available. They also did not ask the police if they would know what to do in the event of Christopher's Alder condition deteriorating. Equally, the police agreed to take Christopher Alder knowing he still required treatment and did not ask for any information about when or if they should return for further treatment.

There was a lack of understanding by nursing and medical staff about the implications of asking the police to take difficult and aggressive patients, who require medical care, into police custody when they had not been charged with committing a crime. They were effectively using the police station as a place of safety, although there is no evidence that Christopher Alder was, or had a history of mental health illness. In the circumstances this was inappropriate. Where a person is discharged to the police under section 136 of the Mental Health Act 1983, the doctor responsible for the discharge needs to keep in mind that the purpose of section 136 is to ensure that the person has the appropriate treatment and care, where discharged with a head injury. It needs to be carefully considered whether that care would be better provided in hospital or in a police station, recognising the particular difficulties with the patient's behaviour.

By the time that the police officers reached the police station, Christopher Alder's condition had changed significantly. He had gone from being able to walk unaided and communicate verbally to being unresponsive and unable to walk when they tried to get him out of the police van. The police failed to recognise the signs of deterioration and did not begin effective and timely resuscitation. This, in turn, resulted in a delayed call to the ambulance service. The police also failed to provide the ambulance crew, when asked, with sufficient information about the change in Christopher Alder's condition. The ambulance crew were unaware that Christopher Alder had been unconscious since his arrival at the police station approximately 20 minutes earlier. It is important that the police provide ambulance staff with accurate information including when they are unsure of a particular answer, or are making assumptions.

The ambulance crew also failed to obtain sufficient information from the police and to take sufficient account of previous events. Although they asked how long Christopher Alder had been "down" they did not probe any further about how or when the police noticed a change in his condition, and what his behaviour was like prior to, and on arrival at the police station. It would also have helped if they had phrased the questions more accurately rather than using the phrase "down" which is ambiguous. This information was available had the ambulance crew probed further.

The ambulance crew did not provide effective care. They should have taken Christopher Alder back to the hospital's A&E department as it was a relatively short journey of five minutes, and by doing so they would have had access to advice from a senior member of the medical staff. There is always some risk of compromise to the care of the patient when transferring them, but ambulance crews are trained to minimise it. The decision to remain at the police station was flawed. This was largely caused by lack of training in exercising their clinical judgements in such situations. It is also probable that, although the call from the police station was described as



urgent" "breathing difficulty" "patient query stopped breathing" the ambulance crew were probably influenced by their previous attendances for minor injuries and were therefore not prepared for the life threatening situation they found.

On balance, staff were undoubtedly influenced by the circumstances of Christopher Alder's injuries. He was a fit, muscular man who had been drinking and 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 as violent and aggressive fuelled the assumptions made by hospital staff and subsequently by police officers. Similarly, the fact that doctor A 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 rightly criticises some of the decisions and actions of the healthcare staff, the commission recognises that there were more serious failings by the police officers once they took Christopher Alder into police custody. The police officers wrongly assumed that Christopher Alder's apparent lack of consciousness was a sham 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 to seek 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 the IPCC's review of the death of Christopher Alder.

## Policies and working practices

Both trusts had a range of policies in 1998 both for clinical care (for example, the management of head injuries and working practices) and management. With the emergence of clinical governance (the systems of steps and procedures adopted by the NHS to ensure that users of the service receive the highest possible quality of care ensuring high standards, safety and improvement in patient's services), many of these policies and working practices have been strengthened and developed. However, some policies such as the zero tolerance policy and policy on discharge and transfer of care need to be adapted and clarified to meet the specific needs of A&E.

Incident reporting forms were available in both trusts, but staff in the acute trust did not recognise the need to record the fact that they were unable to treat Christopher Alder and that he was discharged without a diagnosis and when still requiring treatment. Once they became aware that Christopher Alder had died, they wrote statements, but despite the fact that he died shortly after being discharged from the A&E department, they still did not complete an incident form.

The paramedics also did not consider it necessary to complete an incident form and were not directed towards this course of action by their managers.

It would have been good practice for both trusts to have undertaken a review or a joint review of the care that Christopher Alder received to determine if he received appropriate and timely care and to identify any learning from the incident or changes that needed to be implemented.

It was, and still is, normal practice for the trust staff to seek assistance from the police in managing difficult and aggressive patients. The Healthcare Commission does not underestimate the difficulty for staff, in attempting to treat patients who are abusive or aggressive towards them and agrees that it is entirely appropriate that they should have the cooperation and support of the police when necessary. However, there are no joint written protocols about when to call the police, the consequences of doing so, or their respective role and the limits to this role in A&E. This is illustrated by the fact that the police threatened to use CS spray<sup>22</sup> when Christopher Alder was in the A&E. During her interview, staff nurse C described a more recent example of the police threatening to use CS spray in the A&E demonstrating that this lack of clarity as to the proper limits of the police's role and behaviour continues.

In this case, there was a blurring of responsibilities between healthcare and police officers. Christopher Alder was treated as though he had been arrested. The police were present while doctor A examined him and the hospital staff did not ask Christopher Alder whether he consented to the police being present. They also did not demonstrate an awareness that patients may be reluctant to disclose information if police officers are present. In relation to the patient's privacy, the police officers accompanied Christopher Alder to the toilet and observed him while he urinated, which appears to constitute a breach of his right to privacy as a patient unless good reasons could be advanced for doing so.

There is little guidance about when, or if a police station should be used as a place to hold detainees with health needs. As previously stated, the police were frequently present in A&E and were not always there because the patient being treated was in their custody. It is therefore important for those staff responsible for discharging patients to ascertain whether or not patients are being discharged into the care of the police and to understand the limitations of this. Ultimately, the police must decide if it is appropriate to take a person into custody. Police and medical staff should be clear about the basis on which a patient is being discharged. Staff nurse C knew that Christopher Alder was not under arrest. In her interview with the Healthcare Commission she said they "were using the police station to actually — for want of a better word — provide a place of safety". It is unclear if staff nurse C was referring to section 136 of the Mental Health Act 1983. However, they were unable to manage Christopher Alder's behaviour and although they did not want to keep him in the A&E department, they also did not want him to go home alone. So they asked the police to take him. It is clear from earlier statements and more recent interviews that staff were unsure what powers the police were using to take responsibility for Christopher Alder.

During interviews with the Healthcare Commission, staff from the acute trust did not

22 CS spray causes severe burning in the eyes and throat, coughing, a rise in blood pressure and a decrease in heart rate. Police manuals warn that CS spray should be used out of doors to disperse crowds <http://www.pbs.org/wgbh/pages/frontline/waco/csgas.html>

demonstrate an awareness of the importance of maintaining the confidentiality of patients when police officers were present in the A&E department in 1998. The Healthcare Commission recognises that there is a difficult balance to strike with respect to the sharing of personal medical records and information when both healthcare professionals and the police are concerned with the patient (especially under the pressure of the environment of an A&E department). However, the Commission is concerned about the way in which information relating to Christopher Alder's blood alcohol level was shared with the police. Healthcare staff did not consider whether there were proper grounds for them to disclose the information. This is particularly troubling, given that Christopher Alder was not under arrest at this stage. This is not to say that the decision to disclose information was necessarily wrong in this instance, but that these matters do not appear to have been thought through and no decision-making process is evident. Generally, the Commission believes that careful consideration needs to be given to the sharing of information between healthcare staff and the police. For instance, patients may be reluctant to provide information that may be relevant to their care and treatment if the police are present and they think that the information might be shared with the police.

The Healthcare Commission is also concerned that staff did not always demonstrate a concern to maintain Christopher Alder's dignity. When he wanted to use the toilet, two policemen went with him and watched him while he urinated. While this may have been done out of concern for Christopher Alder's safety, it would have been courteous or good practice to ask if this was acceptable to him.

There were clinical policies and procedures in place for the care and treatment of Christopher Alder. Staff did not fully apply or adhere to them nor did they seek the advice of a senior colleague when they chose to vary them. The guidelines on the discharge of patients with a head injury state that the patient should be discharged into the care of a person who will be able to notice any deterioration and help the patient seek medical assistance. Christopher Alder had said he lived alone. Had the police not been present, doctor A is unlikely to have discharged Christopher Alder and staff might have admitted him to the short stay ward to allow him time to calm down and accept treatment. The confusion about why the police were present influenced doctor A's decision to discharge Christopher Alder.

Apart from a protocol for the sharing of information, there are no policies and guidelines governing the working arrangements between Hull and East Yorkshire Hospitals NHS Trust, Humberside police and Tees, East and North Yorkshire Ambulance Service. It is also of concern that seven years after the event, staff have not received any support to reflect on their clinical practice.

In summary, healthcare staff undoubtedly endeavoured to treat Christopher Alder despite provocation. But, there were a number of failings in their practice particularly their failure to assimilate and share information. More importantly, Christopher Alder should not have been discharged. Christopher Alder's death was a consequence of a flawed response to his initial circumstance, a series of prejudicial assumptions and misunderstandings (by both the police and A&E staff) and a failure by the police to respond in time to his deteriorating condition, thus denying him an increased chance of survival.

## Recommendations

As well as the progress already listed, the Healthcare Commission, in conjunction with the Independent Police Complaints Commission (IPCC), has a series of key recommendations, which the trusts and other relevant organisations need to put into practice. The Commission, along with the IPCC, 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, 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 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 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 in order 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 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.

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- 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.

# Appendices

## Appendix 1

### Summary of events concerning Christopher Alder on April 1<sup>st</sup> 1998

Time if known	Event
02.10	Christopher Alder assaulted outside the Waterfront nightclub.
02.26	Call received by ambulance crew to attend an 'assault/trauma' at the Waterfront.
02:29	Ambulance crew arrive at the Waterfront.
02:37	Ambulance leaves Waterfront.
02:44	Ambulance arrives at Hull Royal Infirmary A&E department. Christopher Alder was moved onto a hospital trolley and assessed in cubicle eight, initially by staff nurse B and then staff nurse C who took over care.
03:00 approx	<p>Security person A, the security guard, attends cubicle eight. Ambulance person 1, ambulance technician, asks two police officers (in A&amp;E for unrelated matters) to attend cubicle eight.</p> <p>Staff nurse C took Christopher Alder's blood pressure and gave him a Glasgow Coma Score. The police officers then leave.</p>
03:05	<p>PC A and PC B (the officers who arrived at the scene at the Waterfront) arrive and go into cubicle eight. The alcotest was administered. Shortly afterwards doctor A attends Christopher Alder.</p> <p>Decision is made that doctor A and staff nurse C will take Christopher Alder to x-ray. In the x-ray department Christopher Alder, when asked to lie on his back, expressed the desire to urinate. Due to Christopher Alder's behaviour it was decided that x-rays could not be taken.</p> <p>The police officers discussed removing Christopher Alder from A&amp;E and then escorted Christopher Alder to the toilet.</p> <p>Christopher Alder was then told that he would only receive treatment if he cooperated and calmed down. Christopher Alder was then removed from A&amp;E by the police officers.</p>
03:40	Outside A&E the police tell Christopher Alder to go home, he refused, became verbally abusive and was arrested. Christopher Alder was placed in the police van once it arrived. Christopher Alder was then taken to Queens Garden Police Station.
03:46	They arrive at Queen's Garden Police Station and Christopher Alder is placed on his front on the floor of the 'charge room' and possible charges are discussed.
03:57	Concern was raised over Christopher Alder's breathing, first aid was administered and an ambulance called.

Time if known	Event
04:02	Call received by ambulance crew to attend a 'breathing difficulty.'
04:05	Ambulance arrived at the police station. Ambulance person 1 attended Christopher Alder while ambulance person 2 returned to the ambulance and retrieved equipment.
04:35	Ambulance crew stopped resuscitation attempts.
04:41	Ambulance person 2 phoned for a doctor to certify death.



## Appendix 2

### Investigation team

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## Appendix 3

### Acts of Parliament and human rights legislation

Due to the circumstances and events that led to the death of Christopher Alder, the investigation team has considered the Acts of Parliament and human rights legislation that have a bearing on this case.

For further information on the above please refer to:

The Mental Health Act Manual by Richard Jones (2004)

The Police and Criminal Evidence Act 1984 by Professor Michael Zander QC (4<sup>th</sup> edition 2002)

Civil Liberties and Human Rights in England and Wales by David Feldman (2002)



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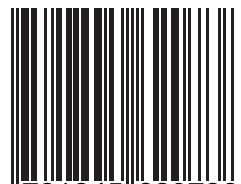
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