‘Life or death’ Ministry warning
HOSPITAL DRUG ALERT AS 5 DIE

Race to find 500 drip-feed bottles

The coroner, Mr W. E. J. Major, was told by Mrs Myatt went into the hospital on February 25 and died on March 1. Dr Hunt said that death was due to collapse following an operation for thrombosis in an artery in the leg. The dextrose solution fed to Mrs Myatt was examined by one of the doctors at the hospital and he asked for it to be examined.

**Difficult to recognise**

In answer to questions from the coroner, Dr Hunt agreed that if any other patients died as a result of the contaminated solution, their bodies would have been disposed of by now.

**The condition would be difficult to recognise, and death would have been accounted for by natural causes.**

The inquest on Mrs Myatt was adjourned.

Later, announcing the hospital inquiry, Mr Major said the five deaths had been caused by the batch of the solution. The bodies had either been buried or cremated.

"We must bear in mind — as Dr Hunt said at the inquest — that it is possible that the purifiers may have had an injection of this stuff may have been more serious than we thought," he said.

**Death mystery**

When the inquest on Mrs Myatt opened yesterday at Plymouth, Dr A. C. Hunt, consultant pathologist, said he could give no cause for her death.

He told the coroner: "Information was given to me that the batch of infusion fluid supplied to the hospital was contaminated with dextrose."

The cause of death was stated to be "trauma due to exhaustion of the heart in the process of giving the fluid." Dr Hunt replied: "I think it was due to the remaining of the solution in the patient's system that we may have been able to account for her death.

**Mixed delivery**

The Department of Health say bottles of the solution are normally delivered in boxes of twelve and it is possible that a warehouseman making up deliveries could have mixed bottles from the contaminated batch with bottles from unaffected batches.

As experts at the Devonport Hospital Office of Health say, this is the most likely explanation for the deaths.

Dr Denis Cahal, senior principal medical officer at the Department of Health, said on television last night that the distribution of the solution was "just a human error" — one of those accidents which sometimes occur.

Dr Cahal said that it would be about two days before all the bottles of batch D 1192/C were located. Most of them were believed to be in south-west England.

**Joint statement**

The joint statement issued last night by the Department of Health and the dextrose manufacturer, Evans Medical Ltd., of Speke, Liverpool, is suspected of being faulty.

The sub-batch number is D 1192/C and it was distributed in May, 1971.

"It is difficult to ascertain all possible steps to ensure that any bottles remaining from this sub-batch, which contains approximately 660 bottles, be removed immediately." So far 156 bottles have been accounted for and an unknown number may have been used since the sub-batch was issued.

**Glxo subsidiary**

Evans Medical Ltd. was founded nearly 200 years ago and is now a Glaxo subsidiary. It manufactures several hundred lines of standard drugs for hospitals and the pharmaceutical trade. Few of its products can be bought over the counter.

A spokesman said last night that 5 per cent. dextrose solution was purely reconstituted to possess certain qualities, and could not be bought at High Street pharmacies.

Guy's Hospital said last night that it had received the warning from the Department of Health and had not had any 5 per cent. dextrose in stock.

A spokesman at St. Thomas' said an immediate check was being made.

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