

**Exeter Partnership NHS Trust Records
Preliminary Project Report
Dr Nicole Baur**

The following report is an update on the above project, covering the time period from November 2008 to 20/02/2009. It outlines briefly the current status of the file deposit and the way of entering the data. The main part of the report shows some preliminary results gained from the data entered so far, and the final part discusses some methodological problems.

1. The deposit

As far as the number of patient files in our deposit is concerned, we have to increase the original estimate of 10,000 by approximately 2,000. This is due to the arrival of a second deposit of around 1,000 files last year, all of which have already been entered into the DB. It has also been found that the first deposit contains files from Digby Hospital. These are much thinner than the Exminster files, i.e. there are more to one shelf. Thus, the total number of files in our project is likely to be around 12,000. These Digby files have increased our admissions considerably, as, contrary to Exminster, it was custom in Digby to keep all admissions of one patient in one pocket, i.e. the deposit contains files with up to 9 admissions in one pocket. This affects the data entry process, as it takes more time to deal with one file.

2. Data entering

The database experienced one final change at the beginning of 2009. The new structure can be seen in appendix 1. It can now store a maximum of 143 pieces of information per patient in 12 related tables.

On 5 January 2009, Eliza Newton started as a new project member, employed four days per week, to speed up data entry. The table below shows the number of files dealt with every day. The redesign of the database after Christmas and the creation of data entry forms have facilitated work enormously, and the current progress rate is about 195 files per week. At the current rate the project would need to continue for about another eight months in order to enter all the patient files. Both employees will be available for the next 2 months. Then Eliza will take over sole responsibility for data entry. Her current rate is around 60 files per week, which makes it rather difficult, if not impossible, to complete the project in the proposed time schedule.

Week / c	No of files dealt with
12/01/2009	204
19/01/2009	258
26/01/2009	200
02/02/2009	168
09/02/2009	180
16/02/2009	160
Total	1170

Work between the two project members has been organised according to a division of the deposit, starting from both ends. Eliza has worked her way up from 1971 to 1966, dealing mostly with Exminster files. I have entered Exminster files up to October 1951 and am now working on Digby files, which have been put in up to July 1960. While this division keeps interference and overlaps to a minimum, it means that the DB now shows a gap for the mid-1950s to the late 1960s.

3. Database – some results (as of 20/02/2009, if not otherwise indicated)¹

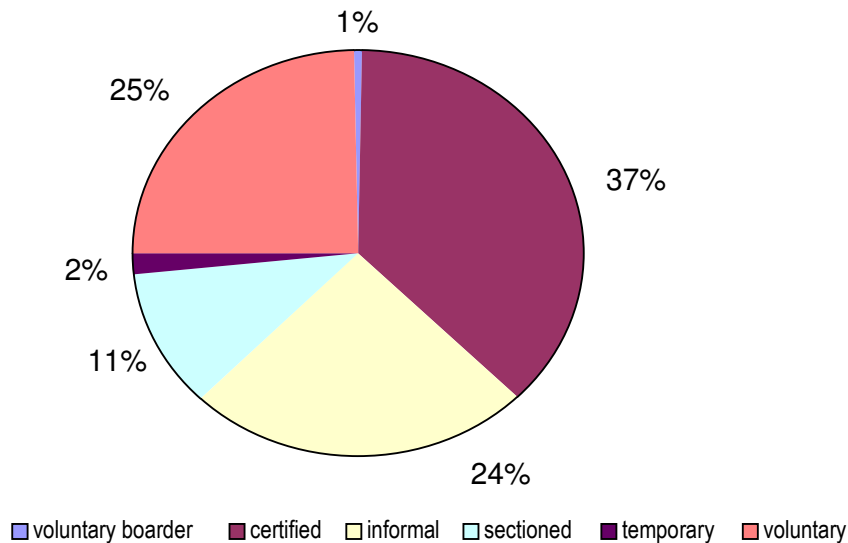
Time period covered in deposit 06/1870 to 10/1971

Patients admitted total 4,517 male 1,758 female 2,759 (= 61.1%)
Criminals total 83 male 59 female 24

Most crimes committed fall into the category of petty crimes, i.e. breaking into houses, stealing and shoplifting. Six in-patients were convicted of indecent behaviour and / or assaulting girls, and three of attempted suicide.

Admissions total 6,792 male 2,601 female 4,191 (= 61.7%)

From the patient's status upon admission, which is available for 5,695 admissions, it can be seen that half of all admissions were compulsory (certified, temporary or sectioned). With 63.0% the proportion of compulsory female admissions is slightly above the proportion of female admissions.



a) Age on admission average age upon admission: 52.6 years (range: 4 to 101 years)
average age upon first admission: 52.1 years
average age upon second admission: 53.1 years
average age upon third admission: 49.0 years
average age upon fourth admission: 50.4 years

These figures suggest that patients with multiple admissions start their “hospital career” in younger years than patients with only one or two admissions.

¹ All figures in this report have to be interpreted with some caution due to the current gap in records between 1952 and 1965 explained above.

The complete age distribution upon admission is as follows

Age upon admission	Total number of admissions	Number (%) of female admissions	Percentage of female admissions
< 10	8	1	12,5
10 – 14	10	3	30,0
15 – 19	149	74	49,7
20 – 24	324	158	48,8
25 – 29	439	234	53,3
30 – 39	933	533	57,1
40 – 49	915	582	63,6
50 – 59	901	590	65,5
60 – 69	1,109	709	63,9
70 – 74	583	324	55,6
75 – 79	426	262	61,5
80 – 84	289	207	71,6
> 84	214	157	73,4

With the data entered so far, the number of admissions is highest for the age group of 60 to 69 year olds. The proportion of female admissions peaks in the older ages, i.e. 80 and over, followed by women in their fifties, sixties and forties. This can be partly explained by the longevity statistics and corresponds with the imbalance towards women in old age generally. Explaining why women in their forties and fifties are more frequently admitted than men is more difficult. It might be to do with the “change of life” many women experience during that age with the children leaving home and working women taking early retirement. It is also an age during which many people have to deal with the loss of close friends and relatives.

b) Admissions by year see appendix 2

A significant increase in admissions can be seen from 1949 onwards. Whether this is related to the aftermath of WWII or the foundation of the NHS remains unclear at the moment.

Re-admissions

Admissions and re-admissions are affected by the bombing of Digby Hospital in November 1942 and its following closure until November 1947 (patients who were transferred to Exminster or Plymouth and later re-transferred to Digby had to be entered as new admissions)

a) The frequency of admissions is as follows:

Number of admissions	Number of patients	Number (%) of females
1	3,316	2,000 (60.3%)
2-4	1,071	676 (63.1%)
5-9	111	69 (62.2%)
10-19	12	8 (66.7%)
20 and more	1	1 (100%)

The highest number of admissions of one patient is 35. Interestingly, up to 9 admissions, the ratio male-female admissions mirrors the male-female patient ratio. Ten and more admissions seem to involve women rather than men, but we have to be aware of the small numbers we are dealing with here.

b) Place of residence

A look at the place of residence (home address) of patients who were admitted repeatedly (see table below) unsurprisingly shows that most patients come from Devon. Nevertheless,

neighbouring counties such as Cornwall or Somerset sent repeatedly patients to the Devon institutions.

Place of residence	Number of admissions								
	2	3	4	5	6	7	8	9	10+
unknown	31	8	2	1	1	1			
Eire	1								
Cornwall	8	1	1	1					
Devon	643	209	113	52	15	16	8	7	13
Dorset	3				1				
Gloucestershire	1								
Hampshire	2	1							
Kent	2	1							
Lincolnshire		1							
London	8	1	1						
Middlesex	1								
NFO	5		1						
Scotland		1	1						
Somerset	9	3	2						
Staffordshire	1								
Surrey		1							
Sussex	2								
Wales	2		1						
Yorkshire	1	1	1						

Appendix 3 shows the place of residence of Devon patients who were readmitted. This table mirrors the one discussed above on a smaller geographical scale. It shows that while patients who were readmitted once or twice came from a wide catchment area, this radius narrows considerably for multiple admissions. These live mainly in areas close to Exeter, particularly along the south coast, as well as in the few major cities in Devon.

Duration of hospitalisation	average	2019 days (approx. 5.5 years)
	Before 06/1948	4,622 days (approx. 12.7 years)
	From 06/1948	231 days (approx. 7.7 months)

Unfortunately, not all admissions could be included in this calculation, as it required the admission and leaving dates. The calculation was based on 6,208 admissions (91.4% of admissions currently recorded). For a number of (mostly early) admissions, leaving dates were unavailable due to the state of the file. It is therefore likely that the average stay in hospital was longer than our calculation suggests.

Information on how hospitalisation changed a patient's condition is available for 3,402 of 6,358 discharges. It is interesting to learn that only around 18.5% of patients recovered while in the institution. A much greater percentage improved (31.5%), and 9.4% left the hospital "not improved" – usually against medical advice. On six occasions hospitalisation was unsuccessful, i.e. the patient deteriorated, and 1,373 patients died in hospital. These deaths relate to 30.1% of patients and 20.2% of admissions currently recorded in the DB. According to our data, the success rate of treating patients in the institution does not increase for patients who stayed there longer.

It might be interesting to note that 16 patients absconded during their stay in hospital.

Geographical information

Admissions to all three hospitals were primarily from Devon (Exminster 94.4%, Digby 95.4% and Wonford House 74.4%). Exminster had the largest catchment area with admissions from 25 English counties, Eire, Scotland and Wales as well as four admissions of patients with a foreign address. Digby admitted patients from 10 English counties, as well as Eire and Scotland, while Wonford House patients came from 16 English counties and Eire / Scotland and Wales. The neighbouring counties Cornwall and Somerset were home for patients particularly admitted to Exminster and Wonford House.

Map 1 (will be available at the meeting) shows the place of residence within Devon for patients admitted to the three hospitals. A clear concentration of patients along the southern coastal regions, particularly Torquay and Paignton is evident. Other areas with large numbers of patients are the bigger cities such as Barnstaple, Bideford, Crediton, etc. (data as of 30/01/2009)

A map showing the number of admissions related to 10,000 inhabitants of the patient's area of origin for the year 1951 is currently being produced.

Linkage information

With the foundation of the NHS and the subsequent emphasis on community care treatment became more spatially dispersed. This placed a new importance on communication, and the more recent files are full of professional correspondence, some of which might be useful in terms of linking institutional and community care.

a) GP

Details of the patient's GP are available for 1,795 patients. Of another 50 patients we know that they were not registered with a GP. Information on the patient's private doctor is available either from the "Statement of Particulars" or via admission / discharge letters. In case of an admission letter we might have the benefit of learning about previous treatment and medication administered to the patient. Correspondence can indicate that, for example, the GP referred the patient to social services or to the Out-patient Department of the nearest hospital where they can be seen by a consultant who might then recommend their admission. The discharge letter issued by the hospital usually discusses diagnosis and treatment as well as recommending further medication and, if required, out-patient care.

b) NI number 338 patients

c) After -care reports 340 patients

Upon leaving the hospital, patients were usually asked to sign a form stating whether they agree / disagree to after-care treatment. In case of agreement a social worker will be visiting the patient occasionally at home and provide a report. A copy of it can usually be found in the patient files. These reports, which are very variable in numbers, can take any form from a few lines up to a 2-page minute account of the patient's experience since either discharge from hospital or the previous visit. Occasionally they suggest a patient's readmission.

d) Previous admissions to other hospitals 681 patients

We have got 1,015 accounts of hospitalisation in mental institutions before treatment was sought in one of the Devon hospitals. Some patients had been treated up to 13 times in

other institutions, and occasionally full accounts of their condition and treatments are available.

e) Out-patient treatment 56 patients

From about the 1950s onwards, most patients are recommended for out-patient treatment after leaving the hospital. Occasionally evidence of their treatment has been placed with the files.

Apart from out-patient treatment there was the option of patients being seen by a consultant psychiatrist before their admission to hospital. These consultations usually took place at a hospital, there is, however, evidence of domiciliary visits by the consultant

It is often difficult to reconstruct what agencies were involved in a patient's admission / discharge because the files contain mostly carbon copies which do not always show the author's name, signature or institution. In addition, there seemed to have been a variety of job titles, such as "Duly Authorised Officer / (Senior) Mental Welfare Officer / (Senior) Social Worker in Mental Health / Psychiatric Social Worker". It remains unclear whether they all had a similar function or in what way they differed. More material on the admission process will be available during our meeting, so suffice it to say that the social / welfare department was usually contacted by either relatives or the patient's GP, occasionally by the consultant psychiatrist or the police, and that these agencies play a key role in the admission process.

f) Other potential linkage material

Welfare committee minutes for the period 1948 to 1961 have been examined, but have to be regarded as of limited linkage value because they do not mention individuals. However, we positively identified records of the Exeter Town Clerk's records with patients in our DB. These records are more detailed and could fill some gaps in our DB, but they refer only to patients diagnosed as M.D.

The Cornwall Records Offices has been contacted regarding a potential comparison with St Lawrence's Hospital, Bodmin. They are, in principle, willing to cooperate and make the patient files available for research, provided that we can obtain clearance from the Cornwall NHS Partnership Trust.

Diagnosis

a) Suicide

278 patients were regarded as suicidal upon admission with a further 77 being "potentially suicidal". Of these 355 patients 206 had actively attempted to commit suicide, some on several occasions. 74% of attempted suicides were committed by female patients. 38 patients had threatened to "do away with themselves" prior to their admission. According to our data, the preferred methods of attempting suicide were overdose of drugs and (coal) gas poisoning. Other methods included cutting throats or wrists, drowning and jumping from a window. Only male patients attempted to shoot or hang themselves or walked in front of a car / bus / train.

b) Frequent diagnoses

The table below shows the proportion of the most frequent diagnosis in our DB (they account for about 89% of diagnoses in male and female patients). Melancholia or later depression was diagnosed in a total of 805 patients, followed by dementia (628), schizophrenia (460), Insanity (323), Psychoses (288) and Insanity (270). Our data suggests that there were considerable differences in male and female patients diagnosed with certain diseases. A much higher proportion of women, for example, was diagnosed with paranoia, mania and

melancholia. The higher proportion of female dementia patients is most likely due to the higher percentage of women admitted in old age. Men, in contrast, were more often treated for alcoholism, GPI, insanity, and schizophrenia. In addition, a larger proportion of male patients were diagnosed as psychopathic personalities and mental defectives.

Diagnosis	Percentage of male patients	Percentage of female patients
Alcoholism	2,9	0,2
Anxiety	3,9	3,2
Confusion	5,1	3,4
Dementia	13,0	16,7
GPI	1,5	0,2
Hypomania	1,2	1,0
Hysteria	0,7	1,1
Inadequate personality	0,2	0,1
Insanity	10,4	6,2
Mania & manic-depressive	4,1	8,2
Melancholia & depression	17,2	21,1
Moron / MD / Imbecile	6,9	5,6
Paranoia	0,8	4,6
Psychosis	7,1	7,0
Psychopathic personality	1,3	0,5
Schizophrenia / dementia praecox	12,5	10,3

c) Diagnosis and age

The variety of diagnoses recorded in the DB makes it difficult to group them according to the patient's age, particularly for "middle-aged" patients. It is worth noting, however that all patients under the age of ten were classed as mental defectives. In the category 10 to 14 years, MD was still the most frequent diagnosis, but it was joined by psychopathic personality, epilepsy and schizophrenia. Depression / melancholia and mania were diagnosed in teenagers as young as 15 to 19 years. Together with anxiety, these mental illnesses account for most diagnoses in patients aged 20 to 59. Even patients in their sixties were frequently diagnosed with depression, but from that age onwards dementia takes over as the main diagnosis.

Treatment

Treatments administered at the Devon hospitals are in line with existing literature on this topic. Our results are again somewhat affected by fragmentary or missing records, but below are results based on 2,533 patients for whom we currently hold information on various treatments. These fall into three main categories:

a) Physical treatment

ECT 730 patients

More than two thirds (483) of patients treated with ECT were women. This is not surprising given the higher percentage of women diagnosed with depressive illnesses, as ECT was primarily used to treat depression / melancholia (44.2%). It came also to use in patients with schizophrenia (11.4%) and various forms of anxiety (8.1%). To a lesser extend it contributed to the treatment of mania / manic-depressive illnesses as well as psychoses and for mentally defective / morons / imbeciles. Most patients received only one course of ECT (usually six to eight treatments) during their hospitalisation.

Insulin Coma Therapy 49 patients

Insulin Coma Therapy was mainly administered between 1947 and 1955 to treat schizophrenia as well as some cases of puerperal psychoses and mania. In more recent years, however, a “modified insulin therapy” was used where patients were injected with insulin “until sweating occurs”. This treatment has a wider application in alcoholism, anxiety, dementia, depression, hysteria as well as schizophrenia.

Malaria Treatment 22 patients treated for GPI, delusional insanity and schizophrenia

UV Treatment 5 patients between 1928 and 1936, all suffering from mania (1) or schizophrenia (4).

Leucotomy 5 patients starting in 1959. Leucotomies attracted great interest among the professional community, and documentary evidence suggests that the patients were anxious to undergo this procedure. Patients of the Devon hospitals were referred to Moorhaven (Ivybridge) or Frenchay (Bristol) to have the operation.

b) Tonics and mixtures were usually given before the onset of drug treatment, some however survived into the 1960s.

c) Psychoactive drugs

Sedative drugs such as paraldehyde, sodium amytal chloral hydrate and phenobarb have a long tradition in the Devon hospitals. The discovery of chlorpromazine in 1952, however, started the widespread use of psychoactive drugs. It is interesting to see that even patients who had been in hospital previously without any drug treatment, were put on one of the new drugs upon readmission.

The two main categories of drug used for the patients in our deposit were anti-psychotics and anti-depressants. In the beginning there seemed to have been a lot of confusion as to the right dosage. Patients had their dosages changed frequently, and some were put on extremely high dosages, such as for example 400 mg daily (Largactil). In more recent years dosages decreased.

Below is a list of the most frequently used drugs and the date when they were first used for our patients:

Anti-psychotics:	Largactil	May 1953
	Fentazin	October 1958
	Melleril	February 1959
	Serenace	August 1959
	Taractan	September 1960 (discontinued in 1962)

Anti-depressants:	Tofranil	January 1959
	Nardil	August 1959
	Marplan	February 1961 (discontinued 1962)
	Tryptizol	May 1961
	Pertofran	February 1963
	Surmontil	April 1966
	Prondol	October 1968

Despite these new drugs, barbiturates continued to play a major role in the treatment of mentally ill patients. Almost every patient was put on a sedative, if only for a few days after admission.

It might be interesting to know that some of the drugs administered to our patients, such as Nembutal or Drinamyl, have since been taken off the UK market due to their severe adverse effects.

4. Methodological problems

As has already been hinted at in this report, there are some methodological problems related to the data itself as well as to our options of manipulating and interpreting it.

Structure and content of the deposit

- a) We currently have potential duplicates in the tables “patient” and “gp”, as we have too little information to verify data (e.g. some doctors have gone into the table with two addresses, as it was impossible to find out whether they have moved or if they are the same people at all). Census data or a register of addresses / professions might help here
- b) Only a small number of files is available for the years 1945 – 1949. It might be good idea to check admission books for annual admissions & then compare how many of them we have got in our DB
- c) Wonford House: hardly any files available, unless patient was also treated in Exminster & Digby. The DB contains records of Wonford patients up to 1944, which have been entered from Hospital Index Cards. Is it worth entering information from the remaining HICs, even if we are unlikely to encounter any files (DRO intends to hold on to all HICs)

Demographic data

- a) The deposit contains a very large number of elderly people from about 1960 onwards. As one of the researchers has started from the end of the deposit, this can cause a slight imbalance in the average age until all files have been entered
- b) If we want to analyse patients’ occupations, these need to be classified. A model, based on the HISCO classifications is provided on the following website on the history of work: <http://historyofwork.iisg.nl/major.php>. Its suitability for our data will have to be evaluated in more detail.

Geographical analyses

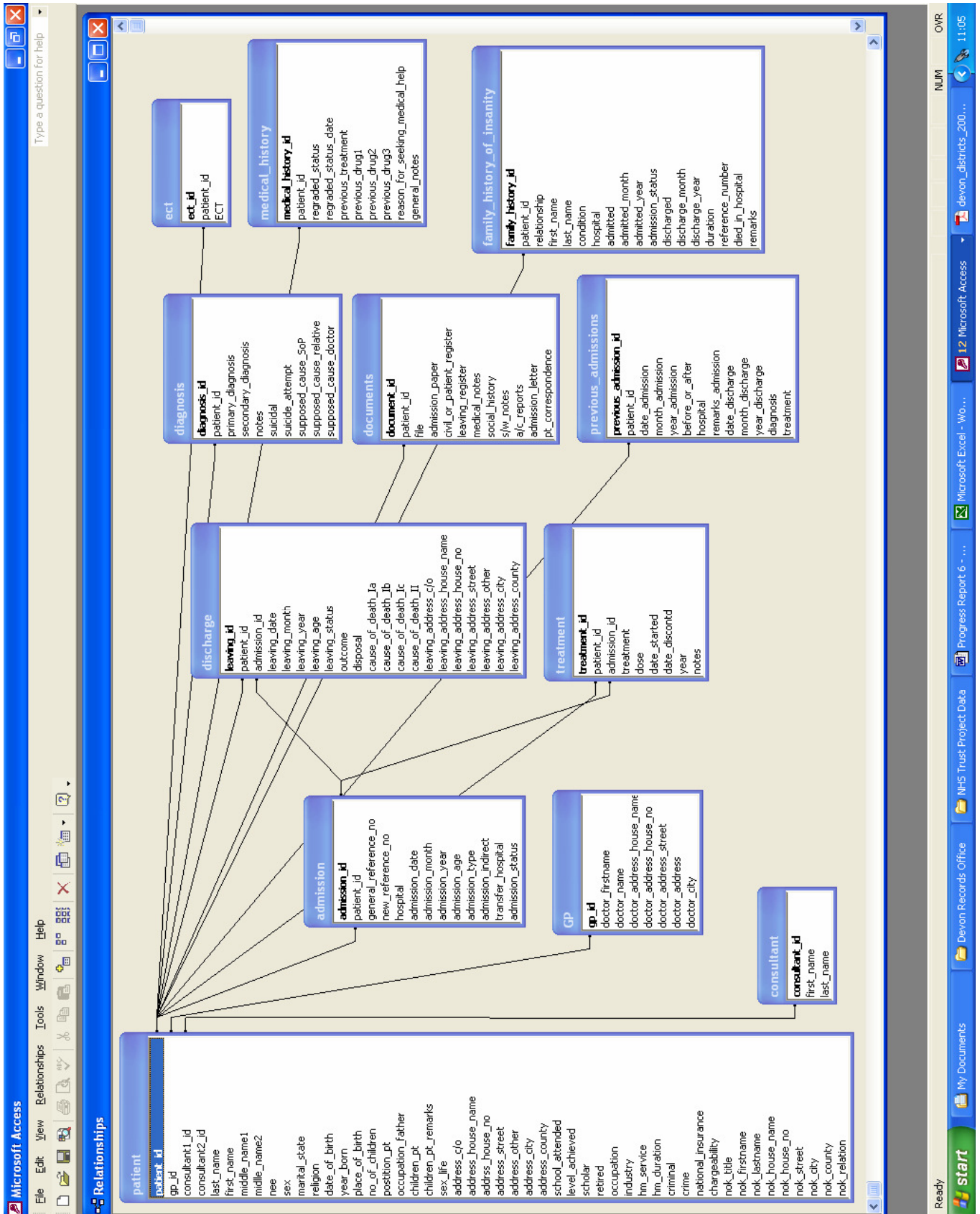
- a) A clear agreement on names of counties (before / after the reform) is vital to any geographical analysis. Particular problems are caused by e.g. Lyme Regis which must have switched between Devon & Dorset, and by whether we want to consider Plymouth a part of Devon
- b) I was able to obtain from the DRO a parish map of Devon and to import it into a graphics programme as well as a population count for these parishes (census data 1801-2001). These tools allow a graphic representation of e.g. the patients’ places of residence. If we want to use a GIS instead, we have to be aware that the patient files give full addresses minus post-codes (I might be wrong, but I assume the GIS maps are post-code based). As we are dealing with a very long time period, it would also be useful to know if the university (probably Geography) has digitised large-scale maps for earlier periods and whether they would allow us access to them

Drug treatment

The collection of data on drug treatment remains the most difficult task of the project and might require some assistance from someone with professional experience in this sector. Specific problems are:

- a) Names of drugs on Medicine Cards are often illegible / abbreviated (e.g. Hst Par = Paraldehyde?); many of the older drug names cannot be found on the internet
- b) The duration of the treatment is not always available; we usually know when patients commenced a particular drug treatment, but whether the dosage changed or when it finished is not always evident from the files
- c) Apothecaries' measures and weights are difficult to decipher, particularly the difference between **℥** "ounce" and **ʒ** "drachme", as the handwriting is often open to wide interpretation...

Appendix 1: Structure of the database (as of 05/01/2009)



Appendix 2: Admissions by year

Year	Number of admissions
1870	2
1875	1
1881	1
1883	2
1886	1
1887	1
1890	2
1891	2
1893	1
1894	1
1895	2
1896	1
1897	3
1898	1
1899	7
1900	9
1901	4
1902	8
1903	4
1904	8
1905	9
1906	6
1907	13
1908	7
1909	9
1910	20
1911	19
1912	15
1913	17
1914	12
1915	11
1916	19
1917	20
1918	32
1919	32
1920	17
1921	28
1922	36
1923	36
1924	45
1925	58
1926	55
1927	47
1928	69

1929	103
1930	95
1931	69
1932	94
1933	83
1934	108
1935	95
1936	123
1937	129
1938	132
1939	135
1940	116
1941	130
1942	156
1943	135
1944	162
1945	61
1946	78
1947	75
1948	95
1949	256
1950	427
1951	349*
1952	147
1953	102
1954	49
1955	64
1956	60
1957	82
1958	179
1959	385
1960	155
1961	163
1962	169
1963	33
1964	17
1965	25
1966	25
1967	147
1968	278
1969	432
1970	286
1971	95

** Years 1951 to 1971 have not been fully entered yet*

Appendix 3: Place of residence of readmissions from Devon

Place of residence	Number of admissions															
	2	3	4	5	6	7	8	9	10	11	12	14	15	17	19	35
Abbotskerswell	1	1														
Appledore	2				1											
Ashburton	5															
Ashcombe		1														
Ashford	1															
Ashprington		1														
Axminster	6															
Bampton	2															
Barnstaple	17	7	4	1												
Beaford	1															
Beaworthy	2	1														
Beer	1	1														
Bestone		1														
Bere Alston		1														
Bickington	2		1													
Bickleigh	1															
Bideford	13	4	4	1												
Bishopsnympton	3															
Bishopstawton	1	1				1										
Bishopsteignton	1															
Blackawton									1							
Bovey	2		1			1										
Bow	2	1														
Bramford Speke					1											
Bradford	1															
Bradninch		1		1												
Bradworthy	1			1												
Branscombe			1					1								
Bratton Clovelly	1															
Bratton Fleming			1													
Braunton	9	1														
Bridgerule	1	1														
Brixham	16	2		2	1					1						
Broadclyst	1	1														
Buckfastleigh	4	1	1	1												
Buckland Brewer	1															
Budleigh Salterton	3	1														
Burrington	1															
Chagford	3		1			1										
Chawleigh	1															
Cheriton Bishop	1															
Chittlehampton		1	1	1												
Clovelly			1													
Christow	1															
Chudleigh	1			1								1				

Kentisbury	1																		
Kenton	2	1	1			1													
Kingsbridge	2			1		1	1												
Kingskerswell						1													
Kingsnympton	1																		
Kingsteignton	5	1																	
Kingston		1																	
Kingswear		1																	
Landkey	3																		
Lamerton			1																
Lapford		1																	
Lewdown	1																		
Lifton	1			1															
Lower Loxhore			1																
Lustleigh	2																		
Lympstone	2	1																	
Lynmouth	1		2																
Lynton	1																		
Malborough	1	2																	
Martinhoe	1																		
Membury		1																	
Merton	1		1																
Modbury	2																		
Monkleigh	1																		
Monkton			1																
Morchar Bishop		2																	
Moretonhampstead	1					1													
Mortehoe	3																		
Musbury	1			1															
Newton Abbot	23	7	9																
Newton Poppleford	1	1		1															
Newton Tracey	1																		
North Bovey			1																
North Molton	1																		
North Tawton	3																		
Northam	2																		
Offwell	1																		
Okehampton	2	3	2	1	1														
Ottery St Mary	3	2	3	2															
Paignton	28	13	4	3	2	1									1				
Parracombe	1																		
Peter Tavy	2																		
Petrockstowe	1																		
Plymouth	6	3	2																
Plympton	8																		
Plympton St Maurice				1															
Plymtree	1																		
Poltimore	1	1																	
Princetown	1																		
Rattery	1																		

Ringmore	1																		
Rockbeare	1																		
Romansleigh		1																	
Salcombe	1		1																
Sandford		1		1															
Seaton	4	4																	
Shaldon		1																	
Shebbear		1																	
Shobrooke			1																
Shute				1															
Sidmouth	22	4	2	2					1						1				
Silverton	4	1																	
Sourton	1																		
South Brent	4	1			1														
South Molton	7	1	1	1															
Spreyton	1																		1
Starcross	5	2	1	1															
Sticklepath	1																		
Strete	1																		
Tamerton Foliot	1																		
Tavistock	3	2	3		1														
Tedburn St Mary		1					1												
Teignmouth	13	5	1	1					1					1					
Tiverton	11	4	2	2	1														
Topsham	10	4	2	1															
Torquay	49	24	9	2				2	2										1
Torrington	3		2																
Totnes	7	2	1					1											1
Uffculme	2		1																
Umberleigh	1																		
Uplyme	2		1																
Upottery	1																		
Upton Pyne	1		1																
Wembury		1					1												
Wembworthy	1																		
Westleigh									1										
West Alvington	1				1														
West Down	1																		
West Ogwell	1																		
Westward Ho!	2																		
Winkleigh	1																		
Witheridge		1																	
Withycombe Raleigh	1																		
Woodbury	1																		
Yealmpton	1																		1
Yelverton	2		1																