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Summary of preliminary analyses of data collected from Gosport War Memorial Hospital.

This report updates the information outlined in the report of 11.11.02. In that report, an initial review of the counterfoils of MCCDs issued by doctors at Gosport War Memorial Hospital (GWMH) from 1987 gave cause for concern about the numbers issued by Dr Barton, and the frequent use by her of bronchopneumonia as the cause of death. However, there were several potential legitimate explanations for these findings, and it was not possible from the data available to draw a reliable conclusion. Since the completion of that report, further information has been obtained. This includes:

- The deaths certified by doctors at GWMH in 2001 (from counterfoils)
- Information on the numbers of beds at GWMH from 1980-1993
- Data from the admissions register for Dryad Ward, 1993-2001
- Data from the controlled drugs registers used on Dryad Ward, March 1995-August 1998.

In addition, information contained in other controlled drugs registers is currently being extracted.

1. Do changes in numbers of beds and bed use explain the numbers of deaths certified by Dr Barton?

The information analysed thus far tends to indicate a relatively high number of deaths associated with Dr Barton's period at the hospital, although there were changes in the types of cases admitted that could explain this finding. Table 1 shows that the mean number of deaths per year up to 1992 was 104. Between 1993 and 1999 the mean was 175. Dr Barton ceased work as a clinical assistant in July 2000, and the mean number of deaths per year 2000-2001 was 110.

Dr Barton began work at the hospital in 1988. At that time, she had responsibility for patients in Redclyffe Annexe, which has been reported by GWMH staff as having 20 beds classified as continuing care. Many of the certificates issued by Dr Barton for patients in Redclyffe Annexe 1988-1993 indicate that many were mentally infirm.

Until 1993/4, there were also two wards (male and female) at the hospital, having a total of approximately 37 beds, of which 19 were GP beds and 7 as GP day surgery beds. Dr Barton was responsible for the care of patients in the remaining 11 beds. (Note: the precise number of beds on the female ward is uncertain since the information is derived from the memories of staff. It is believed to have been 20 or 21.) The total number of beds under the supervision of Dr Barton was therefore 31 until 1993/4.

From 1993/4, Dr Barton appears to have been responsible for a greater number of beds, and for a different group of patients. Dr Barton appears to have ceased responsibility for Redclyffe Annexe, and taken on responsibility for the new Dryad and Daedalus wards in the new hospital building, the male and female wards being closed. This gives a total of 44 beds under Dr Barton's care, with a mix of continuing

care and rehabilitation. The increase in numbers of certificates from 1993 could very well be explained by these changes at the hospital.

	Other docs	Dr B	Total
YEAR			
1987	105	2	107
	98.1	1.9	
1988	85	29	114
	74.6	25.4	
1989	71	31	102
	69.6	30.4	
1990	72	38	110
	65.5	34.5	
1991	59	31	90
	65.6	34.4	
1992	68	32	100
	68.0	32.0	
1993	57	99	156
	36.5	63.5	
1994	56	106	162
	34.6	65.4	
1995	74	81	155
	47.7	52.3	
1996	100	84	184
	54.3	45.7	
1997	106	86	192
	55.2	44.8	
1998	107	107	214
	50.0	50.0	
1999	71	92	163
	43.6	56.4	
2000	80	34	114
	70.2	29.8	
2001	103	2	105
	98.1	1.9	
Column	1214	854	2068
Total	58.7	41.3	100.0

Table 1. Numbers of MCCD counterfoils each year, 1987-2001, completed by	Dr
Barton or other doctors at GWMH.	

Tables 2 and 3 show respectively the certificates issued by the other doctors at the hospital and Dr Barton for deaths on different wards. These data support the case that Dr Barton ceased responsibility for patients in Redclyffe Annexe and took on the new Dryad and Daedalus wards 1993/4.

The numbers of deaths fell in 2000-2001. Caution is required in drawing conclusions since clinical practice is likely to have been influenced by the concerns raised by the complaints first voiced in 1999, and the consequent investigations. On the basis of the evidence available about the numbers of deaths, it is therefore not appropriate to infer that criminal behaviour explains the patterns observed – changes to the numbers of beds and case mix are a highly plausible explanation.

Box 1. Reported bed usage at the hospital (information provided by GWNH staff:

1980-1993:

Northcott house, 11-12 continuing care beds Redclyffe annexe 20 continuing care beds Male ward - 17 beds (9 continuing care, 8 GP beds) Female ward – 20 beds (2 continuing care, 7 GP day surgery, 11 GP beds) Total beds 1980-1993=69

From 1994:

Redclyffe annex was still used; Sultan ward – 24 GP beds Dryad ward – 20 continuing care beds Daedalus – 24 beds in total (8 slow stream stroke from April 1994,, 16 continuing care [24 prior to April\94]); from 2000, the Daedalus beds were used for intermediate care, comprising 8 fast stream stroke, 8 slow stream stroke, 8 general rehabilitation. Dr Barton appears to have been responsible for Redclyffe annex until 1993/4, when she took charge of Dryad and Daedalus wards. Table 2. Deaths certified by the other doctors on wards at GWMH (only 7 MCCD counterfoils from 1986 available; GWMH=Gosport war memorial hospital, ward not stated; Northcote, Mulberry and Collingwood are other wards at GWMH; the other wards are mentioned above, or are not in the hospital).

	place of death												Total
	GWMH	Redcliffe	male ward, GWMH	female ward, GWMH	Northcott Annexe, GWMH	Daedalus ward	Dryad Ward	Sultan Ward	Mulberry	Coldeart hospital	Collingwood	ark royal	
1986	7												7
1987	66	9	9	11	10								105
1988	61	3	13	5	3								85
1989	52	3	3	10	3								71
1990	52	2	9	9									72
1991	37	1	10	11									59
1992	35	1	16	15									67
1993	34	2	3	6		3		8					56
1994	15	5				2		33					55
1995	12					12	5	35	10				74
1996	28	7				10	6	37	11	1			100
1997	10	3				8	7	45	33				106
1998	23	5				12	11	35	18				104
1999	12	7				6	9	27	10				71
2000	20	5				13	12	22	3		5	1	81
2001	59	8				1	4	25	2		4		103
	523	61	63	67	16	67	54	267	87	1	9	1	1216

		place of death								Total
		GWMH	Redcliffe	male ward, GWMH	female ward, GWMH	Northcott Annexe, GWMH	Daedalus ward	Dryad Ward	Sultan Ward	
year of death	1987	1	1							2
	1988	2	6	11	1	9				29
	1989	1	19	8	1	2				31
	1990		23	13	2					38
	1991		18	11	2					31
	1992		23	8	1					32
	1993		51	7	6		35			99
	1994		58	1			42		4	105
	1995	1	4				42	33	1	81
	1996						48	32	3	83
	1997						39	47		86
	1998						51	51	5	107
	1999						42	49	1	92
	2000						15	17	2	34
	2001							1	1	2
Total		5	203	59	13	11	314	230	17	852

Table 3. Deaths certified by Dr Barton on different wards at GWMH.

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2. Is there a difference between Dr Barton and other doctors in the use of different causes of death?

Table for shows the numbers of deaths certified as primarily due to one of six groups of conditions (cancers, heart problems including myocardial infarction and heart failure, strokes, bronchopneumonia in association with other conditions such as dementia, bronchopneumonia as the sole cause of death, and other conditions, including dementia, renal failure etc).

Table 4. Cause of death in groups, according to whether Dr B (2) or other doctors (1) signed the certificate.

				Total
		Other	Barton	
		doctors		
cause of death code	cancer	464	50	514
	heart	170	100	270
	stroke	112	139	251
	bronchopneumonia plus another	247	367	614
	bronchopneumonia only	35	163	198
	other	180	31	211
Total		1208	850	2058

Dr Barton was more likely to give bronchopneumonia or stroke as the cause of death (Chi 0.000, Table 4). A potential explanation is case mix – patients with dementia or stroke would have been admitted to Redclyffe, Dryad and Daedalus wards. A possibility that must be borne in mind is the excess use of sedative medication, leading to development of bronchopneumonia.

3. Deaths on Dryad Ward

The admissions book for Dryad Ward has been retained by the hospital, and contains information about all admissions from 1993. I have assumed that the admissions book dates from the first opening of the ward. There are occasional errors in the book, for example the admissions of some patients were not entered on the day of admission, and some data are sometimes missing, for example the source of admission. Nevertheless, the book was reasonable complete, and can be assumed to represent a fair description of admissions throughout the period.

It should be noted that Daedalus Ward did not have a similar book, but instead a daybook appears to have been employed. This was not helpful in providing information for this review.

The admissions book recorded the date of admission and the date of discharge or death, and it was therefore possible to calculate the length of admission. Table 5 shows the mean length of admissions by year of admission. There was some variation between years, with admission during 1998 having the shortest mean length of admission.

	N	Mean	Std. D	95% CI for Mean		Minimum	Maximum
				Lower	Upper		
1993	37	148.6	182.7	87.6	209.5	4	652
1994	68	41.7	70.2	24.7	58.7	1	326
1995	52	88.8	168.4	41.9	135.6	1	856
1996	43	56.0	72.6	33.6	78.3	1	345
1997	67	33.9	60.0	19.3	48.6	1	365
1998	103	36.0	40.5	28.1	43.9	0	195
1999	131	42.5	58.6	32.4	52.6	0	406
2000	90	65.8	87.8	47.4	84.2	1	487
2001	85	67.5	88.1	48.5	86.6	4	409
Total	676	57.1	93.4	50.0	64.1	0	856

Table 5 Mean length of stay on Dryad ward, days, 1993-2001 (anova p<0.000).

The causes of death of patients of Dryad certified by Dr Barton are shown in Table 6. These data are taken from the MCCD counterfoils. Almost all the counterfoils completed by Dr Barton indicate place of death, although the other doctors do not record this information consistently.

Table 6. Deaths on Dryad ward certified by Dr Barton

	cause of o	death					Total
	cancer	heart	stroke	bronchopneumonia	bronchopneumonia	other	
				plus another	only		
1995	2	4	2	15	8	1	32
1996	1	3	5	17	5	1	32
1997	2	11	4	23	6	1	47
1998	3	4	6	15	18	5	51
1999	7	6	5	12	15	4	49
2000	3	2	3	2	6	1	17
2001					1		1
	18	30	25	84	59	13	229

The mean age of patients on admission to Dryad Ward is shown in Table 7, according to year of admission. There is no difference between years. The admissions book does not record the gender of patients.

	N	Mean	Std. Deviation	95% CI for N	lean	Minimum	Maximum
				Lower	Upper		
1993	38	82.1	7.2	79.7	84.4	66.0	97.0
1994	75	83.7	7.2	82.0	85.3	64.4	100.0
1995	56	82.6	7.2	80.6	84.5	66.9	99.0
1996	45	83.0	6.5	81.0	84.9	69.8	95.2
1997	71	81.8	8.3	79.9	83.8	66.3	98.0
1998	105	83.2	7.5	81.7	84.6	67.1	100.0
1999	133	83.6	7.1	82.3	84.8	65.0	98.2
2000	89	82.7	7.1	81.2	84.2	67.0	100.0
2001	96	80.9	8.4	79.2	82.6	61.0	100.0
Total	708	82.7	7.5	82.1	83.21	61.0	100.0

Table 7. Mean age (yrs)at admission to Dryad ward, 1993-2001. (p ns.)

The Dryad ward admissions book records whether the patient died or was discharged. Table 8 indicates that the proportion of patients who were discharged alive was less than 50% until 1999. Between 1993-5, 80% of admitted patients died on the ward.

Table	e 8. Numbers (%)	of admissions	followed by	death or	discharge,	Dryad
ward	, 1993-2001 (p <0	000).				

year		outc	ome	Total
		died	discharged	
1993	N	29	7	36
	%	80.6%	19.4%	100.0%
1994	N	59	11	70
	%	84.3%	15.7%	100.0%
1995	Ν	42	10	52
	%	80.8%	19.2%	100.0%
1996	N	31	13	44
	%	70.5%	29.5%	100.0%
1997	N	48	21	69
	%	69.6%	30.4%	100.0%
1998	N	64	40	104
	%	61.5%	38.5%	100.0%
1999	N	58	74	132
	%	43.9%	56.1%	100.0%
2000	Z	35	56	91
	%	38.5%	61.5%	100.0%
2001	N	39	47	86
	%	45.3%	54.7%	100.0%
	N	405	279	684
	%	59.2%	40.8%	100.0%

The admissions book recorded brief information about the patient's illnesses at the time of admission. On a few occasions, this information included an indication of the reason for admission, for example respite care. Table 9 summarizes the findings. Medical/mental problems indicates either dementia of a mix of medical conditions and confusion or dementia, post-op indicates people who have had a recent operation, the most common of which was for treatment of fractured hips.

	Discussetia susur										
			r	Dia	agnostic gro	up			l otal		
		stroke	general	medical/	heart	cancer	post op eg	respite			
			medical	mental	problems		~nof	care/social			
			problems	problems				admission			
1993	N	9	19	6	2	2			38		
	%	23.7%	50.0%	15.8%	5.3%	5.3%			100.0%		
1994	N	10	31	14	2	3	14		74		
	%	13.5%	41.9%	18.9%	2.7%	4.1%	18.9%		100.0%		
1995	N	7	23	13		7	5	1	56		
	%	12.5%	41.1%	23.2%		12.5%	8.9%	1.8%	100.0%		
1996	N	1	20	10		7	2		40		
	%	2.5%	50.0%	25.0%		17.5%	5.0%		100.0%		
1997	N	4	29	16	5	8	8		70		
	%	5.7%	41.4%	22.9%	7.1%	11.4%	11.4%		100.0%		
1998	N	6	42	11	3	9	23	10	104		
	%	5.8%	40.4%	10.6%	2.9%	8.7%	22.1%	9.6%	100.0%		
1999	N	10	47	10	6	11	38	9	131		
	%	7.6%	35.9%	7.6%	4.6%	8.4%	29.0%	6.9%	100.0%		
2000	N	8	38	8	2	10	20	3	89		
	%	9.0%	42.7%	9.0%	2.2%	11.2%	22.5%	3.4%	100.0%		
2001	N	11	30	16	1	8	9	14	89		
	%	12.4%	33.7%	18.0%	1.1%	9.0%	10.1%	15.7%	100.0%		
	N	66	279	104	21	65	119	37	691		
	%	9.6%	40.4%	15.1%	3.0%	9.4%	17.2%	5.4%	100.0%		

Table 9. Category of cases admitted to Dryad ward, 1993-2001 (p<0.000).

The data indicate that stroke was more common as the reason for admission in 1993/4, dementia with or without other medical problems was more common 1995-7, and patients recovering from fractures etc more common from 1998. Social admissions/respite care was also a more common reason from 1998.

The admissions book also recorded information about the source of admissions. This information is summarised in Table 10. Please note that Dolphin Day Hospital is a unit at GWMH.

		home	rest/nursi	acute	sultan ward	a ward at	dolphin day	
		nomo	na home	hospital	outur mara	GWMH	hospital	
1993	N	4	2	23	8	1	noopital	38
1000	%	10.5%	5.3%	60.5%	21.1%	2.6%		100.0%
1994	N	8	2.070	56	8	1		75
1001	%	10.7%	2.7%	74 7%	10.7%	1 3%		100.0%
1005	70 NI	10.770	2.770	40	10.770	1.570	1	100.070
1995	IN Of	0	2	42		1	1	55
	%	10.9%	3.6%	/6.4%	5.5%	1.8%	1.8%	100.0%
1996	N	2	4	36	2	1		45
	%	4.4%	8.9%	80.0%	4.4%	2.2%		100.0%
1997	N	3		56	7	3	2	71
	%	4.2%		78.9%	9.9%	4.2%	2.8%	100.0%
1998	N	13		82	4	5	1	105
	%	12.4%		78.1%	3.8%	4.8%	1.0%	100.0%
1999	Ν	19	2	103	1	4	3	132
	%	14.4%	1.5%	78.0%	.8%	3.0%	2.3%	100.0%
2000	N	8	1	76	1	4	1	91
	%	8.8%	1.1%	83.5%	1.1%	4.4%	1.1%	100.0%
2001	N	23	2	49	8	12		94
	%	24.5%	2.1%	52.1%	8.5%	12.8%		100.0%
	N	86	15	523	42	32	8	706
	%	12.2%	2.1%	74.1%	5.9%	4.5%	1.1%	100.0%

Table 10. Sources of admission to Dryad Ward, 1993-2001 (p<0.000).

Most patients admitted to Dryad ward had been discharged from acute hospitals (Table 10). Only in 2001 did the proportion of admissions from home approach 25%.

The time of death had been recorded in the admissions book in 260 cases (64.2% of deaths on the ward). Deaths are reasonably equally distributed among hours of the day.

hr		vear of admission								Total	
		1993	1994	1995	1996	1997	1998	1999	2000	2001	
0	N	1	4		1	1			4		11
	%	5.0%	11.4%		5.9%	3.3%			15.4%		4.2%
1	N	1	2	2	1		1			1	8
	%	5.0%	5.7%	6.7%	5.9%		2.3%			4.3%	3.1%
2	N	1	1	3		1	2	1	1		10
	%	5.0%	2.9%	10.0%		3.3%	4.5%	2.9%	3.8%		3.8%
3	Ν	1	1			1	2	5	1		11
	%	5.0%	2.9%			3.3%	4.5%	14.3%	3.8%		4.2%
4	N		3	2		2	1	3	1	1	13
	%		8.6%	6.7%		6.7%	2.3%	8.6%	3.8%	4.3%	5.0%
5	N	1		1	1	2	2		2	1	10
	%	5.0%		3.3%	5.9%	6.7%	4.5%		7.7%	4.3%	3.8%
6	N			1		2	3			1	7
	%			3.3%		6.7%	6.8%			4.3%	2.7%
7	N	1	2	2	1	3		1	1		11
	%	5.0%	5.7%	6.7%	5.9%	10.0%		2.9%	3.8%		4.2%
8	N		2	1	2	1				3	9
	%		5.7%	3.3%	11.8%	3.3%				13.0%	3.5%
9	N	1				1	3	1		1	7
	%	5.0%				3.3%	6.8%	2.9%		4.3%	2.7%
10	N	1	3	1		2	5	2		1	15
	%	5.0%	8.6%	3.3%		6.7%	11.4%	5.7%		4.3%	5.8%
11	N	2		1	1	1	1	1		1	8
	%	10.0%		3.3%	5.9%	3.3%	2.3%	2.9%		4.3%	3.1%
12	N			2	2	4	2		2	1	13
	%			6.7%	11.8%	13.3%	4.5%		7.7%	4.3%	5.0%
13	N		3		2	1	2				8
	%		8.6%		11.8%	3.3%	4.5%				3.1%
14	N	2	1			1	3	1	3	1	12
	%	10.0%	2.9%			3.3%	6.8%	2.9%	11.5%	4.3%	4.6%
15	N		1	1		2		2	1		1
10	%		2.9%	3.3%		6.7%		5.7%	3.8%		2.7%
16	N						1	2	2	2	0 70/
47	%	4	4			1	2.3%	5.7%	1.1%	8.1%	2.1%
17	0/	E 00/	2.00/	6 70/	E 00/	2 20/	4 50/	<u>ک</u> ۲ م	2 00/	<u>ک</u>	13 E 00/
10	70 N	5.0%	2.9%	0.1%	5.9%	3.3%	4.5%	5.7%	3.0%	0.1%	5.0%
10	0/		E 70/	6 70/	11 00/		2 20/	0 G0/	7 70/		1 60/
10	70 N	1	5.770	0.7%	11.070		2.3%	0.0%	1.170	1	4.0%
19	0/_	20.00/	2 00/	6 70/	5 00/		2 20/	د \۵۵ 8		1 20/	5 00/
20	70 N	20.0%	2.9%	0.770	J.9%		2.5%	0.0%	2	4.3%	1.0%
20	0/	5.0%	5 70/	10.0%	11 80/		2 20/	8 60/	11 50/	12 0%	6.0%
21	70 N	5.0%	5.7%	10.0%	11.070	2	2.570	0.0%	11.570	13.0%	10
	0/2		2 9%			6 7%	د ۸۵۶ ۵	5 7%		8 7%	3 8%
22	/0 N	1	2.9%	2		0.770	0.070	J.170 1	1	0.7%	11
22	0/	5 0%	5 7%	6 7%		2 20/	6 8%	2 0%	3 8%		4 2%
22	70 N	0.0 /0	3.170	0.770		0.070	0.0 <i>1</i> 0	2.3/0	1	1	т. <u>2</u> /0 16
20	0/	5.0%	8.6%	6.7%		3 3%	11.4%	5 7%	3.8%	4 3%	6.2%
\vdash	N	20	35	30	17	30	44	35	26	570	260
\vdash	%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0
	10	100.070	100.070	100.070	100.070	100.070	100.070	100.070	100.070	100.070	%
											70

Table 11. Time of death (data only recorded in 260 cases) (p ns).

4. Prescribing of opiates on Dryad

Many of the concerns about deaths at GWMH relate to the use of opiates. We have obtained information from the controlled drugs registers of Dryad ward, for the period 1995-1998. Thus far, we have collected incomplete data from 1998 to 2001, but anticipate being able to obtain full data for these later years.

Since we have information about admissions to Dryad ward, some indication of the reason for admission, and whether the patient was discharged alive or died on the ward, it has been possible to estimate the proportions of patients admitted with different types of illnesses who received opiates, and whether they died. Those patients who received at least one dose of opiate were included in this analysis.

The findings are summarized in Table 12. The illness groups are stroke, general medical problems, medical and mental problems, heart problems, cancer, post-operative cases such as fractured neck of femur, and respite care. Thus, of the 17 patients admitted with strokes between March 1995 and August 1998, 10 died, of whom 8 received an opiate. None of those discharged alive had received an opiate. Some patients in all illness groups received an opiate except for those in the respite care group. Of those who were admitted with strokes, 47% received an opiate, the proportion for general medical problems was 71.7%, medical and mental problems 73.2%, heart problems 71.4%, cancer 66.7 %, and post-operative cases 60.9%.

Some qualifications must be made about these data. First, 10 patients had been recorded as receiving an opiate although the admissions book did not record them as having been admitted. These patients were omitted from the analysis. Second, no account has been made of the dose, numbers of doses, type of opiate received or administration route. The data will therefore include a number of patients who received only one or two doses, but my impression is that the numbers of such patients would not be sufficiently high to change the general conclusion from the table. Third, it is difficult to judge whether individual patients did have a level of pain that justified the use of opiate medication. Without a case by case review, the appropriateness of opiate medication for each patient cannot be determined. Nevertheless, it should be borne in mind that at least some of the complaints made by relatives of deceased patients involve the alleged excessive use of opiate medication. The CHI review also suggests high use of these drugs until 2000.

The findings reported in Table 12 are compatible with a liberal policy on the use of opiate medication. Two thirds of all patients admitted to the ward between March 1995 and August 1998 received an opiate.

			outcome		Total
illness group	had an opiate		died	discharged	
stroke	No	N	2	7	9
		%	22.2%	77.8%	100.0%
	yes	N	8		8
		%	100.0%		100.0%
	total	N	10	7	17
		%	58.8%	41.2%	100.0%
general medical problems	No	N	7	19	26
		%	26.9%	73.1%	100.0%
	yes	N	55	11	66
		%	83.3%	16.7%	100.0%
	total	N	62	30	92
		%	67.4%	32.6%	100.0%
medical/mental problems	No	N	3	8	11
		%	27.3%	72.7%	100.0%
	yes	N	29	1	30
		%	96.7%	3.3%	100.0%
	total	N	32	9	41
		%	78.0%	22.0%	100.0%
heart problems	No	N		2	2
		%		100.0%	100.0%
	ves	N	5		5
		%	100.0%		100.0%
	Total	N	5	2	7
		%	71.4%	28.6%	100.0%
				a tradition and	
cancer	No	N	5	3	8
		%	62.5%	37.5%	100.0%
	ves	N	16		16
	<i>J</i>	%	100.0%		100.0%
	Total	N	21	3	24
		%	87.5%	12.5%	100.0%
			01.070	12.070	100.070
nost on ea ∼nof	No	N	3	6	9
	110	%	33.3%	66.7%	100.0%
	Ves	N	12	2	14
	ycs	%	85.7%	14.3%	100.0%
	Total	/0 NI	15	8	23
		0/	65.2%	34.8%	100.0%
		/0	00.270	07.070	100.070
respite care/ social admission	No	N		5	5
		%		100.0%	100.0%
	Total	N		5	5
		%		100.0%	100.0%

Table 12. Patients on Dryad ward who received an opiate, March 1995 – August 1998, according to illness group and outcome (died or discharged). N=209.

Commentary

The data extracted from Dryad Ward admissions book tends to give some reassurance about the patterns of deaths. A high proportion of patients were admitted from other wards or acute hospitals with major medical conditions. The high proportion of those admitted who died appears to be at least partly explained by this factor, and the death rate among admissions did not fall until a greater proportion of cases were admitted from home, and were for respite care, a trend evident from approximately 1999. The data about time of death does not suggest an unusual pattern.

In contrast, information about the use of controlled drugs on Dryad Ward is cause for concern since the findings are compatible with a liberal policy on the use of opiate medication. Further investigation of the prescribing of opiates in more recent years, and of prescribing on other wards, is required.

In addition to further investigation of data extracted from the controlled drugs registers, the following steps are required in this review:

1. Review of the clinical records of those patients about whom concerns have been raised by relatives. I have now obtained agreement of the police to this plan.

2. The clinical records of samples of cases identified as receiving controlled drugs must be reviewed to determine the appropriateness of their care. A procedure for ensuring the valid appraisal of the probably large number of records requiring review is being put in hand. The police hand undertaken to consider whether the records of the cases that have been reported to them can be made available for review.

3. Statistical information to enable a comparison between the observed and expected numbers of deaths is required. This work is in hand. However, the influence of casemix among admissions will present some challenges to interpretation.

4. A review of the numbers of deaths in the practice is also in hand.

Richard Baker 13.12.02