[Report of the Medical Officer of Health for Acton].

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Borough of Ecton

ANNUAL REPORT

OF THE

Medical Officer of Health

TOGETHER WITH THE

Report on the Medical Inspection of Schools

FOR THE YEAR 1930

ANNUAL REPORT

OF THE

Medical Officer of Health

FOR THE YEAR 1930.

PUBLIC HEALTH DEPARTMENT,
MUNICIPAL OFFICES,
ACTON, W.3.

To the Mayor, Aldermen and Councillors of the Borough of Acton.

MRS. BARNES AND GENTLEMEN,

I herewith submit the Annual Report required by the Ministry of Health, together with the Annual Report upon the School Medical Services.

The estimated population is that of the Registrar General for the middle of the year 1929. The reason for adopting this figure is given later in the report.

The birth-rate is higher than in 1929. This may be due to many causes. Probably the higher birth-rate is partly due to an under-estimate of the population. A comparatively high rate is also partly due to the erection of new houses in the North East and South West Wards and the consequent immigration of a large number of newly-married couples.

The death-rate is considerably lower than that of 1929, and with the exception of 1926, is the lowest on record for the district.

The infantile mortality is also lower and is the lowest infantile mortality rate on record for the district.

There was an increase in the number of deaths from Diphtheria, but the incidence of the other infectious diseases was low.

The following is a summary of the vital and other statistics for the year 1930 :—

Area of Borough	2,305 acres.
Population (estimated 1930)	65,200
Population (Census 1921)	61,299
Number of inhabited houses (Census 1921)	11,820
Number of inhabited houses (end of 1930) according to Rate Books	15,427

Number of families or separate occupiers (Census 1921)	14,941
Rateable Value (1st October, 1930)	£684,522
Net produce of a penny rate (year ending 31st March, 1930)	£2,812. 13s. 5d.
Total number of births registered	1,105
Legitimate	1,036
Illegitimate	69
Birth-rate per 1,000 inhabitants	16.9
Number of deaths	693
Death-rate per 1,000 inhabitants	10.6
Number of women dying in, or in consequence of, childbirth—	
from sepsis	2
from other causes	2
Maternal mortality per 1,000 births	3.6
Deaths of infants under 1 year of age—	
Legitimate	47
Illegitimate	9
Infantile mortality per 1,000 births	50

	Total Deaths	*Death-rate per* 1,000 *Population.*
Measles	9	.13
Whooping Cough	2	.03
Diphtheria	9	.13
Scarlet Fever	1	.02
Influenza	4	.06
Tuberculosis of Lungs	57	.87
Tuberculosis (other forms)	9	.13
Tuberculosis (all forms)	63	1.0

POPULATION.

The Registrar General estimated the population at the end of June 1929, to be 65,200, and this figure has been accepted as the basis of the population. The figure for 1930 will not be available before the end of June.

The Ministry of Health in a memoranudm states that the Registrar General, in computing his estimate of population for mid-year 1930, intends to take into account the populations as ascertained by the 1931 Census; the 1930 estimate will therefore not be available before the end of June. From a statement made in the House of Commons it appears as if the estimate is not likely to be ready before the 3rd or 4th week in July.

In the Ministry's memorandum, it is suggested that the Registrar General's 1929 estimate of population might be used, and a statement to that effect included in the report. If, however, the Medical Officer of Health possesses reliable evidence

of increase or decrease of population between mid-1929 and mid-1930 of sufficient magnitude to affect materially the calculation of rates, it will, of course, be open to him to make use of an alternative population figure in the report.

I have stated in previous reports my view that the Registrar General's estimated population in redent years has been too low, but as this is only a personal opinion, and the evidence upon which it is based may not be considered sufficiently reliable by others, it is better to accept the 1929 population and base our rates upon that figure.

All the rates have therefore been calculated upon the estimated population of 65,200.

SOCIAL CONDITIONS OF THE DISTRICT.

The physical features and general character of the district were described in the Survey Report of 1925. At that time it was intended that the report of 1930 should also be a Survey one, but as far as the general character of the district is concerned, this can be more profitably discussed when the results of the Census are published.

AMBULANCE FACILITIES.

The ambulance facilities are similar to those described in last year's report.

A motor ambulance is provided for the removal of infectious cases to the hospital.

There are two ambulances provided for accident and non-infectious cases. These are housed in a garage at the fire station and are available at all hours. A new ambulance was purchased by the Council in 1928, but the old one is still kept for emergencies. Last year the ambulance was called out to 655 street accidents, and on 412 occasions to private cases. Fees amounting to £84. 18s. 0d. were paid for the use of the ambulance for private cases.

HOSPITAL PROVISION.

General.—The only General Hospital in the district is the Acton Hospital, Gunnersbury Lane, which has an accommodation of 62 beds.

During the year 1304 in-patients were admitted; this is an increase of 118 on the previous year. Of these 396 were in for only 1 day and 100 for 2 or 3 days.

The Education Committee has an agreement with the Hospital for payment for the removal of tonsils and adenoids and the patients are kept in the Hospital for at least 1 night.

7099 out-patients were treated during the year, an increase of 728, and the out-patient attendances were 286,241, an increase of 421 as compared with 1929.

The Hospital supplies a great need in the district, is greatly appreciated and most of the beds are continuously occupied. Last year the average number of beds in daily occupation was 53.9, and from this figure it can be assumed that vacant beds are a rarity.

Fever.—Acton Council Fever Hospital—88 beds.

Small-Pox.—Acton was one of the constituent bodies which formed the Middlesex Joint Small-Pox Board. Under the Provisional Orders Confirmation Act of 1929, the Joint Board was disolved from the 1st April, 1929, and the duties of the Board transferred to the Middlesex County Council.

Tuberculosis.—The Tuberculosis scheme is administered by the Middlesex County Council, which has sanatoria at Clare Hall and Harefield.

Child Welfare Consultation Centres.—
(*a*)—Church Road. (*b*)—Palmerston Road.
Every Monday and Wednesday afternoon at 2 p.m.
(*c*)—East Acton. Every Thursday afternoon at 2 p.m.
(*d*)—Steele Road. Every Tuesday afternoon at 2 p.m.

Ante-Natal Consultation Centre.—School Clinic every 2nd and 4th Wednesday.

Day Nursery.—169 Bollo Bridge Road.

School Clinic.—45 Avenue Road.

(The above are provided and maintained by the Borough Council).

Tuberculosis Dispensary.—School Clinic on Tuesdays at 5 p.m. and Thursdays at 10.30 p.m.

Treatment Centres for Venereal Diseases.—Various Hospitals in London.

(The two latter are provided by the Middlesex County Council).

SANITARY CIRCUMSTANCES OF THE AREA.

These have been noted in previous reports. All the inhabited houses are supplied from the mains of the Metropolitan Water Board. A few industrial works and the Public Baths obtain their water supply from deep wells.

By arrangement with the London County Council the sewerage is discharged into the London Sewers. Storm water is filtered and emptied into the Thames. All the inhabited houses are provided with water closets and are drained into the main sewerage system.

The house refuse is collected by the Council and burnt in the Destructor. Last year 19,734 tons of house refuse were collected and burnt.

PROFESSIONAL NURSING IN THE HOME.

General.—There are two district nurses employed by the Acton Hospital, one of which is primarily engaged in district nursing.

There are also nursing associations which provide nurses for different classes of cases.

Midwives.—The Supervising Authority under the Midwives Act is the Middlesex County Council and from the County Council I understand that there are 15 certified midwives practising in the Borough.

LEGISLATION IN FORCE.

The following local acts,, special local orders, general adoptive acts and byelaws relating to Public Health are in force in the district.

	Adopted
Infectious Diseases (Notification) Act, 1889.	1889
Public Health (Amendment) Act, 1890.	1890
Infectious Diseases Prevention Act, 1890.	1899
Notification of Births Act, 1907.	1907
Public Health Act, 1907 (Clause 50).	1921
Public Health Act, 1925 (Parts 2, 3, 4 & 5)	1926
The Acton Improvement Act, 1904.	—
New Streets and Buildings.	1925
Removal of House Refuse.	1899
Common Lodging Houses.	1898
Slaughter Houses.	1924
Nuisances, etc., ...	1924
Offensive Trades.	1903
Tents, Vans and Sheds.	1906
Removal of Offensive or Noxious Matters.	1908
Houses Let in Lodgings.	1925
Cleansing of Cisterns.	1912
Employment of Children.	1920
Fouling of Footpaths by Dogs.	1929
Smoke Abatement.	1930

HOUSING.

In view of the provisions of the Housing Act, 1930, and the contemplated erection of houses and flats by the Council I have deemed it advisable to present a report to the Committee upon certain houses,, which, in my opinion, are beyond repair and require demolition. It has been emphasised in Annual Reports that the district is a comparatively new one, and that there are no areas which can be declared clearance areas, but a full description is given of what is probably the oldest part of Acton, or at any rate, the oldest part which contains any considerable aggregation of houses.

The Housing Act, 1930, consists of five parts, containing 65 Sections and 6 Schedules. The Act amends all the Housing Acts which preceded it, and though it does not repeal the preceding Acts, it repeals some of the most important Sections of the Act of 1925. The Housing Act of 1925 was really a consolidating Act, and this Act had repealed most of the purely Housing Acts which had preceded it. Before 1925, the principal Housing Act was the Housing of the Working Classes Act, 1890, and the 1925 Act repealed the whole of the 1890 Act with the exception of Section 74, and this Section was only an amendment of the Settled Land Act, 1882, dealing with the sale &c. of land and buildings. The Act of 1925 also repealed the Housing of the Working Classes Act, 1894, the Housing of the Working Classes Act, 1900, the Housing of the Working Classes Act, 1903, parts of other Housing and Housing and Town Planning Acts.

As far as Public Health Departments are concerned, the Act seeks to improve housing conditions by processes suitable for three different kinds of unsatisfactory property—slums requiring clearance; areas which are bad, but remediable by treatment less drastic than demolition; and insanitary houses requiring individual treatment. These are termed respectively, (1) Clearance Areas, (2) Improvement Areas and (3) Individual unfit houses.

The new law dealing with the last differs from the old merely in certain details, but for clearance areas, there are very drastic changes, and the improvement areas are entirely new features in legislation.

Clearance Areas.

A clearance area is defined in Section 1 of the Act and the definition is substantially the same as that of an unhealthy area under the old laws. We shall return to this definition after considering the method by which a clearance area can be dealt with.

The methods of dealing with a clearance area have been greatly simplified. In future, there will be no schemes for the condemnation of an area, and its reconstruction, but the local authority will declare an area to be a Clearance Area, that is an area to be cleared of all buildings. The area is to be cleared by requiring the owners to demolish the buildings, or by the local authority purchasing the area and then arranging for the demolition of the dwellings thereon.

The first method of requiring the owners to demolish is new, and is designed to enable the local authority to secure the removal of a bad slum without being obliged to incur the heavy capital expense of purchase and clearance. If the Authority proceeds by this method, they will make a Clearance Order which then has to be confirmed by the Minister of Health. Where a local authority, upon consideration of an official representation or other information in their possession are satisfied that an area is an

unhealthy area, the authority shall cause that area to be defined, and shall pass a resolution declaring the area so defined to be a Clearance Area. There is really no absolute necessity for a report from one of the officers of the Council, though in practice, such an official report will always be required, because of the necessity for defining unfitness of a house for human habitation. After a local Authority have declared any area to be a Clearance Area, they order the demolition of the buildings in the area by the owners.

If the owners do not demolish the houses, the local authority may enter, secure the demolition, and charge the cost to the owners. In this event, the land remains in the owners' possession, subject to the right of the authority to impose conditions as to the re-use of the site to prevent a recurrence of the nuisance. If nothing is done with the site for a period of 18 months, the local authority may by resolution purchase it and use as they will or sell or lease it upon conditions. This clause was probably inserted to prevent undue holding of the land. That is the first method of dealing with a clearance area.

The second method is by the purchase of the land by the local authority and the authority then proceeds to demolish the buildings. The local authority may buy the area, either by agreement or compulsorily. When the local authority have bought the land, the houses on the area must be demolished, but they are empowered to dispose of the site as cleared, or they may appropriate the cleared area for some purpose for which they have statutory powers. In a few cases it may be necessary to rehouse on the land or part of it.

There is one condition which must be observed before the local authority can proceed with a Clearance area, and that is that they are prepared to rehouse those who will be displaced by the demolition of the houses. The authority must satisfy themselves that suitable accommodation is available for the persons of the working classes who will be displaced by the clearance of the area. The authority can provide, or secure the provision of such accommodation in advance of the displacements which will from time to time become necessary as the demolition of buildings in the area, or in different parts thereof, proceeds. A Clearance area is defined in Section 1 of the Act, and the definition is substantially the same as that of an unhealthy area under the old law. A Clearance area is one in which all the buildings require to be demolished either (*a*) because they are unfit for human habitation on account of disrepair or sanitary defects, or (*b*) because they are dangerous or injurious to the health of the inhabitants of the area by reason of their structure, or the narrowness or bad arrangement of the streets. Properties which do not fall under either of these categories cannot be included in a clearance area. The Act does not

indicate what should be the normal size of a clearance area, and no doubt such a definition would, by reason of the great variety of circumstances in different places, be impractical.

Section 62 though gives an indication of the nature of the sanitary defects. The expression " sanitary defects " includes lack of airspace or ventilation, darkness, dampness, absence of adequate and readily accessible water supply, or sanitary accommodation or of other conveniences, and inadequate paving or drainage of courts, yards and passages. This definition is not so wide as that which was specified in the Ministry of Health's Manual on Housing.

It is obvious that the houses must by reason of their structural condition or by their insanitary condition or by their insanitary surroundings be unfit for human habitation or dangerous or injurious to health. It would be scarcely reasonable that a house could be condemned as unfit for habitation merely because the paving of a passage was unsatisfactory. The general condition must be bad, although the specific grounds for condemning may vary in different areas.

There is another provision in the Act that in determining whether a house is fit for human habitation, regard is to be had to the extent, to which by reason of disrepair or sanitary defects the house falls short of the provisions of any byelaws in operation in the district or of the general standard of housing accommodation for the working classes in the district.

These matters have been submitted by the Town Clerk to the Housing Committee, but I deemed it expedient to bring them before the Health Committee because some misunderstanding exists about the powers of the Council and the class of property to which the Clearance area and Improvement areas of the Act will apply. It will be seen that the powers in the Act are very extensive, but as I have explained in previous Annual Reports, there are no slum areas in the district. We have no areas which correspond to those contemplated in the sections which have now been quoted. The vast majority of the houses in the district have been built or re-erected since the Council have put in operation the Byelaws for streets and new buildings. With a few exceptions the houses front wide streets. There are no courts, alleys, cul-de-sacs, back-to-back houses, (with the exception of those now reported on) cellar dwellings and houses of the description which usually make up a slum or clearance area. In some of the areas which were built before the operation of the building bye-laws there are a few houses which are beyond repair and must be closed. They will be dealt with under individual houses. It may be well, though, to deal with the older areas, as some people are under the impression that all the houses in these areas are unfit for human habitation, whereas a few houses only are incapable of being made suitable and reasonably satisfactory.

The most extensive area is that which is known as the Steyne. The Steyne includes Steyne Road, Back Street, Billington Place, Nelson Place, Rectory Road, Narrow Street, and East Row.

The area is well known to most of the members of the Council and lies in a hollow to the west of Horn Lane and extends to the old Council offices and Police Station at the bottom of Acton Hill. It is roughly triangular in shape, the apex of the triangle pointing westwards. It is bounded on the East by Horn Lane, on the North by Messrs. Carter Paterson's Depot and the Co-operative Factory, and on the South by the Fire Station and the High Street.

Most of the houses in this area are old, but some have been re-erected comparatively recently. In some of the houses there has been found a piece of lead bearing the date 1528. The oldest houses are probably the eastern part of Steyne Road and the houses in East Row.

Steyne Road runs from the Duke of York Public House in Horn Lane to the bottom of Acton Hill between the old Council offices and the Police Station. All the houses do not front the roadway; two have been erected behind some other houses; or perhaps it would be more correct to state that two houses were erected in the front garden of other houses, which formerly in all probability had a fairly long front garden.

On the north side there are 25 houses together with the block of houses known as the Almshouses. Some of the smaller houses in this road were demolished some years ago, and the most westerly house on the north side at the present time is the detached house formerly known as the Rising Sun, but now called 14, Steyne Road. There used to be other houses on the land west of the Rising Sun, extending to what is now Lexden Road, but these were demolished over a quarter of a century ago. There are no houses now between No. 14 Steyne Road, and 26 Steyne Road. Formerly there were 5 houses on this part of the road, but they have also been demolished.

Between Nos. 28 and 42 Steyne Road are the Acton Almshouses and Billington Place.

With four exceptions the houses are in a fairly good condition.

On the south side are 26 houses; these all have through ventilation and air-space at the rear. The houses are in fairly good condition and are reasonably fit for human habitation.

Billington Place consists of 4 houses situated partly behind the Almshouses and Nos. 42 to 54 Steyne Road. These houses do not conform with the Council's Bye-Laws respecting air-space behind the dwelling house and belonging exclusively to it, but they have gardens or forecourts in front, and in the rear abut on the premises of the Co-operative Society.

Back Street consists of 9 houses and a yard used as a depôt. Nos. 1, 2, 3, 4, are in one block, and Nos. 7, 8, 9, 9a and 10

are in another block. The entrance to the Co-operative Factory is between the two blocks.

Nos. 1, 2, 3 and 4 are three-storeyed houses, have no back yard, but have windows which overlook the Co-operative Factory.

One of the houses was vacant.

Nos. 7, 8, 9, 9a and 10 are all through houses. The back yards are small, but each house has its own sanitary convenience situated at the rear of the house.

Nelson Place consists of 16 houses, 8 on each side of the road. Nelson Place is really a street, 36 ft. wide, and all the houses front on the roadway. All the houses have back yards, each house has sanitary conveniences. The houses are capable of being made into very satisfactory residences.

Narrow Street consists of 9 houses. The houses are old and not in a very good state of repair. All the closets are situated together in the back at some distance from the houses. These houses can be rendered fit for human habitation, but there is some doubt as to the expense, having regard to the cost of the works necessary and the value which it is estimated that the dwelling houses will have when the works are completed. The condition of the houses will be more fully described under individual houses.

Rectory Road. With the exception of the Rectory and the Central Garage, there are no dwelling houses in Rectory Road.

East Row consists of 6 houses fronting the green which slopes down from Horn Lane to East Row. 5 of the houses are in a row, and the 6th is a detached house, built at a more recent date than the others.

All the houses in East Row are old, but, with one exception, have been kept in good condition. The wall along the back of some of the houses has had to be rebuilt.

All the houses are through houses, with a small yard at the back.

Of the total number of houses in the Steyne, there are only 4 which cannot reasonably be rendered fit for human habitation. There are other houses which at the present time are in a poor condition, but these can be rendered fit at a reasonable expense. It will be seen that the area does not come within the category of a Clearance Area. There is, of course, the question of whether the Steyne should be designated an Improvement Area, and it will be desirable to examine the clauses which define Improvement Areas.

Improvement Areas.

This term appears for the first time in an Act of Parliament. An Improvement Area is really an area which is not quite so bad as a Clearance Area. In a Clearance Area all the houses must be unfit for human habitation, but in an Improvement Area, the houses are not all so far gone and the general conditions are not

so bad as to justify clearance. The general conditions in an Improvement Area are those which we associate with a slum area, but some or even the great majority of the houses are not in such state as to make them unfit for human habitation. But the defining of an Improvement Area corresponds largely with that of a Clearance Area, except that the reference is to housing conditions generally in the Improvement Area, and not, as in the Clearance Area, to all the houses in the area.

The Act sets out 3 ways in which the Area may be improved, (*a*) Demolition or repair of houses unfit for human habitation, (*b*) Purchase of land in the area for the improvement of the site and (*c*) The prevention of overcrowding.

For the prevention of overcrowding a model series of Bye-laws has been issued by the Ministry of Health. These are almost identical with those which were made by many Local Authorities in respect of houses let-in-lodgings, but there is one great difference. The Bye-laws which are now issued can come into force at once, whereas the most important of the Bye-laws for houses let-in-lodgings do not come into force until six months after the Rent and Mortgage Interest Restrictions Act, 1920 and 1923 (other than Part II. of the last mentioned Act) or any re-enactment thereof, with or without modifications relating to dwelling houses, shall have ceased to be in force.

It would undoubtedly be an advantage in some instances to possess the powers which the Bye-laws for Improvement Areas confer upon local authorities. But the Steyne does not come under the category of an Improvement Area. Upon the whole the conditions in the Steyne are satisfactory. We certainly have less complaints of overcrowding in this area than we have in other parts of the district.

Individual Insanitary Houses.

The second part of the Act deals with the repair or demolition of insanitary houses, and replaces a number of sections of the Act of 1925, dealing with the repair, closing and demolition of unfit houses. The proceeding has been modified. One of the difficulties which hindered local authorities from dealing with houses which are so unsatisfactory that they ought to be closed was the hardship which would be inflicted upon the tenants of these houses. Most of these houses were "controlled," and if the landlord wished to close a controlled house, he would have to find alternative accommodation for the tenant, and the local authorities were loth to represent a house as unfit. Under the new Act, a grant is provided based on the number of inmates of the demolished house to assist the local authority in providing the other accommodation. The Rent Restriction Acts are not to operate where possession of a house is required for the purpose of a demolition order which has been ordered.

There is no obligation on the part of a local authority to provide other accommodation to tenants disposed by a demolition order of individual houses, but should no alternative accommodation be provided, the local authority may make allowances to persons displaced as the result of a demolition order.

The method provided by the Act distinguishes between houses which can, and those which cannot be rendered fit at a reasonable expense. Where the local authority consider a house is unfit for human habitation and is not capable of being rendered fit at reasonable cost, they may serve upon the owner an order requiring the house to be demolished unless the authority accept an undertaking from the owner that the house shall cease to be used for human habitation or that he will within a specified time carry out such works as will in the authority's opinion render it fit.

If on the other hand, the authority think that the house is repairable, they can serve a notice on the owner requiring him to execute certain specified repairs, but the authority must consider the estimated cost of the works necessary, and the value which the house may be expected to have when the works are completed. An appeal against a decision of the local authority will be decided by the County Court, and not, as in the past, by the Minister of Health. When the local authority has decided, but the County Court has decided against them, the local authority are empowered to acquire the house by agreement or compulsorily. In the latter case the local authority will be under an obligation to carry out the works, which they have themselves considered to be not unduly costly.

To assist owners with limited means, Section 47 empowered a local authority to advance to them the cost of the repairs to houses, in cases where, having regard to such cost or the financial position of the owners, it is deemed reasonable to advance such assistance.

There are in the Steyne only 4 houses which, in my opinion, cannot be made fit for human occupation.

There are scattered throughout the district a few other houses which cannot reasonably be made fit for human occupation.

There are four houses situated on Acton Hill, which are very old and show the inherent defects of old age. On one of these houses there is a stone which states that the house was built in 1588 and restored in 1875.

There are a group of five cottages in East Acton, which are built in one block and built back-to-back; two facing south, two facing west, and one facing east. It can be seen that the houses cannot have through ventilation. The houses are old and dilapidated, partly built of wood and brick exterior and the roofs are of old pan tiles.

There is another group of three houses in East Acton, two of which canont be made reasonably fit for human occupation.

The above houses will be represented as unfit for human occupation shortly, and they represent the worst houses from a structural point of view in the district.

It may be assumed that structural defects are not an important factor in our housing problem, but it would be entirely incorrect to assume that we have no housing difficulties. The character of these difficulties is constantly changing, and it is different now from what it was a few decades ago. A few decades ago, the housing problem was a much simpler one than it is today. Thirty years ago Acton was a self-contained community, isolated to some extent from surrounding districts, and the only important industry was the laundry industry. The northern part of the district, that is as much as was built over, was largely a dormitory of London; most of those living in the northern part of the district worked in London.

One of the chief problems in those days was a scarcity of suitable houses, but whereas then it would have been possible to meet the needs by the erection of a reasonable number of houses, the conditions have now changed. There was plenty of unbuilt land within easy access of the chief industry of the district.

These conditions have entirely changed. Geographically we have become a part of London, and also of the neighbouring authorities. There is no visible sign of demarcation between the district and the neighbouring areas. If it were not for the boundary marks, and the signs upon the streets, it would be impossible for a stranger to know in which borough he was. All the intervening spaces which formerly separated the western suburbs from London and from each other have been built over. In addition Acton has become an industrialised area. Many industries have moved into the district; some of them are new industries, others have migrated from the provinces and from other parts of London. At the last Census it was ascertained that then more people came into the district to work by day than went out to seek their living in other places.

The industrialisation of the district has continued since the Census, and other new industries have been started and factories have been erected. In many, if not in most, instances, the old employees have been retained. This is true at any rate of those factories which have been moved from a part of London. Not in every case do the employees wish to change their residence. The owner of one of the factories in North Acton told me about the negotiations he had had for other sites. One site was situated in surroundings which were almost rural. There was a cottage on the site, and before acquiring the site he made enquiries of a few of his oldest employees whether they would be willing to live in the cottage. He did not wish them to act as caretakers of

the factory. They all lived in the East End of London, where both the streets and the houses were overcrowded. They refused the offer and various excuses were offered, but the chief excuse was that they could not break off with old associations and leave the old familiar haunts. But while this instance may be typical of the attitude of the older employees, it is probably not so of the younger people. They desire to reside near, or at any rate as conveniently near as possible to the place of their work. The influx of these new industries has therefore resulted in a greater demand for a certain class of house, and the supply of this type inside the district has not increased in the same ratio as the people who desire this accommodation.

The Council could not cope with all the demands, as at the present time almost all the land in the district has been built over. Even if the whole of the unbuilt land were appropriated for the erection of houses of a certain type, there would not be sufficient accommodation for all those who now come into the district to work.

It might be assumed that owing to the increased demand for a certain type of house, overcrowding would be more evident, but other factors have been in operation. Coincidentally with the industrialisation of the northern part of the district, there has been a vast change in the means of transport. In this period mechanical transport has become universal, and distance is of less importance than situation in the direct line of the means of transport. To take an instance in our district. The factories in the northern part of the district are conveniently situated for the Central London Tube Railway, to the trams and buses from Willesden, Wembley, Cricklewood, Edgware, etc. It is easier for the employees in these factories to reach their work from these districts and from districts served by the Central London Railway than it would be if they lived in South Acton or Bedford Park. There is no unbuilt land in South Acton or Bedford Park but these are mentioned to show that the employees of the factories in the northern part of the district are more dependent upon housing accommodation in other areas than in our own. The housing problem is part and parcel of that in London and Middlesex, or possibly it would be more correct to say that it is part of the problem in certain parts of London and Middlesex. London and the suburbs are so huge that what is true of one part may be untrue of another. The London County Council have a large housing estate in Dagenham, but the erection of houses there will not affect the housing question in Acton unless some of the inhabitants of Acton find work in factories established in Dagenham and East London. Similarly the erection of houses in Norbury will not relieve those residents of London who are employed in Acton, Willesden and Greenford. Neither can the erection of houses by individual boroughs and urban districts

materially affect the housing conditions in that particular borough. It is only by means of a large comprehensive scheme that the question can be approached.

The Corporation of Acton has erected 320 houses in East Acton, and has converted some houses into flats; it is also contemplating the erection of flats on the Friars Estate. The erection of these houses is a gesture and shows the sincere desire of the Corporation to do as much as it possibly can to relieve any housing shortage, but it cannot be contended that it is a serious contribution towards the provision of even one type of house. Some persons have been able to obtain a better house at a rent below that which it is possible for private enterprise to provide. The houses vacated by the fortunate tenants have been immediately taken by others, who in most cases previously lived outside the district. Any new houses for the unskilled labourer and even for the artisan must be subsidised, for private enterprise will not build houses of this type. In a self-contained district, formerly there was an inducement to the local authority to erect houses for the employees in local factories, but the Local Government Act, 1929, has removed even that inducement. It profits a local authority very little to have new industries in its area; but apart from any such consideration, the reason why overcrowding has not been abated is not far to seek. Overcrowding is not due entirely or even primarily to a scarcity of houses. The causes of overcrowding are social and economic. In most cases of overcrowding which we come across, the rent for better and more accommodation cannot be paid. If the house is not controlled the average weekly rent for a three-roomed flat is 15/- to 20/-, and for a four-roomed one is 20/- to 30/-. For some families, even a four-roomed flat is not sufficient, and unfortunately these are the families which cannot afford a higher rent. Low wages and large families generally go together, and therefore, the smaller the house, the larger the family. These families for some reason or another, are compelled to accept what accommodation is offered, and for sheer profiteering commend us to the man of small means or of no means at all, who has rented a house which can be sub-let. An instance very recently came to our notice. A man bought a house for a comparatively small sum. He immediately sub-let it to eight different families, and two other persons rented the yard. He was receiving over £7 a week from the sub-tenants. The rooms were not legally overcrowded, but sanitary notices had to be served. These people would never accept the accommodation for the rent which they paid unless circumstances compelled them and they were unable to obtain other rooms. It has to be admitted that these are in many ways undesirable tenants and it is not strange that landlords refuse them as tenants. Occasionally we come across instances of overcrowding, where the tenants refuse better accommodation although they can afford to pay for it. Usually these people are

in controlled flats, and they would be sacrificing an advantage if they moved to a bigger house. Recently we came across a case of overcrowding, and the circumstances were peculiar. A man and his family occupied a controlled flat on two floors. The rest of the house became vacant and the whole house was bought by a man who came to live there. Two rooms were given up by the sub-tenant, at the request of the landlord, and the rent was reduced to 9/- a week. The landlord came to us and promptly reported that the sub-tenant was overcrowding the flat. This was found to be true and also there was no means of the separation of the sexes for sleeping accommodation. It was ascertained that the earnings of the family of the sub-tenant who lived at home were about £9 a week, and it was suggested to him that he could afford better accommodation. He admitted this but was unwilling to forego the undoubted advantage which the Rent Restriction Acts had conferred upon him. Instead of seeking a better house, he decided to lodge a couple of his children in a house opposite his own and they slept there and had all their meals at home. The landlord was very indignant and wrote many letters pointing out the unfairness to him. We could not interfere so long as they did not sleep in the house. It is true that about a dozen people had their meals in the house daily. Other instances could be quoted where the occupiers of flats and houses could afford better accommodation but are unwilling to forego the advantages they enjoy as tenants of controlled houses.

Another difficulty arises from the disinclination of landlords to let houses or parts of houses to large families. In some instances landlords stipulate that they are not prepared to let to anyone who has children. Such an attitude is difficult to understand, but it is exhibited. One can understand the refusal of landlords to let a house to a large family of small children, though under present conditions such conduct can hardly be called patriotic, to say the least. Landlords frequently look upon a large family as a feckless one, and think that the condition of the house will suffer in direct ratio to the size of the family. To be quite frank, individual landlords are not unique in this respect. There is a tendency on the part of local authorities that have erected houses to have more regard to the ability of the tenant to pay his rent regularly than to the needs for better housing accommodation. It has been suggested in some quarters, that some assistance should be given in the form of a rent rebate to those who have families, such rebate to be in some ratio to the size of the family. This suggestion has been made in some quarters, but I am not aware that it is feasible or possible to carry out in practice. In very many instances it would not be desirable.

It is well known that many, if not most, of the better type of artizan resort to birth limitation, and these families are small. Most of the large families belong to parents whose homes are in

a very unsatisfactory condition. In some instances the cause lies in the environment: they live under conditions which are almost impossible of improvement. But in most instances, the cause is inherent in the parents themselves. Some are mentally defective, some are intemperate, others are lazy and indifferent. It would be invidious to discriminate between those who are genuinely trying and would benefit by a change of surroundings and those who would remain unsatisfactory under the best housing conditions.

TABULAR STATEMENT OF INSPECTIONS & DETAIL OF WORK CARRIED OUT BY THE SANITARY INSPECTORS.

Number of Inspections and Action Taken.

Total number of dwelling houses inspected for housing defects (under Public Health or Housing Acts)		1244
(1) Dealt with by service of Informal Notice	811	
(2) Dealt with by service of Statutory Notice under Section 3, Housing Act 1925 and Section 17, Housing Act, 1930	189	
(3) Dealt with by service of Statutory Notice under Public Health Acts	172	
Premises (other than defective dwelling houses) inspected for nuisances and miscellaneous defects		940
(1) Dealt with by service of Informal Notice	807	
(2) Dealt with by service of Statutory Notice under Public Health Act, &c.	133	
Reinspections subsequent to service of Notice		7242
Enquiry visits on notification of Infectious Disease		320

Number of Premises under Periodical Inspection.

Workshops and Workplaces	141
Bakehouses	29
Slaughterhouses	2
Public Health Urinals	37
Common Lodging Houses	1
Houses-let-in-lodgings	30
Butchers Shops	44
Fish Shops	28
Premises where food is manufactured or prepared	33
Milk Purveyors	81
Cowsheds	Nil
Piggeries	Nil
Rag and Bone Dealers	8
Mews	4
Schools	11
Show Grounds	Nil

Rent Restriction Act.

Number of Certificates granted	13

Detail of Work carried out.

Sanitary Dustbins provided	514
Yards paved or yard paving repaired	283
Insanitary forecourts remedied	35
Defective drains repaired or reconstructed	45
Defective soil pipes and ventilating shafts repaired or renewed	94
Defective fresh air inlets repaired or renewed	77
Defective gullies removed and replaced by new	42
Rain water downpipes disconnected from drain	10
Dishing and curb to gullies repaired and new gratings fixed	286
Defective W.C. pan and traps removed and replaced by new	61
Defective W.C. flushing apparatus repaired or new fixed	407
Defective W.C. seats repaired or new fixed	105
Defective flush pipe connections repaired	122
Insanitary sinks removed or new fixed	21
Sink waste pipes repaired or trapped	224
Insanitary wall surface over sinks remedied	143
Ventilated food cupboards provided	12
Drinking water cisterns cleansed	219
Defective covers to drinking water cisterns repaired or new fixed	74
Insanitary sites beneath floors concreted	12
Spaces beneath floors ventilated	165
Dampness in walls from defective damp-proof course remedied	117
Dampness from defective roof, rain water gutterings, etc., remedied	844
Defective plastering repaired (number of rooms)	509
Rooms where dirty walls and ceilings have been cleansed and redecorated	3106
Defective floors repaired	135
Defective or dangerous stairs repaired	17
Defective doors and windows repaired	373
Defective kitchen ranges and fire grates repaired	218
Defective washing coppers repaired	157
Coal cupboards provided and repaired	12
New W.C. apartments provided	13
Accumulations of offensive matter removed	37
Drains unstopped and cleansed	432
Overcrowding nuisances abated	16
Drains tested, exposed for examination, etc.	85
Smoke observations taken	234
Smoke nuisances abated on service of notice	32
Nuisances from pigs and other animals abated	12
Notifications of waste of water sent to Metropolitan Water Board	192

INSPECTION AND SUPERVISION OF FOOD.

Milk Supply.

There are 83 dairies and milkshops on the register.

There are at present no cowsheds in the Borough and all the milk is produced outside the district.

In last year's report, the conditions under which milk is distributed within the district were mentioned, and it was stated that in the altered circumstances, the Council had relaxed the stringency of requirements formerly insisted upon. This accounts for the increased number of retailers.

BAKEHOUSES.

There are 30 bakehouses in the district; of these 6 are underground bakehouses and were occupied before the passing of the Factory Act of 1901.

MEAT INSPECTION.

There are two slaughter-houses in the borough; in one of these, pigs alone are slaughtered, and in the other no pigs are slaughtered.

It has been usual in the past to supply a full list of the unsound food condemned, and the following tables are inserted so that the conditions can be compared with former years.

UNSOUND FOOD SURRENDERED DURING 1930.

TABLE I. Diseased Meat.

Tuberculosis.

PIGS.

11 Carcases with Heads.
82 Heads.
1 Forequarter
2 Hindquarters.
1 Neck and Shoulder.
1 Belly.
1 Chine.
3 Legs.
2 Feet.
40 lbs. of Pork.
122 Plucks.
2220 lbs. of Chitterlings.

CATTLE.

7 Cows' Carcases with Offal.
16 Cows' Offals complete.
8 Forequarters of Beef.
2 Short F'quarters of Beef.
1 Side of Beef.
1 Topside of Beef.
5 Rumps of Beef.
8 Loins of Beef.
31 Sets of Cows' Lungs with Hearts.
18 Cows' Heads & Tongues.
1 Cows' Carcase with Offal (Emaciated).
13 Cows' Livers.
3 Sets of Ox Lungs with Hearts.
1 Stirk's Carcase with Offal.
2 Stirks' Heads & Tongues.
1 set of Stirk's Lungs with Heart.
3 Stirks' Livers.
3 Calves' Carcases with Offal.
32 Calves' Plucks.
3 Calves' Kidneys.
2 Calves' Livers.
1 Stirk's Carcase with Offal (Emaciated).

Parasites.

PIGS.

1 Skin.

CATTLE.

4 sets Cows' Lungs with Hearts.
15 sets Cows' Lungs.
37 Cows' Livers.
4 Cows' Kidneys.
4 Stirk's Livers.
1 set Calf's Lungs.

SHEEP.

135 sets Sheeps' Lungs.
64 Sheeps' Livers.
7 Sheeps' Plucks.

GOATS.

1 Goat's Liver.

Pleurisy. CATTLE.

1 set Cow's Lungs with Heart.
2 sets Stirks' Lungs with Hearts.
9 sets Calves' Lungs with Hearts.
11 Calves' Plucks.
7 Breasts of Veal.

SHEEP.

2 sets of Sheeps' Lungs.
7 Sheeps' Plucks.
4 Ribs of Mutton.
5 Breasts of Mutton.

Suppurating Pleurisy.

CATTLE.

1 Calf's Carcase.
5 Calves' Plucks.

SHEEP.

2 Forequarters of Mutton.
1 Sheep's Pluck.

Abscesses.

PIGS.

1 Carcase with Head (Pyaemic).

CATTLE.

1 Cow's Head.
1 Topside of Beef.
1 Clod Sticking and Shin of Beef.
1 Stirk's Shoulder.
4 Calves' Heads.
9 Calves' Plucks.
18 Calves' Livers.
2 Calves' Kidneys.
1 Loin of Veal.

SHEEP.

1 Shoulder of Mutton.
½ Chine of Mutton.

Bruising. PIGS.

2 Hindquarters of Pork.
4 Legs (Fractured).
56 lbs. of Pork.

CATTLE.

1 Forequarter of Beef.
2 Shins of Beef.
1 Flank of Beef.
1 Top Piece of Beef.
1 Gross Piece of Beef.
1 Clod and Sticking of Beef.
1 Calf's Carcase.
3 Calves' Kidneys.
2 Legs of Veal (Fractured).
2 Breasts of Veal ,,

Dropsy. CATTLE.

2 Flanks of Beef.
2 Clods, Stickings, Shins, Briskets and Flanks of Beef.
1 Calf's Carcase with Offal (Congested).
1 set Cow's Lungs with Heart (Parasitic).
2 Shoulders of Veal (Parasitic).
1 Cows' Carcase with Offal.
1 Stirk's Carcase with Offal (Emaciated).
1 Cow's Carcase with Offal (Emaciated).
1 Cow's Carcase (Tuberculous).

Dropsy.

SHEEP.

14 Carcases with Offal (Emaciated).

Cystic.

CATTLE.

2 Ox Kidneys.
2 Stirk's Kidneys.
1 Cow's Kidney.

SHEEP.

2 Sheeps' Kidneys.

Unsound.

PIGS.

1 Carcase with Head.

CATTLE.

2 Hindquarters of Beef.

Other Conditions.

Urticaria. PIGS.

2 Skins.
36 lbs. of Pork.

Arthritis.

1 Hock.

CATTLE.

Congestion.

1 Cow's Offal.
1 Cow's Liver.
1 set Cow's Lungs.
1 Calf's Pluck.

Actinomycosis.

1 Ox Head with Tongue.
14 Cows' Heads with Tongues.
2 Stirks' Heads with Tongues.
1 Cow's Liver.

Moribund.

1 Cow with Offal.
10 Calves with Offal.

Nephritis.

11 Cows' Kidneys.
6 Calves' Kidneys.

Fatty Infiltration.

1 Cow's Liver.

Emphysema.

1 set Stirk's Lungs with Heart.

CATTLE.

Pericarditis.

1 set Calf's Lungs with Heart.

Bacterial Necrosis.

1 Calf's Liver.

Pseudo Leukemia.

1 Calf's Carcase with Offal.

Pyaemia

1 Calf's Carcase with Offal.

Pneumonia.

1 set Ox Lungs.
1 Calf with Offal.
2 sets Calves' Lungs with Hearts.
1 set Calf's Lungs.

Cirrhosis.

8 Cows' Livers.
5 Calves' Livers.
5 Stirks' Livers.

Adenitis.

11 Calves' Livers.
4 Calves' Plucks.

Died.

1 Calf with Offal.
3 Calves' with Offal (died in transit).

Cavernous Angioma.

4 Cows' Livers.

Hydro-Nephrosis.

2 Calves' Kidneys.

Endocarditis.

1 Calf's Heart.

Jaundice.

1 Calf's Pluck.

Pseudo Hodgkins Disease.

1 Calf's Carcase with Offal.

SHEEP.

Lymphomata.

2 Sheeps' Kidneys.

Other Foods.

Unsound.

5 stones of Smoked Cod Fish
1 Box of Kippers.
2 Tins of Prawns.

TABLE II.

NUMBER OF PIGS' CARCASES INSPECTED FROM 1st JANUARY TO 31st DECEMBER, 1930, WITH ANALYSIS OF SURRENDERS ON ACCOUNT OF DISEASE (TUBERCULOSIS).

1930	No. of Carcases Inspected.	No. of Heads Diseased.	No. of Carcases Diseased.	No. of Sides Diseased.	No. of Fore Quarters Diseased.	No. of Hind Quarters Diseased.	No. of Legs Diseased.	No. of Shoulders Diseased.	Plucks (Lungs, Livers and Hearts).	Mesenteries, Stomachs and Intestines	Pieces of Pork.	Weights
												Tons Cwts. Qrs. Lbs.
January	1273	8	1	—	—	—	1	—	9	224 lbs.	— lbs.	3 2 4
February	1002	6	2	—	—	2	1	—	10	192 ,,	70 ,,	6 1 4
March	1042	11	1	—	—	—	6	—	10	248 ,,	28 ,,	6 0 19
April	956	7	2	—	—	—	1	—	10	248 ,,	64 ,,	5 2 20
May	951	8	2	—	—	—	—	1	11	208 ,,	42 ,,	7 3 9
June	679	—	—	—	—	—	—	1	8	152 ,,	— ,,	* 3 1 16
July	703	8	—	—	—	—	—	—	11	176 ,,	26 ,,	* 4 1 5
August	692	6	—	—	—	—	—	—	8	136 ,,	37 ,,	* 2 0 1
September	1265	11	1	—	—	—	—	—	9	216 ,,	— ,,	* 4 0 17
October	1536	8	2	—	—	—	—	—	14	288 ,,	34 ,,	3 3 16
November	1237	14	1	—	—	—	—	—	16	280 ,,	— ,,	4 2 3
December	1323	6	—	—	—	—	—	—	6	160 ,,	11 ,,	1 1 2
TOTAL	12659	93	12	—	—	2	9	2	123	2528 ,,	312 ,,	2 14 0 14

* Sent to Kensington Destructor.

TABLE III.

Counties from which animals were consigned, and percentage diseased (1st Jan.—31st Dec. 1930).

County	No. of Towns from which Animals were consigned	No. of Carcases Inspected	No. of Animals Diseased	Percentage of Animals Diseased
Bedfordshire	2	135	2	1.48%
Berkshire	2	7	—	—
Buckinghamshire	1	8	—	—
Cambridgeshire	6	674	5	.74%
Dorsetshire	6	1569	21	1.34%
Essex	3	89	—	—
Gloucestershire	2	282	5	1.77%
Hampshire	11	456	2	.43%
Huntingdonshire	2	179	—	—
Ireland	1	11	—	—
London	1	14	—	—
Middlesex	9	276	—	—
Norfolk	14	2596	27	1.04%
Nottinghamshire	1	30	6	20.0 %
Somerset	10	902	12	1.33%
Suffolk	18	3593	24	.67%
Surrey	5	831	—	—
Sussex	1	77	2	2.59%
Warwickshire	1	910	8	.88%
Yorkshire	1	20	—	—
TOTAL	97	12,659	114	.90%

BIRTHS.

Table 7 gives particulars of the births registered and notified in the district, and the births belonging to the district which have occurred and been registered outside the district.

As there is no Maternity Home in the district the number of "outside" births tends to become higher and higher. There is a greater demand for institutional care in the birth of children. The factors which operate in the case of illness are also in operation when such an event as a confinement is about to take place. Modern houses are so planned and constructed as to occupy the least possible amount of space, and there is hardly sufficient room in them to allow of any nursing with any degree of comfort.

The total number of births are those registered during the calendar year and are corrected for inward and outward transfers. This figure is obtained at the end of the year from the Registrar General. Last year the total number was 1,105, and is equal to a birth-rate of 16.9 per 1,000 inhabitants. This rate is higher than that of 1929, and is higher than that of England and Wales and that of the 107 great towns.

The birth-returns recieved from the Registrar General do not permit of the allocation of the whole of the births into wards, but if the ward birth-rate is based upon the notification figures and 1 per thousand added to these rates, it will be sufficiently correct for all practical purposes.

The birth-rate, based upon the notifications in the different wards was :—

North East.	*North West.*	*South East.*	*South West.*
16.7	17.3	10.6	19.6

69 children were born out of wedlock, which number corresponds to an illegitimate birth-rate of 6.2 per cent. of the total births.

This is not the highest illegitimate birth-rate on record for the district, but it very nearly approaches the record. The highest rate was in 1915 when it reached 6.3 per cent., and in 1917 and 1919, the rates equalled that of last year, namely 6.2 per cent.

It is sometimes assumed that the increased incidence of illegitimacy was a war phenomenon, but this is not quite true of this district. The illegitimate birth-rate began to ascend in 1912 when the rate was 4.7 per cent. and previous to that date it had never been higher than 3 per cent. In 1913 it was 5 per cent. and in 1914 5.1 per cent. After the war it gradually descended from 4 per cent. in 1920 to 2.9 per cent. in 1924. Since 1924 it has gradually risen.

Although illegitimacy is primarily a social question it has its public health aspects, and usually is reflected in a district's statistics, especially in infantile mortality. It is not generally admitted that the infantile mortality is higher amongst children born out of wedlock than amongst legitimately born children.

41 still-births were registered, a number which is equal to .63 per 1,000 of the inhabitants and represents 3.7 per cent. of the total live births registered.

DEATHS.

440 deaths were registered in the district : of these 31 were of non-residents. 284 deaths of residents occurred outside the district. The total number of deaths belonging to the district is 693, which corresponds to a death-rate of 10.6 per 1,000 inhabitants.

On Table 1 is given the death-rate for England and Wales and the large towns. It will be seen that our death-rate is lower than that of the whole of England and Wales, and also of London and the 107 large towns, in which group Acton is included.

On Table 2 is given the statistics for the district in the last 6 years, and from that table it will be seen that last year's death-rate was considerably lower than that of 1929. In 1929, there was an extensive epidemic of Influenza which reflected itself in the death-returns of that year.

WARD DISTRIBUTION OF THE DEATHS.

North East.	*North West.*	*South East.*	*South West.*
196	168	143	186

DEATH-RATE OF EACH WARD.

North East.	*North West.*	*South East.*	*South West.*
10.3	12.3	9.5	10.6

The comparatively high death-rate in the North-West Ward is probably due to the age-distribution of the population in the different wards.

Causes of Death.

In some of the important causes of death, I have endeavoured to bring our returns to correspond with those of the Registrar General, but in several others, the figures are hopelessly at variance. The total number of deaths is the same as that of the Registrar General, and this also holds true of the principal infectious diseases, and some causes such as suicide and other violent deaths, though in the case of the latter some difficulty arises.

In the manual of the international list of causes of death issued by the Registrar General, certain rules are given for the selection of one or more jointly stated causes of death. Where any forms of violence and disease are jointly stated as causes of death, the violence is to be preferred except in the following instances :—

(*a*) Deaths from any definite disease stated to have been accelerated, aggravated, &c. by accident are to be classed to the disease.

(*b*) Deaths from tetanus, erysipelas, pyaemia, septicaemia, blood poisoning, &c., following accident are to be classed to the disease if the injury is slight, such as "scratch" or abrasion, but if the injury was apparently severe enough to be of itself dangerous to life (*e.g.* by vehicle, machinery, &c.), the death is to be classed to violence.

Unfortunately the verdict given at an inquest does not always give sufficient evidence upon these points. For instance there were three inquests and in all cases it was stated that the cause of death was Myocarditis accelerated by an accident. In one case the accident was a fall downstairs, in the second the man had fallen out of bed, but in the third the woman was knocked down by a motor cycle in the street. Obviously the latter was a violent death though a specific disease was mentioned.

In another case it was stated that the cause of death was Pneumonia and acute Phlebitis accelerated by being knocked down by a motor van. Other verdicts might be quoted which show that there are difficulties in assigning the cause of death, but these are insignificant compared with the vagueness and indefiniteness of some of the certificates which are sent by medical practitioners. It is unfortunate, but true, that under

present conditions it is not possible to get even approximately correct death-returns. Under the best conditions it is not possible to get exact returns. It has been computed that even with full post-mortem examination, the cause of death can be accurately given in about 85 to 90 per cent. of the cases, but that under present conditions the exact cause of death is not given in more than about one-half of the deaths. There are many reasons for this want of accuracy, but I need only point out one of them. I refer to the suspicion with which the doctors look upon the present method of death certification.

The Act of 1926 made it possible to obtain a death certificate slightly less inaccurate and evasive than was obtainable before its passage, and that is all that can be said about it. In practice it has made hardly any difference, apart from the ordering of a post-mortem examination without an inquest and the registration of still-births. The alteration of the law so that the certificate is sent direct to the registrar instead of being given to the relatives of the deceased looked on the surface as though it would allow the practitioner to state what he knew to be true without the risk of offence to the bereaved; in practice it does nothing of the kind. The signing of the death certificate and sending in a separate envelope to the local registrar and the filling up of the separate slip for relatives to be handed to the registrar is the greatest farce which can be imagined. Although it keeps the original certificate from the relatives, they can obtain copies and for many purposes must obtain a copy, and they can compel the registrar to furnish them with a copy. It is obvious that in spite of the elaborate precautions the death certificate is by no means private. The copies are used mainly for insurance purposes, and solely in the interest of the insurance companies. There are many reasons why insurance companies should not obtain a copy of the death certificate. It should suffice that companies are informed that a certain person had died on a certain date. If any further information be required, this should be obtained from the doctor in attendance. If we want reliable death-returns, the first essential should be an assurance to the doctor that the death certificate is a strictly confidential one. An opportunity offered itself when the Local Government Act, 1929 abolished the Boards of Guardians to bring about an effective reform, but it was missed and the vital statistics will still continue in the same unsatisfactory condition. The death certificate should be treated in the same confidential manner as a tuberculosis notification, and under the present condition this cannot be done.

Deaths in Public Institutions.

Of the total number of deaths, 329 occurred in Public Institutions and 14 in Nursing Homes. It has been pointed out in previous reports that there is an increasing tendency to remove the patient to an institution whenever an illness occurs in a

private house. There are many reasons for this phenomenon and one of these is the preference shown for smaller houses. In London many people prefer to live in service flats, but even in the suburbs owing to the difficulty of obtaining domestic assistance, spare rooms are becoming fewer and scarcer. When an illness happens there are insufficient facilities for efficient nursing of the case.

Inquests and Coroner's Inquiries.

40 inquests were held and in 24 instances the Coroner issued a certificate without an inquest after he had ordered a post-mortem examination.

INFECTIOUS DISEASES.

Scarlet Fever.

207 cases of Scarlet Fever occurred in the district during 1930, and there was one death from the disease. The fatal case was one in which the patient suffered from both Scarlet Fever and Measles. During the early part of the year there was an epidemic of Measles and some of the patients contracted both diseases. Apart from instances of double infection, the disease was of a mild character. It is possible that the mildness of the disease forms one of the greatest difficulties in the control of Scarlet Fever epidemics, and it is doubtful if any of the means at our disposal at the present time are effective in preventing the spread of an epidemic. Accepting the general opinion that most cases of Scarlet Fever are contracted directly from another human source, and that the infecting person may be quite unrecognisable either as a mild case or as a clinically healthy carrier, it is easy to see how the conditions of today favour the spread of Scarlet Fever and make its control a very difficult matter. The aggregation of people in towns and cities, the enormous increase in transport facilities and the growing inclination to be carried in vehicles rather than to walk, all these facts of modern life have multiplied the opportunities for susceptibles coming into contact with infectives; they have aiso made it almost impossible in thickly populated districts to trace any case to its origin.

Among the newer suggestions for the control of Scarlet Fever is the active immunisation by means of the Scarlet Fever Streptococcus Toxin. Those who have had the widest experience of the practical application of measures dealing with the Scarlet Fever problem are almost universally of the opinion that the routine active immunisation of susceptible individuals is not advisable for not only do the attendant reactions prevent its general acceptance, but the immunity lasts only about two years. The position is different from that encountered in the case of Diphtheria. Active immunisation of Scarlet Fever contacts after Dick testing may be useful in isolated communities and in boarding schools, but under present conditions it is not a feasible method in towns and especially in the inner suburbs of London.

Diphtheria.

103 cases of Diphtheria were notified and 9 deaths occurred; 2 of the deaths occurred outside and had not been notified to us. They were in the infirmary and had contracted Diphtheria there.

There is a considerable increase both in the notifications and the deaths, compared with 1929. In 1929 only one death occurred from this disease.

The disease was distributed throughout the district and no particular area or school had any abnormal incidence.

Tuberculosis.

97 cases of Pulmonary Tuberculosis and 13 cases of other forms of Tuberculosis were notified during the year.

There were 57 deaths from Pulmonary Tuberculosis and 9 deaths from other forms of Tuberculosis.

There was an increase in the number of deaths and in the number of notifications both from Pulmonary Tuberculosis and from other forms of Tuberculosis.

The death notification interval of the 57 patients who died of Pulmonary Tuberculosis in 1930 was :—

Information from Death Returns	10
Died within 1 month after notification	7
Died between 1 and 3 months after notification	6
Died between 3 and 6 months after notification	5
Died between 6 and 12 months after notification	9
Died between 1 and 2 years after notification	7
Died between 2 and 3 years after notification	3
Died over 3 years after notification	10

On December 31st the following is a statement of the particulars appearing in the Register of cases of Tuberculosis.

	Pulmonary.		Non-Pulmonary.		Total
	Males.	Females.	Males.	Females.	
Number of Cases of T.B. on the Register at the commencement of year	116	106	24	17	263
Number of Cases notified for the first time during the year	54	49	9	4	116
Number of Cases removed from the Register during the year	51	31	3	1	86
Number of Cases remaining on the Register at the end of the year	119	124	30	20	293

During the year the Tuberculosis Officer removed 12 cases of Pulmonary Tuberculosis and 2 cases of Non-Pulmonary Tuberculosis from the Register. These are, of course, in addition to the cases removed on account of death.

In 1930, the Tuberculosis Officer examined 64 new cases of Pulmonary Tuberculosis and 11 new cases of Non-Pulmonary Tuberculosis. 55 patients were admitted to Sanatoria under the county scheme and 18 were admitted to Hospitals.

I pointed out in last year's report the conditions under which notification is not sent or there is delay in notification,, and the same conditions obtained last year.

In 1930 the Public Health (Tuberculosis) Regulations 1930, were issued. These consolidated and amended the Public Health (Tuberculosis) Regulations of 1912, 1921 and 1924. The new Regulations came into operation on January 1st, 1931.

The most important alteration has been the wording of the first proviso to article V of the Regulations of 1912, which has been amended with a view to making it clear that previous notification in another sanitary district of the same county or another county does not relieve a medical practitioner from the duty of notifying. The new regulation requires that the case shall be notified unless the practitioner has reasonable grounds for believing that it has already been notified to the Medical Officer of Health for the same sanitary district. The regulation means that the case must be notified if a patient has moved from one sanitary district to another.

Meningococcal Meningitis.

Meningococcal Meningitis, or as it is sometimes called, Spotted Fever is a compulsorily notifiable infectious disease, but owing to the peculiar conditions under which it occurs, all the cases which occur are not notified. The disease was described in detail in last year's report, and it is unnecessary to deal with the subject again this year. It is curious, though, that the same number of deaths occurred in 1930 as in 1929, but none of these cases had previously been notified. There were five deaths from the disease, but there was no notification.

Encephalitis Letharigca.

There were 2 notifications of Encephalitis Lethargica and 4 deaths from the disease. The two cases notified this year proved fatal, and as far as could be ascertained the other two fatal cases had not previously been notified.

This phenomenon is not surprising. Many cases of this disease remain unnotified. Frequently the initial symptoms are so trivial that the nature of the disease has remained undiagnosed, but the severity of the acute phase of the disease is no criterion of what is to follow. The mildest acute cases may finish with the worst chronic stages, whereas the most acute cases frequently recover completely, if they do not die at once. This is probably due to the fact the post-encephalitic symptoms are not sequelae, due to destroyed nerve cells, but are caused by continued chronic infection. What the infection is remains as yet unknown. The

disease is not infectious in any ordinary meaning that can be given to the word. There is no evidence to show that the infection is spread from case to case, and multiple cases in the same house or same family are very rare. Its history in this, and other countries shows that it occurs in epidemics, and it is difficult to conceive a disease as an epidemic that is not at some stage spread from person to person. Carriers have been suggested but their existence has never been proved.

Small-Pox.

During the year 7 cases of Small-Pox were notified. All the cases were of the mild type which has been prevalent in and around London during the past few years. Although the cases have been similar to each other clinically, from an infectious point of view there has been a considerable difference. In this respect it resembles the virulent type of disease, the so-called Eastern or Asiatic Small-Pox. In most epidemics of the virulent type of Small-Pox there are instances in which the disease is intensely infectious, whilst at other times the disease seems hardly at all infectious. Presumably the same strain of germ or virus is present at both periods, but at one time the infectivity seems to be much greater than at another time. The same phenomenon has been noticed in the present epidemic. The number of admissions to the Metropolitan Small-Pox hospital in 1929 was 3,031, made up mainly of the mild "native" type, but including some of the Tuscanian group. There were 10 deaths, one in a patient who had not had Small-Pox; two and possibly three of the Tuscanian cases; two premature infants, towards whose deaths Small-Pox may have contributed a little; two cases in which it may have had more say and two of confluent Small-Pox who died from septic absorption following maturation. These figures suggest that there was no change in the type of the disease. I believe that the same phenomenon has been observed in 1930. The type has been mild and there has been no tendency to enhanced virulence in the cases. All the cases which occurred here were of the same mild character. The first occurred at East Acton, and was notified on June 17th. The patient was a bus conductor, but he had been confined to the house from the time the rash appeared until his removal to Hospital. The contacts were easily traced and they all consented to be vaccinated or re-vaccinated. The children in the house had not been previously vaccinated. No further cases occurred as a result of infection from this patient. The case was a simple one, the contacts were easily traced and re-vaccinated and control was not difficult.

The next instance was of an entirely different character. Two cases were notified from Ramsey Road,—one on June 28th and the other on July 1st. These were two brothers, and on enquiry, it was found that another brother had been ill about three

weeks previously. He had seen a doctor who had diagnosed Chicken-Pox. When the "Chicken-Pox" patient was examined at the end of June, it was evident that he had had Small-Pox. During his illness he had not been confined to the house, but had wandered freely about the district. He had probably been in contact with hundreds of people and any attempt to trace the contacts was impossible, and yet, as far as can be ascertained, no further cases resulted.

The third outbreak occurred in North Acton. This was, of course, the fourth case in the district. It was notified on July 26th, and the rash appeared on July 20th. It is almost certain that this patient had been in no way connected with the previous cases in Acton. Her husband was employed in one of the local factories, but no illness resembling Small-Pox occurred amongst the other employees. Her sister from Crayford had visited and the patient had been in London on several occasions. The source of infection, though was not traced. This again, was a fairly simple case. She was confined to bed from the date of the eruption of the rash and no one outside the family had visited her. The contacts were easily traced and the only other case which occurred was a daughter.

The fourth importation was in August, and the case was notified on August 15th. On that date he attended the Acton Hospital as an out-patient suffering from a rash on the face, which was diagnosed as Small-Pox. The patient had mixed with a number of persons, and the list of contacts was very incomplete. No further cases occurred.

During the summer months the infectivity of the disease appeared to be a low one. Several other instances could be given. A case was notified in Chiswick. He was employed in a factory in Acton and he had been at work for two days after the appearance of the rash. He had been in immediate contact with a score of people, in probable contact with another score and in possible contact with about 500 persons. It was impossible to visit the houses daily of all these and supervision had to be exercised through the factory. No other cases occurred, and the immunity was not due to recent vaccination or re-vaccination.

In contrast with the low infectivity of the disease during the summer months, has been the high infectivity of the disease in December. A case was notified on December 13th. She was one of 5 Small-Pox contacts which had been forwarded from Hammersmith. It appears that a missed case had occurred in that borough, and was discovered through a notified case early in December. On December 6th, the Medical Officer of Health of Hammersmith received a notification of Small-Pox. On enquiry he found that another inmate of the same house had had a rash about the middle of November, and the case had been diagnosed as Chicken-Pox, but which was undoubtedly Small-Pox. During

the period between November 16th and December 6th the house was visited by very many people. Among the contacts was one person who lived in Acton and 4 others who worked here, but who lived in Hammersmith. The contact who resided here contracted Small-Pox and 3 out of the 4 contacts who worked here but resided elsewhere also contracted the disease. I understand that other contacts of this same case have also contracted Small-Pox. One of the contacts caused us much anxiety. The four were employed in local laundries and the proprietors refused to take the risk of Small-Pox amongst their employees, and arrangements were made for the contacts to keep away from work until quarrantine was over or re-vaccination had been successful. As usual in missed cases, some contacts are either missed or their identity concealed, and one of the laundry workers was not included in the list. She developed Small-Pox, the rash appearing on December 5th and she was at work on December 4th.

Other medical officers of health have told me of cases which have occurred in the late autumn and winter of this year, and in which the infectivity appears to be high. In former times, winter was always considered a favourable season for epidemics of Small-Pox in temperate regions, and various reasons were given for this seasonal incidence. One of the favourite reasons was that there was more overcrowding of persons in houses in winter and thus a condition favourable to the spread of infection was produced. No satisfactory reason has been adduced for the varying degree of infectivity of Small-Pox, even when the type of the disease does not vary.

ISOLATION HOSPITAL.

During the year 459 cases were admitted into the Hospital compared with 419 in 1929. On January 1st, 1930, there were 75 cases in the Hospital and on January 1st, 1931, there were 41. 476 cases were discharged and there were 22 deaths.

The following is a list of the cases admitted :—

	Acton	Wembley	Kingsbury	Total
Scarlet Fever	165	91	23	279
Diphtheria	92	49	36	177
Measles	2	—	—	2
Other Diseases	—	1	—	1
	259	141	59	459

The 22 deaths were as follows :—

	Acton	Wembley	Kingsbury	Other Districts	Total
Scarlet Fever	1	3	—	—	4
Diphtheria	8	3	3	1	15
Other Diseases	3	—	—	—	3
	12	6	3	1	22

Scarlet Fever.

279 cases of Scarlet Fever were admitted, and there were 4 deaths from the disease. The high mortality was due to cases of mixed infection which were admitted early in the year. In the early part of the year there were epidmics of Measles and Whooping Cough, and several cases of Scarlet Fever were admitted incubating either Measles or Whooping Cough.

Diphtheria.

177 cases of Diphtheria were admitted with 11 deaths.

BACTERIOLOGICAL EXAMINATIONS.

(*a*) For Diphtheria	*Positive.*	*Negative.*
Total Examinations—1551	193	1358
Sent by Medical Practitioners	57	409
do. (re-examinations)	6	48
Sent from Isolation Hospital	116	583
do. (re-examinations)	1	3
Convalescents (1st Swabs)	—	31
Contacts	4	156
do. (2nd examinations)	4	58
do. (3rd examinations)	—	2
Precautionary Swabs	—	12
School Sore Throats	4	50
do. (2nd Swab)	1	3
do. (3rd Swab)	—	2
do. (4th Swab)	—	1

(*b*) For Ringworm.	*Positive.*	*Negative.*
Total Exmainations—5	4	1

(*c*) For Tubercle.	*Positive.*	*Negative.*
Total Examinations—154	31	123

MATERNITY AND CHILD WELFARE.

Infantile Mortality.

56 deaths occurred in children under one year of age. This number corresponds to an infantile mortality of 50 per 1,000 births.

The infantile mortality is lower than that of England and Wales and that of the 107 great towns and of London.

It is also the lowest infantile mortality for the district, the next lowest being that of 1926 when it was 55 per 1,000 and 1928 when it was also 55 per 1,000 births.

It is natural to review the results of any activities when any particular stage is reached, though the division may be quite artificial and arbitary. It is not so very long ago when public health authorities looked upon an infantile mortality of 100 per 1,000 births as a goal which might ultimately be reached. Although that figure now appears absurdly high, it must be remembered that in the early years of this century, the infantile

mortality was invariably between 150 and 200 per 1,000 births, and when a town reached the 100 per 1,000 it rejoiced. We have now reached the figure of 50 per 1,000 births, and it is natural to enquire what are the factors which have been instrumental in this reduction of the infantile mortality.

Many factors have been in operation, but I think it is fair to claim that one of the most important of these is the infant care scheme which is now a part and parcel of every public health department in the country. The development of Infant Welfare Schemes has been a gradual one—the appointment of health visitors, the passage of the Notification of Births Act, the establishment of Child Welfare Clinics, and Pre-natal Clinics, the provision of Maternity Beds, etc. All these activities have had immense educative effects upon the mothers, and if I were to single out one of these, I should place the establishment of breast feeding as one of the most important. At the beginning of this century it was seriously suggested that mothers were losing the power to secrete milk, as so few of them naturally fed their babies, but the experience gained in infant welfare work, has shown that it is a very rare phenomenon for a woman to be unable to nurse her own baby. If a woman is capable of performing the difficult task of bringing a living baby into this world she has it within her power to keep it alive afterwards with nutriment from her breast. It is admitted that the occasional unsuitability of the mother's milk for the infant is not a unique phenomenon, for the same phenomenon is sometimes witnessed in the animal world. The precise biological explanation of these cases has not been forthcoming, and in any individual case nothing more can be said than that there is some incompatibility between the nutrient properties of the milk of the individual mother and the nutritive requirements of the child in question.

It is possible that the occurence of such a case in the past has determined the doctor in his advice to wean in other cases without enquiry into all the circumstances and using every endeavour to avoid unnecessary weaning. Women are too prone to believe on insufficient grounds that they cannot nurse their babies, and they are often aided and abetted in their belief usually by ignorant friends and relatives but sometimes by doctors and nurses who should know better.

The present-day baby is not easy to rear, breast milk or no breast milk. The trouble commences during the establishment of the milk flow, and difficulties are often experienced later in maintaining the activity of the mammary glands. We frequently hear the remark that the milk "went away" as soon as the mother got up after the confinement. It is true and has been proved experimentally that there may be a diminution in the amount of milk secreted immediately following the resumption of household duties. One of the most important conditions of breast feeding

is a cheerful mental attitude on the part of the mother. The worries incidental upon the active resumption of household duties and the increased exertion probably do affect the secretion of the milk, but these are not sufficient to take the baby off the breast. It is gratifying to know that frequently the advice of the health visitors is successful in showing that these conditions are transient and temporary and that the suckling should be persevered with. We frequently hear the remark that the mother believes her milk is "too thin," or that her milk does not agree with the baby, and she imagines that in some other way her milk was not sufficiently nutritious. When things go wrong, as they often do, the tendency is to utilise the resources placed within easy reach, without making any search for other causes for the want of growth and progress in the baby. It is so easy to lay the blame on the food, and so difficult to examine all the circumstances. If the infant is breast fed, he is weaned, if bottle fed, his food is changed. There may be no justification for believing that if breast fed milk fails there will be any better results with an artificial substitute. The breast fed infant requires a considerable amount of management even though the milk be of the best quality. But it is easier to change the food than to seek patiently for the cause.

From the point of view of the baby the advantages of breast feeding are so enormous that every effort should be made by all concerned to make lactation a success. The artificially fed baby may put on weight adequately, indeed, the weight chart may be better than that of a breast fed baby, but nevertheless, there may be differences which are obvious to the expert observer. Thus the vascularity of the skin may be deficient and the baby will therefore not exhibit the rosy fresh appearance of perfect health. Artificially fed infants are known to be more liable to rickets than breast fed infants, although the hygienic conditions in regard to light and fresh air be perfect. It is true that rickets does develop occasionally in breast fed babies, but the liability is far less, and the comparative absence of severe rickets at the present time is probably due to the increased vogue of breast feeding.

The most important difference, however, between the two classes of infants concerns the matter of resistance to infection in which the breast fed baby is considerably superior. Babies fed on cow's milk suffer more from those infective intestinal disorders of an acute or chronic character, which so seriously affect their nutrition.

Our efforts are therefore directed towards the establishment of breast feeding, but there are other directions in which advice is often urgently needed. Too often the babies are irregularly fed. If a baby cries, the mother imagines that he is hungry and gives him a feed, thereby starting a train of digestive troubles by irregular feeding.

But it is not only on the question of food and feeding that advance has been made, though in some other directions the obstacles are greater. I think it will be admitted that an improvement has occurred in the matter of clothing. One of our greatest difficulties in effecting an improvement in the matter of clothing has been the fight against tradition. From time immemorial, it has been the custom to wrap up the tiny baby in swaddling clothes, which so cramp the baby's movements that he is unable to move his limbs. It has taken may years to educate the mothers to the fact that the only exercise the baby can have is by kicking his legs and moving his arms about, and that these movements are restricted when he is confined in his long clothes. These long clothes also exclude the beneficial effects of the sun and the air from his body. Mothers are becoming much more sensible of the good effects of exposure of the body to the action of the sun, and they make every effort to put the baby out of doors in the perambulator. Occasionally we hear of the difficulties which the mothers have to contend with. They may be occupying an unstairs flat and they are not allowed the use of the back garden. Fortunately, most of the houses in Acton have a fair sized garden, but this garden is often in the sole possession of the tenants of the ground floor flat. But the mothers make every effort to overcome this difficulty by trying to take the baby out in the perambulator during some part of the day. We are fortunate in this district in the matter of open spaces, and I think it can be said that the mothers are taking increasing advantage of these open spaces for the benefit of the baby's health.

There is one other article of clothing which is taking a great deal of time in its banishment. Some mothers still cling to the old tight binder around the baby. Its original purpose, I imagine, was its supposed efficacy in imparting support to the back and protection to the organs of the abdomen. If this function were at any time fulfilled, it would have to be so tight as to be positively harmful. More frequently it was found to have slipped up under the arms and impeded the free movements of the chest, and in this manner was more harmful even than in its original position and more uncomfortable. These conceptions of what is a suitable clothing are gradually passing away and the tight binder is gradually giving way to the warm loose vest reaching to the lower part of the body.

These are some of the features in which success has been gradually attained and the success is reflected not only in a lowered infantile mortality, but also in a much lower mortality in the years immediately following. In contemplating the lowered infantile mortality we sometimes lose sight of the still greater improvement which has taken place in the age period 1 to 5 years. The baby reaches the end of his first year in a far better condition to withstand the trials and illnesses which await the toddler.

But there is one period in which success has not been attained, or at any rate to a very limited extent. I refer to the mortality in the first few weeks of life. The lowered mortality is almost entirely limited to the later months. The mortality in the first month of life remains almost unaltered.

Last year of the 56 deaths which occurred amongst children under one year of age, 33 of them occurred in the first 4 weeks after birth, and this is about the same proportion which is observed year after year. About one half of the deaths of infants under 12 months occur in the first 4 weeks of life. It is difficult to see how this waste can be avoided, except by greater efforts to conserve the health of the mother. Until this can be accomplished, there is not much prospect of reducing much further the infantile mortality. Fortunately, there is a greater tendency on the part of expectant mothers to consult their doctors or to attend a pre-natal clinic. One of the difficulties which militates against the success of our pre-natal clinic was the want of provision of maternity beds for normal cases of confinement. It is hoped that the arrangements which are now being made for maternity beds will overcome this difficulty and popularise the pre-natal clinic.

Maternal Mortality.

Two deaths occurred from Puerperal Sepsis and two deaths from diseases of Parturition. One of the latter was due to Necrosis of the Liver and the other to uncontrolled vomiting of pregnancy.

There were 4 notifications of Puerperal Fever and 9 notifications of Puerperal Pyrexia.

It is significant that the four deaths which occurred in childbirth, not only occurred in a hospital, but the confinement took place in the hospital, and there had been no difficulty in the admission of the patient.

Two of the deaths were due to Puerperal Sepsis and this is the condition which is generally regarded as one which should be prevented.

The particulars of the deaths were as follows :—

(1) Single woman aged 34 years, admitted to Charing Cross Hospital as a married woman.
Cause of death—Toxaemia of pregnancy.
Child born alive and lived 27½ hours.
Attended pre-natal clinic regularly, but there were no pre-natal symptoms.
Baby was delivered on June 18th, and the patient died on June 22nd.
Post-mortem, there was massive Necrosis of the Liver.

(2) Single woman admitted to Hospital as a married woman.
Attended pre-natal clinic at Queen Charlottes Hospital, and there was no difficulty in admission to the hospital.
Cause of death—Puerperal Sepsis.

(3) Single woman admitted as a married woman to Hammersmith Maternity Hospital, Ducane Road.
Attended pre-natal clinic.
Admitted to Hospital September 1st, baby born September 2nd. Date of death, September 19th.
Cause of death—Puerperal Sepsis.

(4) Single woman admitted to Hospital for uncontrolled vomiting of pregnancy.

Under present conditions it is difficult to see how these four deaths could have been prevented. The difficulty of eradicating puerperal fever lies in the fact that there is very much yet to discover in connection with the disease. Although it is known that certain microbes cause puerperal fever, it is possible that more than one variety may be capable of doing so. At one time it was thought that the disease was due to the germ called haemolytic streptococcus, but now it is possible that another strain called the anaerobic streptococcus may also be an occasional cause.

Of more importance is the mode by which these dangerous types of streptococcus reach the woman who is giving birth to a child. Some are convinced that the woman carried these dangerous microbes on her own person, and is therefore self-infected. It is known that a few women, about 25 in every 1,000, do carry streptococci, which are indistinguishable from those of puerperal fever, but most of these women, in spite of having potentially dangerous microbes do not get puerperal fever after their child-birth. Why some women are able to resist the attack of microbes while others do not is still a matter which awaits further research. One of the advantages of pre-natal examination and investigation is the possibility of remedying any focus which may result in auto-infection, and also in detecting any abnormal condition which may result in a long difficult labour. Great fatigue does diminish the power of the blood to kill microbes.

In the majority of cases of puerperal fever, though, the infecting organism is introduced from an outside source by those in attendance during labour. An improvement in this respect can only come from better midwifery. Not only will this result in less exhaustion of the mother, and therefore in less diminution of her powers to resist infection, but it will mean greater vigilance in guarding against the transference of dangerous microbes to the mothers during and after child-birth. The improvement may mean a revolution in the practice of both doctors and midwives. It was formerly taught that extraneous infection was usually brought about by the transfer of streptococci from an infected patient to an uninfected one. This, of course, is still a source of infection and prevention here is largely a question of the sterilisation of the hands and instruments. There is much more room for improvement in the sterilisation of the hands apart

from the occurrence of cases of puerperal fever. Some nurses and doctors do not appreciate that a perfunctory rinsing of the hands in a disinfectant for a few seconds does not suffice to sterilise them or even get rid of the dangerous microbes. One of the highest authorities on the subject states that we ought to recognise frankly that the use of naked hands in midwifery is wrong and should give place to a general employment of rubber gloves.

But another source of infection has recently been recognised. Investigations have recently been and are still being carried out which point to another source of outside infection. It is possible and even probable that haemolytic streptococci can be carried in the throats of attendants at the confinement. The occurrence of a sore throat in any one in attendance becomes at once a serious matter. The reports already issued suggest that the phophylaxis of puerperal fever cannot be effective unless rigid asepsis of hands and instruments or the wearing of rubber gloves is supplemented by the use of masks by attendants during examination and delivery. They also point to a new regime in maternity hospital practice designed to secure definite bed isolation in the wards and stringent aseptic surgical technique, including masking of the attendants during manipulative interference, delivery and treatment.

Pre-natal Clinic.

The clinic is held once a fortnight in the School Clinic and Dr. Bell is in charge.

24 sessions were held with a total of 170 attendances.

There is an agreement with the Acton General Hospital for the reception of complicated cases of pregnancy and during the year six patients were admitted under the scheme.

Although the numbers who have attended the pre-natal clinic are higher than those of previous years, the working of our maternity scheme cannot be regarded as entirely satisfactory.

Certain developments have already taken place in 1931, and a report will be submitted to the Committee which will bring the pre-natal work more in line with these developments.

Child Welfare Centres.

There has been no change in the arrangement of the child welfare centres in the year. It was stated in last year's report that the attendances at East Acton School necessitated a weekly opening of the Centre there instead of a fortnightly one.

Six sessions are now held weekly : two each in Church Road and Palmerston Road, and one each in East Acton School and Steele Road.

A reference to Table 8 will show that the work has gradually increased. In almost every branch of the work the figures are higher than those of the previous year.

Day Nursery.

The Nursery is situated in Bollo Bridge Road, and is open on five days a week. Saturday opening has been tried but the attendance did not justify the Saturday opening.

The Nursery was open on 212 occasions, and 4,307 whole-day and 177 half-day attendances were made.

Nurse Children.

Section 2 of the Local Government Act, 1929, provided that as from April 1st, 1930, the functions under Part I. of the Children Act, 1908, formerly discharged by poor law authorities, should be discharged by the councils of counties and county boroughs as functions under the Maternity and Child Welfare Act, 1918, except that where the council of a district have established a maternity and child welfare committee, the said functions shall in that district be discharged by the council of that district.

The main object of Part I. of the Children Act is to secure that any child under seven years of age who is maintained "for reward" shall be notified to the local authority in order that it may be kept under observation and supervision.

Every person who undertakes for reward the nursing and maintenance of one or more infants under the age of seven years apart from their parents, or having no parents, must give notice to the local authority, giving certain particulars. Written notice must also be given in the case of death, or change of residence or removal of the child.

Certain persons are prohibited from receiving children for reward, and under certain conditions children can, on an order from a magistrate, be removed from premises or persons that are undesirable or unsatisfactory.

The local authority has to provide for the administration of the Act and the Boards of Guardians had to appoint Infant Protection Visitors, but in a Memorandum issued by the Ministry of Health, it was suggested that the Health Visitors should be appointed Infant Protection Visitors under Part I. of the Children Act, and the Council adopted this suggestion.

The Health Visitors were already visiting most of the children under 5 years of age who had been adopted for reward, and it simply meant that they should continue visiting until the children were seven years of age. Two officers carry out home visiting of infants and school children in their respective areas.

When the duties were taken over from the Guardians, a list of children was forwarded, and on this list there were 39 names. Between April 1st and December 31st 26 other names were added, but 13 names were removed from the register in the same period. There were remaining on the register on December 31st, 52 names.

TABLE 1.

BIRTH-RATE, DEATH-RATE, AND ANALYSIS OF MORTALITY DURING THE YEAR 1930.

	Rate per 1,000 Population		Annual Death-rate per 1,000 Population.									Rate per 1,000 Births		Percentage of Total Deaths			
	Live Births.	Still-Births.	All Causes	Enteric Fever	Small Pox	Measles	Scarlet Fever	Whooping Cough	Diphtheria	Influenza	Violence	Diarrhoea and Enteritis (under 2 yrs.)	Total deaths under 1 year	Certified by Registered Medical Practitioners	Inquest Cases	Certified by Coroner after P.M. No Inquest	Uncertified Causes of Death
England and Wales	16.3	0.69	11.4	0.01	0.00	0.10	0.02	0.05	0.09	0.12	0.55	6.0	60.	90.4	8.9	1.7	1.0
107 County Boroughs and Great Towns, including London	16.6	0.71	11.5	0.01	0.00	0.15	0.02	0.05	0.10	0.11	0.50	8.3	64.	90.6	6.6	2.3	0.5
156 Smaller Towns (1921 Adjusted Population, 20,000—50,000)	16.2	0.69	10 5	0.00	0.00	0.83	0.01	0.05	0.07	0.13	0.43	4.4	55.	91.8	5.9	1.2	1.1
London	15.7	0.56	11.4	0.01	0.00	0.23	0.02	0.03	0.10	0.08	0.55	9.9	59.	88.3	7.4	4.3	0.0
Acton	16.9	0.63	10.6	0.00	0.00	0.13	0.02	0.03	0.13	0.06	0.38	5.5	50.	90.8	5.8	3.4	0.0

TABLE 2.

VITAL STATISTICS FOR THE WHOLE DISTRICT DURING 1930 AND PREVIOUS YEARS.

Year	Population estimated to Middle of each Year	Births		Total Deaths Registered in the District		Transferable Deaths		Nett Deaths belonging to the District			
		Nett						Under 1 year of Age		At all Ages	
		Number	Rate	Number	Rate	of Non-Residents Registered in the District	of Residents Registered outside Dist.	Number	Rate per 1,000 Births	Number	Rate per 1,000 inhabitants
1925	63,110	1047	16.5	446	6.8	18	241	80	76	669	10.6
1926	63,040	1098	17.4	422	6.7	15	250	60	55	657	10.4
1927	63,750	1026	16.1	445	6.9	21	280	62	60	704	11.04
1928	64,870	1003	15.4	479	7.4	29	244	55	55	694	10.7
1929	65,200	1026	15.7	540	8.3	21	307	85	83	826	12.7
1930	65,200	1105	16.9	440	6.7	31	284	56	50	693	10.6

TABLE 3. AGES AT DEATH, AND WARD DISTRIBUTION OF DEATHS IN 1930.

Causes of Death.	Age in Years.									Ward Distribution.			
	All ages	Under 1 year	1 and under 2	2 and under 5	5 and under 15	15 and under 25	25 and under 45	45 and under 65	65 and upwards	North East	North West	South East	South West
Whooping Cough	2	—	—	2	—	—	—	—	—	1	—	1	—
Measles	9	1	3	3	2	—	—	—	—	1	1	2	5
Scarlet Fever	1	—	—	—	1	—	—	—	—	1	—	—	—
Diphtheria	9	1	—	5	3	—	—	—	—	5	—	1	3
Encephalitis Lethargica	4	—	—	1	—	1	2	—	1	—	3	1	—
Meningococcal Meningitis	5	1	1	—	—	2	—	1	—	—	1	2	2
Influenza	4	—	—	—	—	—	—	2	2	1	2	—	1
Phthisis	57	—	—	—	1	9	31	15	1	15	7	11	24
Other tubercular diseases	9	2	1	3	1	—	1	1	—	4	1	—	4
Syphilis	2	—	—	—	—	—	—	2	—	—	1	—	1
Cancer	86	—	—	—	—	—	5	40	41	23	24	22	17
Rheumatic Fever	2	—	—	—	—	—	1	1	—	1	—	—	1
Heart Disease	77	—	—	—	4	5	9	19	40	24	23	10	20
Cerebral Hæmorrhage	35	—	—	—	—	—	1	12	22	9	13	4	9
Arterio-scelerosis	38	—	—	—	—	—	—	11	27	8	10	10	10
Diabetes	5	—	—	1	—	—	—	2	2	2	1	2	—
Bronchitis	41	1	2	—	—	—	1	16	21	9	7	12	13
Pneumonia (all forms)	42	4	3	3	1	—	8	9	12	9	9	8	16
Other respiratory diseases	9	—	—	2	1	1	1	2	2	3	2	1	3
Diarrhœa	6	5	1	—	—	—	—	—	—	2	2	—	2
Ulcer of Stomach and Duodenum	12	—	—	—	—	—	3	5	4	3	4	3	2
Appendicitis	2	—	—	—	—	—	1	—	1	—	—	1	1
Cirrhosis of Liver	3	—	—	—	—	—	—	2	1	1	—	1	1
Nephritis	27	—	—	—	—	1	2	13	11	10	7	6	4
Puerperal Sepsis	2	—	—	—	—	1	1	—	—	1	1	—	—
Other diseases or accidents of Parturition	2	—	—	—	—	1	1	—	—	—	1	1	—
Prem. births, congenital diseases & deformity	37	27	—	—	—	—	—	—	—	11	9	6	11
Suicide	6	—	—	—	—	2	2	—	2	2	2	1	1
Other violent deaths	24	—	—	—	2	8	3	5	6	13	6	2	3
Other defined diseases	134	4	4	1	1	4	9	26	85	36	31	35	32
TOTALS	693	56	15	23	17	34	82	184	282	196	168	143	186

TABLE 4.

INFANTILE MORTALITY 1930.

Causes of Death.	Ages.									Wards.			
	Total	Under 1 week	1—2 weeks	2—3 weeks	3—4 weeks	1—3 months	3—6 months	6—9 months	9—12 months	North East	North West	South East	South West
Measles	1	—	—	—	—	—	—	—	1	—	—	—	1
Diphtheria	1	—	—	—	—	—	1	—	—	—	—	—	1
Tubercular Meningitis	2	—	—	—	—	—	—	2	—	1	—	—	1
Myocarditis	1	—	—	—	—	—	—	1	—	—	—	—	1
Bronchitis	1	—	—	1	—	—	—	—	—	1	—	—	—
Pneumonia	4	—	—	—	—	—	—	2	2	—	1	—	3
Diarrhœa	5	—	—	—	—	1	3	1	—	1	2	—	2
Premature Birth	20	18	—	—	1	1	—	—	—	3	6	5	6
Congenital Malformation	4	4	—	—	—	—	—	—	—	1	—	1	2
Injury at Birth	5	5	—	—	—	—	—	—	—	3	2	—	—
Asphyxia Neonatorum	2	2	—	—	—	—	—	—	—	—	1	1	—
Hydrocephalus	2	—	—	—	—	—	—	1	1	1	1	—	—
Inanition	2	—	—	—	1	—	1	—	—	1	—	—	1
Asthesia	1	—	—	—	—	—	1	—	—	1	—	—	—
Atelectasis	1	—	1	—	—	—	—	—	—	—	—	—	1
Accidental Burns	1	—	—	—	—	—	—	1	—	1	—	—	—
Status Lymphaticus	1	—	—	—	1	—	—	—	—	1	—	—	—
Otitis Media	1	—	—	—	—	1	—	—	—	—	—	—	1
Meningitis	1	—	—	—	—	—	1	—	—	—	1	—	—
TOTALS	56	29	1	1	3	3	7	6	6	15	14	7	20

TABLE 5.

CASES OF INFECTIOUS DISEASE NOTIFIED DURING THE YEAR 1930.

Notifiable Disease.	Cases notified in whole District. At Ages—Years.								Ward Distribution.			
	At all Ages	Under 1	1 to 5	6 to 15	16 to 25	26 to 45	46 to 65	Over 65	North East	North West	South East	South West
Small-Pox	7	—	—	3	1	3	—	—	2	2	—	3
Scarlet-Fever	207	—	60	108	21	18	—	—	75	30	41	61
Diphtheria	103	1	32	58	8	4	—	—	38	21	10	34
Typhoid	1	—	—	—	—	—	1	—	—	1	—	—
Paratyphoid B.	2	—	—	1	1	—	—	—	—	2	—	—
Pneumonia	37	—	8	2	4	11	7	5	7	7	6	17
Puerperal Fever	4	—	—	—	2	2	—	—	1	1	—	2
Encephalitis Lethargica	2	—	1	—	—	1	—	—	—	2	—	—
Ophthalmia Neonatorum	10	10	—	—	—	—	—	—	2	2	—	6
Puerperal Pyrexia	9	—	—	—	6	3	—	—	3	3	—	3
Erysipelas	20	—	1	1	2	6	7	3	5	8	1	6
Tuberculosis (resp.)	97	1	—	3	27	53	13	—	27	23	12	35
Tuberculosis (other)	13	1	1	4	4	2	1	—	3	1	4	5
TOTALS	512	13	103	180	76	103	29	8	163	103	74	172

TABLE 6.

CASES REMOVED TO HOSPITAL.

	N. East.	N. West.	S. East.	S. West	Total
Scarlet Fever	62	20	36	53	171
Diphtheria	38	21	10	34	103
Typhoid	—	1	—	—	1
Paratyphoid B.	—	1	—	—	1
Pneumonia	3	2	1	5	11
Puerperal Fever	1	—	—	—	1
Encephalitis Lethargica	—	2	—	—	2
Puerperal Pyrexia	1	2	—	—	3
Erysipelas	1	1	—	3	5
	106	51	47	95	299

TABLE 7.

BIRTHS.

LIVE BIRTHS.

	Male.	Female.
Total	555	550
Legitimate	523	513
Illegitimate	32	37

STILL BIRTHS.

Total	26	15
Legitimate	22	15
Illegitimate	4	—

NOTIFIED LIVE BIRTHS.

	Total.	Ward Distribution. N. East.	N. West.	S. East.	S. West.
Total Births notified in the district	830	256	179	114	281
Notifications received from other districts	217	58	54	48	57
Births registered but not previously notified	12	4	3	—	5
	1059	318	236	152	343

NOTIFIED STILL BIRTHS.

Inside .... 15. Outside .... 8.

NOTIFICATIONS WERE RECEIVED FROM :—

Doctors and Parents .... 747.

Midwives .... 323.

TABLE 8.

INFANT WELFARE CENTRES, 1930.

Health Visitors' Attendances	299
Number of Children who attended	1765
Number of attendances by Children	16352
Number of Children under 1 year of age	874

Number of Children over 1 year of age	891
Children who attended for first time	1372
Children treated at Dental Clinic	165
Children treated at Ophthalmic Clinic	8
Mothers treated at Ophthalmic Clinic	—
Children treated for Enlarged Tonsils and Adenoids	3

TABLE 9.

ANTE-NATAL CLINIC.

Number of attendances by Dr. Bell	24
Number of Expectant Mothers who attended	113
Number of attendances made by Expectant Mothers	170
Mothers referred for Dental treatment at the Clinic	46
Mothers supplied with Dentures	10
Expectant Mothers to whom Dried Milk was supplied	20
Number of packets of Dried Milk supplied	248

TABLE 10.

INQUESTS.

INQUESTS—40.

Run over by a motor car	11	Fall in road	1
Accidental fall	8	Fall from bicycle	1
Suicide	7	Accidental drowning	1
Injury at birth	3	Killed by a train	1
Accidental burns	2	Phthisis	1
Knocked down by a bicycle	1	Syncope	1
Injury to finger	1	Toxaemia of pregnancy	1

CORONER'S CERTIFICATE AFTER POST-MORTEM WITHOUT INQUEST—24.

Fatty degeneration of Heart	4	Status Lymphaticus	1
Arterio-scelerosis	4	Bronchitis	1
Cerebral Haemorrhage	2	Endocarditis	1
Cardiac Denegeration	2	Ulcer of Stomach	1
Nephritis	2	Congenital heart disease	1
Pneumonia	2	Intestinal obstruction	1
Rupture of Aortic valve....	1	Meningococcal Meningitis	1

FACTORIES, WORKSHOPS AND WORKPLACES.

1.—*Inspection of Factories, Workshops and Workplaces including Inspections made by Sanitary Inspectors.*

Premises. (1)	Number of Inspections. (2)	Written Notices. (3)
Factories	83	7
(Including Factory Laundries).		
Workshops	304	18
(Including Workshop Laundries).		
Workplaces	18	Nil
(Other than Outworkers' Premises).		
Total	405	25

2.—*Defects found in Factories, Workshops and Workplaces.*

Nuisances under the Public Health Acts :—

Particulars. (1)	Found. (2)	Remedied. (3)
Want of Cleanliness	17	17
Want of Ventilation	Nil	Nil
Overcrowding	Nil	Nil
Want of drainage of Floors	Nil	Nil
Other Nuisances	12	12
Sanitary Accommodation :—		
Insufficient	Nil	Nil
Unsuitable or defective	28	28
Nor separate for sexes	Nil	Nil
Offences under the Factory and Workshop Acts :—		
Illegal Occupation of underground Bakehouses	Nil	Nil
Other Offences	Nil	Nil
Total	57	57

3.—*Outwork in unwholesome premises, Section* 108 Nil

HOUSING.

Number of Houses erected during the year :—

(*a*) Total [including number given separately under (*b*)] 514

(*b*) With State assistance under the Housing Acts :—

(i) By the Local Authority 12

(ii) By other bodies or persons .... Nil

1.—Unfit Dwelling Houses.

Inspection.

(1) Total number of dwelling-houses inspected for housing defects (under Public Health or Housing Acts) 1244

(2) Number of dwelling-houses which are inspected and recorded under the Housing (Inspection of District) Regulations 1910, or the Housing Consolidated Regulations, 1925 670

(3) Number of dwelling-houses found to be in a state so dangerous or injurious as to be unfit for human habitation .... Nil

(4) Number of dwelling houses (exclusive of those referred to under the preceding Sub-Head) found not to be in all respects reasonably fit for human habitation 1172

2.—Remedy of Defects without Service of Formal Notices.

Number of defective dwelling-houses rendered fit in consequence of informal action by the Local Authority or their Officers	811

3.—Action under Statutory Powers.

A.—Proceedings under Section 3 of the Housing Act, 1925, and under Section 17 of the Housing Act, 1930.

(1) Number of dwelling-houses in respect of which notices were served requiring repair	189
(2) Number of dwelling-houses which were rendered fit after the service of formal notices :—	
(*a*) by owners	189
(*b*) by local authority in default of owners	Nil
(3) Number of dwelling-houses in respect of which Closing Orders became operative in pursuance of declarations by owners of intention to close	Nil

B.—Proceedings under Public Health Acts.

(1) Number of dwelling-houses in respect of which notices were served requiring defects to be remedied	172
(2) Number of dwelling-houses in which defects were remedied after service of formal notices :—	
(*a*) by owners	172
(*b*) by local authority in default of owners	Nil

C.—Proceedings under Sections 11, 14 and 15 of the Housing Act, 1925.

(1) Number of representations made with a view to making of Closing Orders	Nil
(2) Number of dwelling-houses in respect of which Closing Orders were made	Nil
(3) Number of dwelling-houses in respect of which Closing Orders were determined, the dwelling-houses having been rendered fit	Nil
(4) Number of dwelling-houses in respect of which Demolition Orders were made	Nil
(5) Number of dwelling-houses demolished in pursuance of Demolition Orders	Nil

STAFF.

D. J. THOMAS, M.R.C.S., L.R.C.P., D.P.H., Medical Officer of Health (Medical Superintendent of the Isolation Hospital and School Medical Officer).

M. W. KINCH, Member of the Royal Sanitary Institute, holds Meat and Smoke Certificates; Chief Sanitary Inspector (Inspector under Diseases of Animals Acts and the Rag Flock Act).

J. J. JENKINS, Cert. of Royal Sanitary Institute; holds Meat and Smoke Certificates, Sanitary Inspector. (Inspector under Fabrics Mis-description Act).

E. W. BROOKS, Cert. of Royal Sanitary Institute. Sanitary Inspector.

J. J. MATTHEWS, Cert. of Royal Sanitary Institute; holds Meat Certificate, Sanitary Inspector.

Miss A. COOKSEY, Certificate of Royal Sanitary Institute. Health Visitor.

Miss J. WELSH, Certificate of Royal Sanitary Institute, C.M.B., Health Visitor.

Miss B. G. SORLIE, S.R.N. Certificate of Royal Sanitary Institute, C.M.B., H.V. Diploma, Health Visitor (and part-time School Nurse).

Miss A. WOOSNAM, S.R.N., C.M.B., Health Visitor (and part-time School Nurse).

W. GOODFELLOW,* Cert. of Royal Sanitary Institute; holds Meat Certificate, Chief Clerk.

Miss G. OVERALL,* Clerk.

Mrs. LIGHT, Clerk.

Miss V. E. ARNOLD, Clerk.

NOTE.—To the salaries of all the above officials, excepting those marked with an asterisk, contribution is made under the Public Health Acts or by Exchequer Grants.

I have again to thank all the members of the Public Health Department for ungrudging assistance during the year.

I am,

Your Obedient Servant,

D. J. THOMAS.