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

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Borough of Acton.

ANNUAL REPORT

OF THE

Medical Officer of Health

TOGETHER WITH THE

Report on the Medical Inspection of Schools

FOR THE YEAR 1935.

ANNUAL REPORT

OF THE

Medical Officer of Health

FOR THE YEAR 1935.

PUBLIC HEALTH DEPARTMENT,

MUNICIPAL OFFICES,

ACTON, W.3.

To the Mayor, Aldermen and Councillors

of the Borough of Acton.

LADIES AND GENTLEMEN,

I beg to submit the Annual Report for 1935, required by the Ministry of Health, together with the Annual Report on the School Medical Services.

Area.—In last year's report it was stated that there had been a re-arrangement of boundaries between the Acton Council and the Brentford and Chiswick Council, and also the Ealing Council. The area of the district at present is 2,317 acres.

Rateable Value.—The rateable value of the Borough on 1st April, 1935, was £765,110, and the sum represented by a penny rate was £2,825 (year ended 31st March, 1935).

The number of inhabited houses, according to the Rate books at the 31st March, 1935, was 16,338.

ANNUAL REPORT

OF THE

Medical Officer of Health

FOR THE YEAR 1935.

Extracts from Vital Statistics.—The following table gives the extracts from the vital statistics required by the Ministry of Health :—

POPULATION 68,960.

	Total.	M.	F.	
Live Births.				Birth-rate per 1,000
Legitimate	823	436	387	of estimated popu-
Illegitimate	45	25	20	lation—12.6
	868	461	407	
Still Births.				
Legitimate	31	18	13	Rate per 1,000 births
Illegitimate	3	1	2	—39
	34	19	15	

Deaths .... 704 Death-rate per 1,000 inhabitants—10.2

Deaths from Puerperal causes (Headings 29 and 30 of the Registrar General's short list).

		Deaths	Rate per 1,000 births
No. 29	Puerperal Sepsis	2	2.3
No. 30.	Other Puerperal causes	2	2.3

Death-rate of Infants under 1 *year of age.*

All infants per 1,000 births	59
Legitimate infants per 1,000 legitimate births	57
Illegitimate infants per 1,000 illegitimate births	127
Deaths from Measles—all ages	0
Deaths from Whooping Cough	3
Deaths from Diarrhoea—under 2 years of age	11

POPULATION.

The Registrar General has given the estimated population for mid 1935 at 68,960, a reduction of 383 on the estimate for mid 1934, and a reduction of 1,550 on the Census population.

The number of parliamentary electors in Acton since 1931 has been as follows :—

1931	47,865
1932	48,126
1933	48,245
1934	48,228
1935	48,258

The number of new houses erected during the last five years were :—

1930-31	449
1931-32	257
1932-33	188
1933-34	224
1934-35	134

SOCIAL CONDITIONS OF THE DISTRICT.

Although there has been no sudden change in the social conditions of the district, a gradual change has been in operation for many years, and the process still continues. There are certain periods in the history of the district when possibly the conditions have more definitely altered, and the period since the Great War has been one of those. Otherwise the conditions which obtain are similar to those described in last year's Annual Report.

Unemployment is slowly but steadily diminishing as the following figures show :—

31*st December*, 1933.
2816 men
461 women
3277

31*st December*, 1934.
2273 men
447 women
2720

31*st December*, 1935.
2074 men
551 women
2625

AMBULANCE FACILITIES.

The ambulance facilities are similar to those described in previous reports.

There is a motor ambulance for the removal of infectious cases to the Isolation hospital, and two ambulances provided for accident and non infectious cases. The latter are housed at the fire station and are available at all hours. Last year the ambulance was called out to 537 street accidents, and on 465 occasions to private cases. Fees amounting to £89 9s., were paid for the use of the ambulance for private cases.

There has been no development or marked changes in the services provided in the area under the following heads :—

Laboratory facilities.
Ambulance facilities.
Nursing in the home.
Clinics and Treatment Centres.
Hospitals—Public and Voluntary.

HOSPITAL PROVISION.

General.—The only General Hospital in the District is the Acton Hospital, Gunnersbury Lane, which has an accommodation of 65 beds.

During the year, 1269 patients were admitted ; this is a decrease of 33 on the previous year, but as their average length of stay was 18.1 days against 17.29 days in the previous year, this decrease is accounted for. The beds have been continuously occupied, and the average number of patients resident daily was 62.94.

The Education Committee continues its agreement with the Hospital for payment for the removal of tonsils and adenoids and the patients are kept in the Hospital for at least one night.

8508 out-patients were treated during the year, an increase of 757 and the out-patient attendances were 37,118 an increase of 3,745 as compared with 1934.

The Hospital supplies a great need in the district, and the work in the out-patient Department has grown so rapidly the last few years that it has become necessary to enlarge that Department.

A new Ward is also being built to accommodate a few more men who are constantly being refused admission owing to lack of accommodation. When this has been completed it will be possible to give the children better accommodation in the Ward which up to the present has been used for men.

Fever.—Acton Council Fever Hospital.

Small-Pox.—Acton was one of the constituent bodies which formed the Middlesex Joint Small-Pox Board. Under the Provisional Order Confirmation Act of 1929, the Joint Board was dissolved 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*)—47, Avenue Road—Every Monday, Tuesday, Wednesday and Thursday afternoons at 2 p.m.

(*b*)—John Perryn—Every Monday afternoon at 2 p.m.

(*c*)—Steele Road—Every Tuesday afternoon at 2 p.m.

(*d*)—Noel Road—Every Thursday afternoon at 2 p.m.

Ante-Natal Consultation Centre.—School Clinic every Wednesday at 10.30 a.m.

Day Nursery.—169 Bollo Bridge Road.

School Clinic.—45 Avenue Road.

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

Tuberculosis Dispensary.—Green Man Passage, Ealing, W.13 on Monday at 2 p.m., Tuesday, Wednesday, Thursday and Friday at 10.30 a.m. First and Third Tuesday in each month at 6 p.m.

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

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

PROFESSIONAL NURSING IN THE HOME.

General.—There are two district nurses employed by the Acton Hospital, who visit the homes of both the poor and those who are able to pay.

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 24 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 and 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, &c.	1924
Offensive Trades	1903
Tents, Vans and Sheds	1906
Removal of Offensive or Noxious Matters	1908
Cleansing of Cisterns	1912
Employment of Children	1920
Fouling of Footpaths by Dogs	1929
Smoke Abatement	1930
Houses let in Lodgings	1934

HOUSING.

Several reports were made during the year to different Committees of the Council on the Housing Act of 1935 and as the question of overcrowding and its abatement will have to be discussed during 1936, I shall only make a brief reference to the special work which was done under the Act during last year.

Under Section 1 of the Housing Act, 1935, a survey had to be made in order to ascertain the extent of overcrowding in the district, and in October the Ministry of Health issued Memorandum B, in which detailed instructions were given as to the methods to be adopted in order to obtain the information.

Section 2 and the first Schedule to the Act set out the new overcrowding standard which is to apply throughout the whole country. Two standards are laid down, the first dealing with persons per room, and the second relating the floor area of the rooms to the number of inhabitants. The number of persons permitted to use a house for sleeping is the lesser of the figures obtained by using both bases of calculation.

For convenience, the two tables in the first schedule to the Act are reproduced :—

Table I.

Where a house consists of :—		*The permitted number of persons is :—*
(*a*)	One room	2
(*b*)	Two rooms	3
(*c*)	Three rooms	5
(*d*)	Four rooms	$7\frac{1}{2}$
(*e*)	Five rooms or more	10 with an additional 2 in respect of each room in excess of five.

(In using this table, a room of less than 50 square feet is not counted as a room).

Table 2.

Where a room in any house has a floor area of :—		
(*a*)	110 sq. feet or more	2
(*b*)	90 sq. feet or more, but less than 110	$1\frac{1}{2}$
(*c*)	70 sq. feet or more, but less than 90	1
(*d*)	50 sq. feet or more, but less than 70	$\frac{1}{2}$
(*e*)	Under 50 sq. feet	Nil.

Approximately 12,000 houses were inspected, containing 16,943 tenements. Of these the tenements were as follows :—

Size of Letting.	*Number.*	*Overcrowded.*	
		Possibly.	*Definitely.*
1 room	422	86	17
2 rooms	1,354	327	114
3 ,,	5,385	709	151
4 ,,	3,242	162	29
5 ,,	3,465	57	5
6 ,,	2,112	9	–
7 ,,	633	1	–
8 ,,	176	1	–
9 ,,	92	–	–
10 ,,	41	–	–
11 ,,	17	–	–
12 ,,	3	–	–
13 ,,	–	–	–
14 ,,	1	–	–
	16,943	1,352	316

In the first enumeration there were 316 tenements overcrowded, based upon Table I. It was also found that there were 1,352 tenements potentially overcrowded. These were divided as set out above.

It was to ascertain definitely whether these tenements were actually overcrowded that the second survey had to be made. In this survey each room had to be measured to decide whether the tenement was overcrowded according to Table 2. As a result of both surveys we found that this is the present state of affairs as regards overcrowding :—

Size of Letting.	*Number.*	*Number definitely overcrowded.*
1 room	422	39
2 rooms	1,354	132
3 ,,	5,385	186
4 ,,	3,242	60
5 ,,	3,465	11
6 ,,	2,112	2
7 ,,	633	–
8 ,,	176	–
9 ,,	92	–
10 ,,	41	–
11 ,,	17	–
12 ,,	3	–
13 ,,	–	–
14 ,,	1	–
	16,943	430

HOUSING.

Number of Houses erected during the year :—

(*a*) Total (including number given separately under (*b*) 70

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

(i) By the Local Authority 2

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

1. *Inspection of Dwelling-houses during the Year* 1935 :—

(1) (*a*) Total number of dwelling-houses inspected for housing defects (under Public Health or Housing Acts) 1909

(*b*) Number of inspections made for the purpose 4706

(2) (*a*) Number of dwelling-houses (included under sub-head(1) above), which were inspected and recorded under the Housing Consolidated Regulations, 1925 1388

(*b*) Number of inspections made for the purpose 3160

(3) Number of dwelling-houses found to be in a state so dangerous or injurious to health 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 1876

2. *Remedy of Defects during the Year without Service of formal Notices* :—

Number of defective dwelling-houses rendered fit in consequence of informal action by the Local Authority or their officers — 1670

3. *Action under Statutory Powers during the Year* :—

A.—Proceedings under sections 17, 18 and 23 of the Housing Act, 1930 :

(1) Number of dwelling-houses in respect of which notices were served requiring repairs ..... — 183

(2) Number of dwelling-houses which were rendered fit after service of formal notices :—

(*a*) By owners .... — 183

(*b*) By local authority in default of owners .... — Nil.

B.—Proceedings under Public Health Acts :—

(1) Number of dwelling-houses in respect of which notices were served requiring defects to be remedied .... — 32

(2) Number of dwelling-houses in which defects were remedied after service of formal notices :—

(*a*) By owners .... — 32

(*b*) By local authority in default of owners .... — Nil.

C.—Proceedings under sections 19 and 21 of the Housing Act, 1930 :

(1) Number of dwelling-houses in respect of which Demolition Orders were made ..... — Nil.

(2) Number of dwelling-houses demolished in 1935, in pursuance of Demolition Orders ..... — Nil.

D.—Proceedings under section 20 of the Housing Act, 1930 :—

(1) Number of separate tenements or underground rooms in respect of which Closing Orders were made .... — Nil.

(2) Number of separate tenements or underground rooms in respect of which Closing Orders were determined, the tenement or room having been rendered fit .... — Nil.

TABULAR STATEMENT OF INSPECTIONS AND 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)		1909
(1) Dealt with by service of Informal Notice	1670	
(2) Dealt with by service of Statutory Notice under Section 17, Housing Act, 1930	183	
(3) Dealt with by service of Statutory Notice under Public Health Acts	32	
Premises (other than defective dwelling houses) inspected for nuisances and miscellaneous defects		665
(1) Dealt with by service of Informal Notice	548	
(2) Dealt with by service of Statutory Notice under Public Health Act, &c.	48	
Reinspections subsequent to service of Notice		6701
Inspection after notification of Infectious Disease		130

Number of Premises under Periodical Inspection.

Workshops and Workplaces	126
Bakehouses	29
Slaughterhouses	2
Public House Urinals	37
Common Lodging Houses	1
Butchers' Shops	39
Fish Shops	33
Premises where food is manufactured or prepared	35
Milk Purveyors	119
Cowsheds	Nil.
Piggeries	Nil.
Rag and Bone Dealers	7
Mews	4
Schools	13
Caravan Grounds	3

Rent Restriction Act.

Number of Certificates granted	23

Detail of Work carried out.

Sanitary Dustbins provided	496
Yards paved or yard paving repaired	226
Insanitary forecourts remedied	85
Defective drains repaired or reconstructed	124
Defective soil pipes and ventilating shafts repaired or renewed	70
Defective fresh air inlets repaired or renewed	59
Defective gullies removed and replaced by new	31
Rain water downpipes disconnected from drain	23
Dishing and curb to gullies repaired and new grating fixed	152
Defective W.C. pan and traps removed and replaced by new	159
Defective W.C. flushing apparatus repaired or new fixed	471
Defective W.C. seats repaired or new fixed	322
Defective flush pipe connections repaired	145
Insanitary sinks removed or new fixed	79
Sink waste pipes repaired or trapped	246
Insanitary wall surface over sinks remedied	174
Ventilated food cupboards provided	23
Drinking water cisterns cleaned	363
Defective covers to drinking water cisterns repaired or new fixed	263
Insanitary sites beneath floors concreted	11
Spaces beneath floors ventilated	168
Dampness in walls from defective damp-proof course remedied	238
Dampness from defective roof, rain water gutterings, &c., remedied	1160
Defective plastering repaired (number of rooms)	473
Rooms where dirty walls and ceilings have been cleansed and redecorated	2848
Defective floors repaired	277
Defective or dangerous stairs repaired	78
Defective doors and windows repaired	669
Defective kitchen ranges and fire grates repaired	392
Defective washing coppers repaired	115
Coal cupboards provided or repaired	10
New W.C. apartments provided	6
Accumulations of offensive matter removed	37
Drains unstopped and cleansed	246
Overcrowding nuisances abated	23
Drains tested, exposed for examination, &c	62
Smoke observations taken	161
Smoke nuisance abated on service of notice	11
Nuisances from animals abated	9
Notifications of waste of water sent to Metropolitan Water Board	273

UNSOUND FOOD SURRENDERED DURING 1935.

Cattle.

Carcases	*Heads*	*Plucks*	*Organs*	*Parts of Carcase*
54	7	41	5 sets Ox Lungs with Hearts	2 Ribs of Beef
			7 Ox Livers	2 Flanks ,,
			6 Ox Kidneys	1 Leg ,,
			1 Ox Tripe	1 Stirk's Rump
			1 Ox Mesentery	
			52 sets Calves' Lungs with Hearts	17 Breasts of Veal
			29 Calves' Kidneys	7 Ribs ,,
			15 Calves' Livers	5 Legs ,,
				4 Shoulders
				2 Knuckles
				1 Loin ,,
				1 Hindquarter

Sheep.

Carcases	*Plucks*	*Organs*	*Parts of Carcase*
4	16	66 sets Lungs with Hearts	2 Ribs Mutton
		3 Livers	2 Shanks ,,

Pigs.

Carcases	*Heads*	*Plucks*	*Chitterlings*	*Parts of Carcase*
73	1115	474	3362 lbs.	95 lbs. Ribs
				38 lbs. Collars
				118 lbs. Foreq'ters
				330 lbs. Hindq'ters
				132 lbs. Shoulders
				148 lbs. Legs.
				408 lbs. Sides

Other Foods.

44 Fowls.
17 Ducks.
17 cwt. Preserved Pork & Veal.
17 lbs. Pressed Beef.
6 lbs. Corned Beef.
9 st. Norway Herrings.
6 st. 12 lbs. Cod.
4 boxes Kippers.
3 boxes Whiting.
9 gallons Whelks.
1 tin Prawns.
6 boxes Canary Tomatoes.

NUMBER OF PIGS' CARCASES INSPECTED FROM 1st JANUARY TO 31st DECEMBER, 1935
WITH ANALYSIS OF SURRENDERS ON ACCOUNT OF DISEASE.

1935	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.
January	1661	57	6	—	1	—	—	—	30	264 lbs.	— lbs.
February	1776	87	4	—	—	—	—	—	39	306 ,,	68 ,,
March	1939	81	6	—	—	—	2	—	36	344 ,,	— ,,
April	2003	88	5	—	—	—	—	—	53	296 ,,	25 ,,
May	2101	85	3	—	—	—	—	—	43	312 ,,	— ,,
June	1722	66	4	—	—	—	1	11	22	208 ,,	— ,,
July	1601	88	3	3	1	4	—	—	23	184 ,,	— ,,
August	1695	85	4	—	—	—	—	—	44	276 ,,	59 ,,
September	2549	158	7	—	—	1	—	—	57	408 ,,	13 ,,
October	3500	181	13	—	2	1	—	—	59	368 ,,	— ,,
November	4505	182	17	—	—	—	—	—	41	252 ,,	— ,,
December	4009	111	8	—	—	5	—	—	73	486 ,,	— ,,
TOTAL	29061	1269	80	3	4	11	3	11	520	3704 ,,	165 ,,

INSPECTION AND SUPERVISION OF FOOD.

Milk Supply.

There are no cowsheds in the Borough, all the milk being produced outside.

There are 119 persons or firms retailing milk in the district under the following categories :—

Dairymen.			Purveyors of Milk
No. with rounds *not* occupying premises in the Borough.	No. with rounds occupying premises in the Borough.	No. of General shops from which milk is sold from covered pans only	No. of shops from which milk is sold in closed and unopened receptacles only.
12	19	2	86

Special Designated Milk

The number of persons or firms licensed to sell Special Designated Milk is as follows :—

3 " Certified "
7 " Grade A (Tuberculin Tested) "
1 " Grade A "
6 " Pasteurised "
1 " Grade A Pasteurised "

The Express Dairy Co., have a pasteurising plant at No. 100 Bollo Lane.

BAKEHOUSES.

Of the 29 bakehouses in the Borough 5 are underground. These were licensed under the Factory Act of 1901.

SMOKE ABATEMENT.

During the year, 56 factory chimneys have been watched on 161 occasions, and only 11 complaints of smoke nuisances have been received. In no case was it necessary to institute Police Court proceedings as the offenders promptly took steps to comply with the Notices served upon them. One firm has installed a new and larger boiler to meet their needs, abolished the iron chimney, and substituted a brick shaft one hundred feet high. With suitable fuel carefully stoked no nuisances from smoke should occur at these works in future.

For the abatement of smoke from the chief offender, the domestic fire burning raw coal, there is no solution, the reason being that sufficient heat cannot be generated to burn the hydrocarbon gases which are driven off. Many patent grates are on the market, constructed to effect an economy in the consumption of coal, but these do not in any way diminish the smoke emitted into the atmosphere. Inventors have also turned their attention to the construction of grates and ranges for burning coke, which are very successful up to a point, the drawback being that one cannot keep a coke fire low ; to get the best results the fire should be deep and high-banked. It has been found that the transformation of coal to coke does not diminish the sulphur content by any appreciable amount so that coke fires emit almost as much sulphur dioxide into the air as coal fires, and as sulphur acids are the cause of the corrosion of stone-work, deterioration of paint-work, &c., there is no advantage from burning of coke so far as this destructive impurity is concerned, but it would be an advantage from the point of view of a cleaner atmosphere and the abolition of dirty fogs.

With regard to large steam raising plants such as Power Stations, the difficulty is the prevention of the emission of grit and sulphurous acid gases. In such works no expense is spared in providing the latest methods of burning coal as nearly smokeless as possible, and thousands of pounds are spent in installing apparatus for arresting grit and washing the flue gases. The best of these appliances, I understand, will arrest from 85 to 95 per cent. of the grit, the remainder being discharged into the air, and 98 per cent. of sulphur dioxide can be removed from the smoke by washing. The boilers in all large steam raising plants are fitted with combustion chambers beyond the firegrates, and the temperature in this chamber with the addition of the secondary air which is admitted over the fire is sufficient to consume the volatile gases. Factory chimneys, therefore, pollute the air far less with the tarry volatile gases than domestic chimneys.

It can be readily understood that it is impossible to prevent smoke from steam raising plants when the fires are first lighted, as the temperature of the combustion chamber is not high enough to consume the gases.

A really efficient grit arrester would not be suitable for small steam raising plants, and the cost also would be prohibitive. The only practical remedy therefore, is to get the owners of such plants to install suitable fire bars in their present boilers to burn coke, but if the boiler is being forced by the use of mechanical draught in consequence of being too small in capacity, there would

still be a nuisance from grit. In such cases, new boilers of sufficient capacity must be installed, and worked under natural draught, but coke should certainly be the fuel used.

In practice, however, difficulties enter into the matter such as the cost of coke, 30s. per ton, as compared with the cost of cheap slacks, 20s. per ton, and in these days of keen competition this is an important factor.

The solution of the problem of smoke and grit emission seems to lie in the more extensive use of gas and oil. With regard to the domestic fires, although gas and electricity are extensively used, there is still a prejudice in favour of the open coal fire, and in the case of working class families it is the question of expense which determines the continued use of one coal fire for all purposes.

BIRTHS.

Table 7 is in the same form as in previous years. The total number of births is obtained from the Registrar General, and includes all the births which belong to the district wherever they may have been registered throughout the kingdom. The registered births numbered 868—461 males and 407 females. From this total we are not able to distinguish the births into wards, but as there is only a difference of 19 between the number of registered and notified births, the ward distribution of the notified births is approximately correct also for the registered births.

The total number of registered births corresponds to an annual birth-rate of 12.6 per 1,000 inhabitants. The birth-rate is the same as it was two years ago, but the number of births is the lowest recorded for 40 years. We have to go back to 1894, to find a smaller number of births registered and belonging to the district ; in that year, 834 births occurred, but as the population then was about 27,000, the birth-rate was nearly 31 per 1,000 of the inhabitants.

The birth-rate for the whole of England and Wales last year was 14.7 per 1,000 ; for the 121 County Boroughs and the 140 smaller towns with populations between 25,000 and 50,000 inhabitants it was 14.8 and for the Administrative County of London 13.3 per 1,000 inhabitants.

A falling birth-rate is general throughout the kingdom, but while a district is developing, the phenomenon is not noticed, because some of the features are masked ; the total supply of births is kept up by the increasing population, and the lowered birth-

rate does not become marked on account of the migration into the district of young married couples. When these factors disappear, and the population of a district becomes as it were stabilized, the effects of a falling birth-rate are then more apparent. In some of the Metropolitan boroughs, the number of births has been nearly halved in the last 10 years ; there is a smaller population in these boroughs because the families are smaller than they were, but the lower population is not the only cause of the drop in the number of births.

Whenever the Registrar General's reports are published, articles appear in the daily press pointing out the dire results which will follow if the tendency continues. As these articles usually refer to a general state of things, it is doubtful if we ever take the trouble of asking the question how the figures may affect our own district, and what problems do the figures present to us. Frequently, when figures in the mass do not appeal, when these are analysed, their significance becomes clearer.

The following Table gives the births and population in the different Wards at intervals of 10 years.

	North-East		North-West		South-East		South-West	
	Population	Births	Population	Births	Population	Births	Population	Births
1906	13,000	325	11,000	229	11,000	255	17,000	724
1915	14,700	324	11,650	210	14,800	334	17,000	522
1925	18,000	268	14,000	168	16,000	188	15,000	362
1935	22,300	292	16,700	184	15,300	105	15,000	268

Although the figures for the Wards are not absolutely correct, they are approximately and relatively correct.

In the interval between 1906 and 1935 the population of the North-East and North-West Wards has increased and altered very considerably, but even in these wards the number of births is 78 less in 1935 than it was in 1906. But it is in the South-East and South-West Wards that the numbers are startling. These two wards have increased very little in population in 30 years ; in 1906 their population was estimated at 28,000 and in 1935 at 30,300. The births in these two wards have fallen from 979 in 1906 to 373 in 1935. What is the trend of events, and what effect will this trend have ; even if the conditions have become stable in the South-East and South-West Wards, will the same course

of events follow in the North-East and North-West Wards in the next decennium ?

We may look at the figures from another angle—the angle of the distribution of the population into age-groups, because the altered incidence of the ages presents problems as important if not as acute as the falling birth-rate.

The following table gives the population and the proportion of persons living in the different age-groups at the last four Censuses.

	1931		1921		1911		1901	
Age in years.	Total	Percentage.	Total	Percentage.	Total	Percentage.	Total	Percentage.
Under 1	944	1.34	1,196	1.95	1,283	2.23	994	2.63
1–5	3,663	5.21	3,783	6.18	5,140	8.93	3,569	9.46
5–15	10,173	14.44	11,470	18.7	10,930	19.00	8,014	21.23
15–25	12,840	18.22	10,393	16.91	10,286	18.00	7,334	19.43
25–45	22,672	32.15	19,452	31.73	19,010	33.00	11,277	29.88
45–65	11,598	22.11	11,788	19.22	8,624	15.00	5,171	13.69
Over 65	4,620	6.56	3,212	5.24	2,325	4.04	1,385	3.67

Examination shows that in the last 30 years there has been a steady and continuous fall in the proportion living in the age periods under 15 years of age ; this of course is due to the fall in the number of births, though the improved infantile mortality has modified the fall to some extent.

So far there has been no marked difference in age periods 15 to 25 years and 25 to 45 years, but in age periods after 45 years of age, there is a steady rise in the proportion living at those age-periods.

There are thus 3 phases established here at the present time—a declining population under 25 years of age, a stationary population between 25 and 45 years of age, and an increasing population at all ages over 45. These phases have created and will create problems for future administrators ; fortuitous circumstances, combined with a certain amount of foresight will solve one problem, of which it is unnecessary to enter into at the present time.

The position will soon reflect itself in our death-rate. As there is a diminishing number of young people with a low death-rate and an increasing number of ageing people with a high death-rate, the ultimate effect of these inter-related factors is that the decline in the death-rates at all ages recorded hitherto will cease

to appear and it is almost certain that the death-rate at all ages will increase. This feature has not, as yet, made itself felt on our death rate because of the great improvement which has occurred in the general health of the people and especially in the improved infantile mortality.

There is a vast difference between facts and values, and the importance of these figures lies in the value attached to them and their interpretation. Sensational and alarming articles have appeared in the Press, but most of the writers forget that they are not dealing with mechanical figures alone, and there is a biological factor concerned in the problem. Although we may not contribute to the views recently expressed in the Press, the figures should convey to all local administrators a hint as to the lines of future development.

Another set of figures may be mentioned which will gain added importance from the Midwives' Bill, which has recently been introduced in the House of Commons. Under this Bill, it is proposed to set up a salaried Midwifery Service in all districts, and in this district it appears as if this will mean a Municipal service. The present proposals, as they affect Acton, would make the Middlesex County Council the local authority for the purposes of the Act. It is probable that the authorities at the Middlesex Guildhall will not be fully acquainted with the course of events and the trend of opinion here, and if proposals are made, irrespective of recent phenomena, some mistakes will be made. For instance, in addition to the fewer number of births, the percentage of confinements taking place in the home is falling at a very fast rate. In 1925, 909 births out of a total of 1047 or nearly 87% took place in the homes of the mothers. Last year, only 407 births occurred in the district, or less than half of the total births. We have on several occasions pointed out that the tendency to enter an institution for the confinement is growing stronger in this district from year to year. As the factors operating in this direction have in recent reports been fully commented on, it is unnecessary to deal with them again, but so far the same influences which have hitherto affected the increase in institutional confinements, seem still to be in operation.

DEATHS.

417 deaths were registered in the district; of these 41 did not belong to Acton, and were transferred to other districts.

328 deaths of Acton residents occurred outside the area, and have been included in our returns. The total number of deaths

belonging to the district is therefore 704, which corresponds to a death-rate of 10.2 per 1,000 inhabitants. In last year's report, it was stated that the Registrar General supplies each district with a comparability factor for adjusting the local death-rate to make it comparable with other districts. This comparability factor is based upon the age distribution and sex incidence of the district at the Census of 1931. The comparability factor for Acton is 1.08. The standardised death-rate for Acton would be 11.01 per 1,000 inhabitants. The death-rate for England and Wales for 1935 was 11.7 per 1,000 ; the crude death-rate for London Administrative County 13.3 ; for the 121 County Boroughs and Great Towns with over 50,000 inhabitants 11.8 ; and for the 140 Smaller Towns with a population between 25,000 and 50,000 inhabitants 11.2 per 1,000 inhabitants.

Although the death-rate was not a record low one, and the reasons for this have been discussed in a preceding paragraph, it is correct to state that 1935 was, in many respects, one of the healthiest years on record ; during 1935 we were probably freer from physical disease than in any previous year for which we have records. Some of the causes for this freedom from illnesses which are particularly fatal were not due to any human thought or action. Although we have learnt to control many of the diseases which occur in epidemics, the so-called infectious diseases, there are others which still make their appearance with a regular periodicity and others which appear at irregular intervals. For instance, measles still appears regularly every other year, but 1935 as far as Acton was concerned was an interepidemic year, and we had no deaths from the disease. Influenza also took but a small toll. We do not know the conditions under which influenza appears in epidemic form, but during a severe winter a larger number of deaths is ascribed to influenza. The early part of 1935 was mild and the climatic conditions in the latter part of the year were of a mild character almost up to Christmas. These were the conditions which may be said to be accidental in their nature, but there are grounds for stating that there is a general improvement in freedom from disease, and if there had not been a re-distribution in the age incidence of the population, record low death-rates would have been observed in the last few years. If the causes of death be examined, it will be noticed that those which loom large are those which are associated with advancing years, such as cancer, cerebral haemorrhage, old age, heart disease in people over 65 years of age. 357, or more than one-half of the total deaths, were of people over 65 years of age. Not only is the age at death being raised, but even the process of decay can be delayed so that life can be enjoyed for a longer period. But it is not at the later ages alone that the improvement

has occurred ; we are redrafting our conception of health. Formerly we were apt to define health as some negative quantity, merely a freedom from disease, but we are far from satisfied now with that definition. We do not consider a person healthy unless he is in such a physical condition that he can enjoy life to the full. The diseases which were particularly fatal in the nineteenth century now occupy a very small space in our returns, and in a diminishing quantity. Small-pox and typhus fever are almost unknown, and the typhoid and paratyphoid fevers are comparatively rare ; very seldom is there a death from scarlet fever. But in the last quarter of the nineteenth century, some of these diseases occurred every year, and all of them periodically and occasionally.

Infantile mortality appears to have fallen permanently to the neighbourhood of 50 per 1,000 births ; not only has the infantile mortality been reduced, but the nature and the cause have been altered. Formerly in the infantile mortality list, diarrhoea was by far the most formidable disease, and some deaths every year occurred from suffocation from overlaying.

Another noticeable change has been not only the general improvement, but the especial improvement of some of the areas. Formerly the death-rate of the South-West Ward was greatly in excess of that of the whole district, and the infantile mortality was always two or three times higher than that in the rest of the district. Last year the deaths were distributed through the district as follows :—

North-East	North-West	South-East	South-West
223	164	140	177

The death-rate in each ward was as follows :—

10.0	9.8	9.2	12.1

Last year the death-rate in the South West Ward was higher than that of the other wards, but the excess is nothing comparable to that of former years.

I have pointed out the diseases which have increased in their incidence and most of these are associated with the altered age distribution of the population, but there is one cause of death which has not only relatively but absolutely increased, and that is deaths from violence. Such causes, of course, as being knocked down by a motor vehicle, and being involved in a motor smash, are mostly post-war experiences. The motor car, of course, was in use before the war, but the transport question has now become an acute question, and an inceasing number of deaths are due to this cause. Suicide also has become relatively more common, and

last year nine cases of suicide occurred, compared with eight the previous year.

I have pointed out in previous reports the attitude of the public towards the treatment of disease in Institutions, and the increasing number of deaths in Public Institutions. Last year 363 deaths occurred in Public Institutions compared with 358 in 1934.

Inquests and Coroner's Inquiries.

38 inquests were held last year, and in 28 instances the Coroner issued a certificate without an inquest after he had ordered a post-mortem examination. The list of inquests together with the causes of death is given on a later page.

INFECTIOUS DISEASES.

Scarlet Fever.

103 cases of Scarlet Fever were notified, but there was no death from the disease. These figures indicate that on the whole the disease was of a mild character, but Scarlet Fever, under present conditions, is one of the diseases concerning which it is impossible to generalise. We might say of last year's cases that they were characterised by the absence of the very severe toxic type, but every grade of case from the very mild to the severe was met with. This variety of type is important not only from the clinical, but also from the epidemiological point of view. Sydenham named the disease from the appearance of the rash, and from his time the presence of the punctate rash of the skin has been regarded as an essential element of the clinical picture, but there are reasons for thinking that the same strain of the haemolytic streptococcus may in one person cause the train of symptoms (including a rash) which we associate with Scarlet Fever, while in another person, one or other symptom (including a rash) may be absent, and yet the latter may be the source of an infection which will exhibit a rash in the infected individual. Scarlet Fever is essentially an infective naso-pharyngitis, and the symptoms will depend not only on the infecting organisms, but also on the reaction of the individual to the infection.

This is probably one of the reasons of the failure of isolation hospitals to stamp out the disease or even to control epidemics. The hospitalisation of large numbers (here the vast majority) of patients suffering from so-called Scarlet Fever, has quite failed to

control the incidence of the disease, and the reasons are familiar to every epidemiologist. A doctor will not notify a case unless the classical symptoms are present, and especially the rash, but there are reasons for thinking that the number of cases of streptococcal fever and sore throats notified represents but a minority ; the more numerous, and, because unrecognised, more dangerous, sufferers from sore throats caused by the same organism, and the carriers remain at large. But, though we recognise that hospitalisation will not solve the problem of the epidemicity or endemicity of Scarlet Fever, the percentage of cases treated in hospital continues and will continue to be a high one ; the public insists upon institutional treatment as a social service, and it should be recognised as such. Scarlet fever is a disease which requires, in the majority of cases, skilled treatment ; medical, nursing, dietetic, &c., and the sequelae and complications require prompt treatment. Apart from the treatment, it is an infectious disease, and for three or four weeks at least the patient is infectious ; so that, even if there are facilities in the home for isolation and nursing, a case nursed at home places a good deal of restriction on the movements of the rest of the family.

It is doubtful if hospitalisation is responsible entirely for the " return " case. After the patient's return home from hospital, scarlet fever occurs in some other member of the household in 2 to 4 per cent. of cases. Last year in the case of three patients discharged from hospital, other cases occurred in the household. These return cases always cause annoyance, and occasionally complaints are made that the infecting case has been prematurely discharged from hospital. In inter-epidemic years, this, of course, would be obviously incorrect ; last year there was not at any time any pressure upon our accommodation. One of the cases had been in hospital four weeks, one four weeks and four days, and the third five weeks. In 1927, a memorandum was issued by the Ministry of Health, as a result of evidence obtained from all over the country. The opinion was expressed that there was no good evidence for prescribing a routine period of detention in hospital of more than four weeks in uncomplicated cases, and the old six-weeks period which was based on the now exploded belief in the infectivity of pealing, has long been abandoned by most fever authorities. In a number of hospitals, uncomplicated cases are discharged under 3 weeks, and the shortened period of detention has not increased the percentage of return cases, probably it has decreased it. This may sound paradoxical, but the explanation probably lies in the fact that a shortened period of detention in uncomplicated cases has diminished overcrowding of wards.

DIPHTHERIA.

80 cases of diphtheria were notified during the year, and there were 8 deaths ; 2 deaths occurred outside the district, and the disease in these cases was also contracted outside.

Although there has been a reduction in the number of notifications, the figures indicate that the disease on the whole has been of a virulent type ; but the virulent cases have been in non-immunised children. We have now been artificially immunizing children for nearly four years, and since we have commenced artificial immunization no deaths have occurred in a child who has been fully inoculated. During last year, 11 children who had been inoculated contracted diphtheria, but in every instance the disease was of a mild character, and in most cases it was not necessary to administer antitoxin. This is in accordance with the experience of most of those who have carried out artificial immunization. It has been recognised for a long time that a certain percentage of children who have been immunized revert or relapse and become positive. Considerable variation in relapse rates has been found, in some instances as high as 14 per cent. has been stated to have relapsed within a year of immunization, but as far as we are concerned, although artificial immunization does not confer absolute immunity, the process for all practical purposes confers such immunity that no patient who has been immunized is in any danger of his life, nor does he suffer from the sequelae of diphtheria.

TUBERCULOSIS.

77 cases of Pulmonary Tuberculosis, and 19 cases of other forms of Tuberculosis were notified during the year.

There were 32 deaths from Pulmonary Tuberculosis and 9 deaths from other forms of Tuberculosis.

The death notification interval of the 32 patients who died of Pulmonary Tuberculosis in 1935, was :—

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

The following is a statement of the particulars appearing in the Register of cases of Tuberculosis on 31st December, 1935 :—

	Pulmonary	Non-Pulmonary	Total
Number of Cases on the Register at the commencement of the year	152 males 143 females	31 males 20 females	346
Number of Cases notified for the first time during the year	31 males 34 females	10 males 7 females	82
Number of Cases previously removed from the register which have been restored thereto during the year	1 male 2 females	1 male — females	4
Number of Cases added to the Register other than by notification	6 males 6 females	— males 2 females	14
Number of Cases removed from the Register during the year	31 males 24 females	8 males 4 females	67
Number of Cases remaining on the Register at the end of the year	159 males 162 females	35 males 25 females	379

In 1935, the Tuberculosis Officer examined 65 new cases of pulmonary tuberculosis, and 5 new cases of non-pulmonary tuberculosis. Forty-two patients were admitted to Sanatoria under the County Scheme, and thirteen were admitted to hospitals.

Age Periods	New Cases.				Deaths.			
	Respiratory.		Non-Respiratory		Respiratory.		Non-Respiratory	
	M.	F.	M.	F.	M.	F.	M.	F.
0–	—	—	—	—	—	—	—	—
1–	—	1	2	—	—	—	—	2
5–	—	3	3	5	—	—	—	2
15–	10	16	2	1	2	3	1	2
25–	7	10	—	2	4	6	—	—
35–	7	5	2	—	5	3	—	—
45–	8	2	—	—	1	1	—	—
55–	2	1	1	—	2	1	1	—
65 and upwards	3	2	—	1	3	1	—	1
	—	—	—	—	—	—	—	—
Totals	37	40	10	9	17	15	2	7

ISOLATION HOSPITAL.

544 cases were admitted during the year, compared with 718 during 1934.

On January 1st, 1935, there were 61 cases in the hospital, and on January 1st, 1936, there were 44.

The following table gives a list of the cases admitted, together with the diseases from which the patients suffered.

	Acton.	Wembley.	Other districts	Total.
Scarlet Fever	78	218	24	320
Diphtheria	76	92	40	208
Measles	2	1	–	3
Erysipelas	1	3	–	4
Chicken Pox	1	1	–	2
Whooping Cough	–	2	–	2
Mumps	4	1	–	5

There were 12 deaths :—

Scarlet Fever	1
Diphtheria	11

The Scarlet Fever death was that of a Wembley patient, aged 35 years.

The Diphtheria deaths were distributed as follows :—

Acton	5
Wembley	4
Other districts	2

On 7 Scarlet Fever patients a complete mastoidectomy was performed, and on two of these the operation was done on both sides.

BACTERIOLOGICAL EXAMINATIONS.

(a) **For Diphtheria**	*Positive.*	*Negative.*
Total Examinations 2873	321	2552
Sent by Medical Practitioners	45	378
do. (re-examinations)	10	35
Sent from Isolation Hospital	204	1172
Convalescents (1st Swabs)	4	27
Contacts	15	197
do. (2nd examinations)	2	20
do. (3rd ,,)	1	3
Carrier's Swab.	1	—
Precautionary Swabs	—	29

School Sore Throats	5	61
Berrymede School 276	17	259
John Perryn School	8	282
John Perryn School—2nd Swabs	3	5
Derwentwater School	6	81

(*b*) **For Ringworm.**	*Positive.*	*Negative.*
Total Examinations—17	5	12

(*c*) **For Tubercle.**	*Positive.*	*Negative.*
Total Examinations—125	17	108

MATERNITY AND CHILD WELFARE.

Infantile Mortality.

51 deaths occurred in infants under 1 year, corresponding to an infantile mortality of 60 per 1,000 births.

The infantile mortality is 19 per 1,000 births higher than that of 1934, and 14 per 1,000 higher than that of 1933.

The increase is almost entirely confined to two causes—prematurity and diarrhoea. There were 11 deaths from diarrhoea and 13 from prematurity. The increase from diarrhoea is not easily explainable, as the third quarter of 1935 was not characterised by the weather usually associated with digestive disturbances. There is always a slight increase in the incidence of diarrhoea during a hot and dry summer, in spite of the improvements which have been effected in infant feeding, but the summer of 1935 was neither hot nor dry.

There was an increase also in the number of deaths from premature birth, together with congenital conditions such as spina bifida, and congenital heart disease.

5 deaths occurred as the result of injury at birth, compared with none in 1934. 29 of the deaths occurred under the age of 4 weeks.

Toddlers.

The present trend of interest among welfare workers is in the direction of improvement of the services for pre-school children, and it is significant that almost all the subjects discussed

at the National Conference on Maternity and Child Welfare in 1935, concerned children between the ages of two and five years of age. Most of the propaganda of some associations has recently been concentrated on the needs of the toddler. Throughout the country it appears that in spite of the comparative neglect of the pre-school child, the mortality trend at that age period has been favourable. This has only been partly true of Acton. There has, of course, been a tremendous improvement since the commencement of this century, but not to the same extent as that which has occurred in the case of mortality of infants under one year of age. The improvement in the infantile mortality began earlier than that of the mortality of the child of school age. In Acton, the infant mortality began to fall about 1908, and with slight intermissions, has been falling steadily up to the present time. The infantile mortality did not fall under 100 per 1,000 births until 1912, but it was falling since 1908 until 1911, when it again rose to 140 per 1,000 births. 1911 was a very hot year and the district suffered greatly from infantile diarrhoea during the hot summer months of that year. In 1912 the infantile mortality fell to 73 per 1,000 births, and with the exception of 1915, when it was exactly 100 per 1,000 births, the infantile mortality has always been below 100 per 1,000 births since 1911. The fall has been almost a continuous one, and in 1933 the infant mortality was 45 ; in 1934, 41 per 1,000 births. In 1935, there has been a sharp rise in the infantile mortality and a drop in the number of deaths between the ages of 1 and 5 years.

The death-rate of children between the ages of 1 and 5 years has shown a curve which is rather curious and not entirely explicable. In Acton there was a sharp rise in the toddlers mortality in the year 1904 which continued fairly high until the end of the Great War. There were slight intermissions in 1910 and 1915, but broadly speaking the toddler mortality did not fall perceptibly and steadily until the year 1919. In that year there was a sharp drop, and although there had been a slight improvement, it has not been a continuous and steady one. Until last year we had the lowest number of deaths in 1923, when there were 20 deaths between the ages of 1 and 5 years ; in 1935 there were only 12 deaths at this age period. If we separate the age periods into 1 to 2 years and 2 to 5 years respectively, 1935 was the record year only in the earlier period with 2 deaths, the previous lowest at that age period being 1933 with 7 deaths.

In the age period 2 to 5 years, there were 10 deaths last year compared with 7 in 1925 and 9 in 1931. If the table at the end of the report be examined, it will be noticed that in the in-

fantile mortality rate there has been an even and almost continuous drop, but the numbers of deaths of toddlers show an alternate rise and fall in the even and odd years. If the period since the war be taken, there is a slight but appreciable difference between the even and odd years. Since 1918, measles has occurred here regularly every other year, and the appearance of this disease biennially is sufficient to account for this difference in the mortality rates. Measles usually makes its appearance in the winter months, and some of the deaths which belong to even-year epidemics occur at the end of the odd year : otherwise the difference between the epidemic and inter-epidemic measles years would make itself more evident in the mortality in the age period 1 to 5 years. Apart from measles in the even years, which in Acton have been the epidemic ones, the diseases which recently have been the most fruitful cause of death amongst toddlers have been whooping cough diphtheria and pneumonia.

As far as measles and whooping cough at the present time are concerned, we have no effective means of preventing them, but the administrative measures now adopted have probably been the means of saving many lives and the prevention of many deaths from measles. It was pointed out in last year's Annual Report that measles is now much less fatal than it was in the early part of this century. Many factors have contributed—a better appreciation of the seriousness of measles, better housing conditions, improved economic conditions, better infant nurture as a result of education and of infant welfare work ; probably the latter plays the most important role. Another factor is the institutional treatment of measles, more especially of its lung complications. It is frequently stated that measles alone seldom kills, but the fatal result is brought about by one of its complications, usually bronchopneumonia, and it is on this account that institutional treatment has resulted in a lessened number of deaths from the disease. In the last decade, we have been able to treat a proportion of cases in the Fever Hospital. It would be impossible to admit into hospital all the cases of a disease like measles which occurs in an explosive epidemic, but we have been able to admit most of the cases in which the home conditions have been unfavourable. So that, although we are unable to prevent or even control epidemics of measles, we are able to mitigate to a considerable extent its ravages. There is one disease to which toddlers are especially susceptible, and which can be brought under control, and that is diphtheria. The need for more extensive immunisation of pre-school children cannot be too strenuously stressed. Although it would be an exaggeration to state that diphtheria does not occur in immunised children, if it does occur, it is of so mild a character that even

anti-toxin serum is unnecessary. We have been immunising children for nearly 4 years, and have inoculated over 5,000 children, and there has not been a single death in those who have received three inoculations. It is recognised that if we are to succeed in our effort to stamp out diphtheria a large proportion of pre-school children must be immunised. Statistics from different towns show that until a certain percentage of school children are rendered immune, a marked fall in the incidence and morbidity of diphtheria will not occur. So long as we concentrate on the school child, our success will only be partial. We have a diphtheria immunisation clinic for pre-school children on Saturday mornings, and judged by results, it has been successful, but it is only by persistent effort and propaganda that we are able to get the consent and co-operation of the parents. So long as diphtheria was prevalent in the district, fear was sufficient to drive the parents to seek the protection which artificial immunisation provides. Immunisation having succeeded to such an extent that notifications now are very few, the parents again are apt to sink into apathy and indifference.

Dental supervision is another subject which has here received special attention. In the school holidays, we have for many years, arranged for a special dental clinic for the examination of the toddlers' teeth. The school dental surgeon attends, and gives an address to the mothers in addition to carrying out the routine inspections of the toddlers' teeth. The Chairman and members of the Child Welfare Committee have arranged a tea for the mothers. In spite of all the advantages, the attendance during the past year or two at these special toddlers' clinics has not been as satisfactory as we could wish. Parents are still too apt to regard the care of the milk teeth as an unimportant item in the toddlers' hygiene ; there is an apparent need for the strenuous education of the parent in the importance of dental hygiene to the ultimate healthy development of the child.

Apart from the special facilities provided and which we are anxious that the parent should take advantage of, the general nurture of the child between the ages of 1 and 5 years is of extreme importance. The importance of nutrition and of the best diet has been over and again emphasised, and it is not unusual to find that mothers pay particular attention to the feeding of the baby under 1 year old, but are indifferent in the second and third years of the child's life, and frequently allow him to take pot-luck at the family meal table.

To what extent does supervision at the present time exist, and can it be extended ? Last year 6,275 home visits were paid to children between the ages of 1 and 5 years, compared with 6,375

to babies under 1 year old, and 7,818 visits were paid to the clinic by children between 1 and 5 years, compared with 10,295 visits of infants under 1 year old. In addition we have in the district, 4 nursery classes, which are attended of course by toddlers between the ages of 3 and 5 years old, and where supervision is exercised. It cannot therefore be stated that the toddlers are being neglected in this district. The taunt has frequently been levelled that the toddlers are not catered for because they come in the period between the infants' clinic and welfare, and the school medical service. At the same time, it is admitted that more could be done for the child in this important epoch of his career, and the difficulty has been discussed from different angles. Too many physical defects are found in the entrants when they are medically examined at school for us to remain complacent. But the difficulty arises when we try to devise the means by which these facilities can and will be utilised. It has been suggested that a specail toddlers' clinic will be the best solution. Will the mothers bring the toddlers to a special clinic? At the present time if there is a baby as well as a toddler in the family, the mother very frequently brings both, and we have to consider if the mother would bring the toddler and make a special journey. On the other hand, some mothers are unwilling to bring the toddlers on account of the overcrowding which occasionally occurs, and they feel that the clinic is primarily for the infants. This of course, is a mistaken notion.

Another objection is our want of staff and accommodation. At the school clinic, infant clinics are held on four afternoons a week, and on the remaining afternoon—Friday—a dental anaesthetic session is held. As the accommodation is crowded and segregation is difficult, Friday afternoon would not be an ideal time for such an experimental work as a toddlers' clinic. We might try one as an experiment in one of the other clinics, if the rooms are available. If the clinic is to be held, it must be conducted practically on the same lines as the entrance examination to the infants' department.

DEATHS OF INFANTS AND CHILDREN UNDER 5 YEARS OF AGE.

Year	*Deaths.*			— *Births.*
	Under 1.	1—2	2—5	
1935	51	2	10	
1934	39	14	12	943
1933	41	7	20	886
1932	60	15	24	970

1931	62	11	9	1018
1930	56	15	23	1105
1929	85	12	14	1026
1928	55	11	15	1003
1927	62	10	12	1026
1926	60	18	7	1098
1925	80	11	13	1047
1924	65	30	18	1158
1923	77	10	10	1171
1922	75	15	12	1203
1921	92	15	17	1314
1920	100	11	21	1541
1919	72	15	13	1096
1918	76	29	42	954
1917	94	38	48	972
1916	102	32	24	1288
1915	148	53	36	1390
1914	138	30	25	1474
1913	127	56	33	1486
1912	107	38	41	1477
1911	205	67	49	1458
1910	151	55		1475
1909	158	102		1480
1908	188	106		1568
1907	200	94		1535
1906	201	91		1533
1905	172	73		1527
1904	207	90		1450
1903	150	43		1422
1902	187	94		1242
1901	206	44		1211
1900	—	—		1080

Maternal Mortality.

4 deaths occurred in child-birth—2 from puerperal sepsis and 2 from other accidents or diseases of parturition.

One of the deaths from puerperal sepsis occurred under conditions which, as far as could be ascertained, were almost perfect. The confinement occurred in a nursing home and the patient was under a doctor throughout the latter part of her pregnancy.

One of the deaths was due to ruptured ectopic gestation. The fourth death occurred from haemorrhage and shock following removal of placenta.

3 cases of puerperal pyrexia were notified and all of them were removed to hospital ; 2 of them recovered and the third died.

In the case of one of the deaths from puerperal sepsis, notification of puerperal pyrexia was not received by us. The confinement took place in a nursing home outside the district, and the patient was removed to a hospital ; the notification of puerperal pyrexia was sent to one district, the death registered in another.

No case of puerperal pyrexia was treated in Queen Charlotte's hospital during the year. We have an arrangement with the authorities of that hospital for the admission and treatment of such cases, but arrangements for the removal of the three cases notified last year to other hospitals had been made by the doctors in attendance before we received the notification.

Maternity Home.

In previous reports an account has been given of the agreement with the Middlesex County Council for the admission of cases into the Central Middlesex County Hospital, and 270 cases were admitted last year under that agreement.

Day Nursery.

The Nursery is situated in Bollo Bridge Road, and is open on five days a week.

The Nursery was open on 233 occasions, and 5,577 whole-day attendances were made.

Child Welfare Centres.

There has been no change in the arrangements for the Child Welfare Centres since last year. Seven sessions are held weekly—4 in Avenue Road, 1 each in Steele Road Mission, John Perryn School and St. Gabriel's Hall.

Nurse Children.

At the end of the year 1934, there were 49 children and at the end of the year 1935, there were 39 children on the register.

FOSTER CHILDREN.

No. as at 31st. Dec. 1934.	Notice of Reception of Children during 1935.	NOTICE OF REMOVAL TO :					Children Adopted	Died.	Children reached age of 9	No. as at 31st. Dec. 1935.
		Parents.	Another area with Foster Parent.	Another Foster Mother	Public Institution or Home.	Other causes.				
49	19	11	1	6	8	—	1	—	2	39

FOSTER MOTHERS.

No. as at 31st Dec., 1934.	Application for Registration during 1934.	Removed to another Area with child.	No longer a Foster Mother.	No. as at 31st. Dec., 1935
44	12	1	19	36

TABLE I.

BIRTH-RATE, DEATH-RATE, AND ANALYSIS OF MORTALITY DURING THE YEAR 1935.

The Mortality rates for England and Wales refer to the whole population, but for London and the towns to civilians only.

	Rate per 1,000 Total Population.	ANNUAL DEATH-RATE PER 1,000 POPULATION.										RATE PER 1,000 LIVE BIRTHS	
	Live Births.	Still-births.	All Causes.	Enteric Fever.	Small-pox.	Measles.	Scarlet Fever.	Whooping Cough.	Diphtheria.	Influenza.	Violence.	Diarrhoea and Enteritis (under two years).	Total Deaths under one year.
England and Wales	14.7	0.62	11.7	0.00	0.00	0.03	0.01	0.04	0.08	0.18	0.52	5.7	57
121 County Boroughs and Great Towns, including London	14.8	0.68	11.8	0.00	0.00	0.04	0.01	0.04	0.09	0.16	0.45	7.9	62
140 Smaller Towns Estimated Populations, 25,000-50,000)	14.8	0.64	11.2	0.00	0.00	0.03	0.01	0.03	0.07	0.17	0.41	3.8	55
London	13.3	0.52	11.4	0.00	0.00	0.00	0.01	0.04	0.06	0.11	0.51	11.2	58
Acton	12.6	0.5	10.2	0.00	0.00	0.00	0.00	0.04	0.1	0.11	0.5	12.0	60

The maternal mortality rates for England and Wales are as follows :—

	Puerperal Sepsis.	*Others.*	*Total.*
per 1,000 Live Births	1.68	2.42	4.10
per 1,000 Total Births	1.61	2.32	3.93

TABLE II.

VITAL STATISTICS FOR THE WHOLE DISTRICT DURING 1935 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
1926	65,760	1098	16.70	422	6.42	15	250	60	55	657	9.99
1927	66,700	1026	15.60	445	6.67	21	280	62	60	704	10.55
1928	67,645	1003	14.83	479	7.08	29	244	55	55	694	10.26
1929	68,600	1026	14.96	540	7.87	21	307	85	83	826	12.04
1930	69,565	1105	15.88	440	6.33	31	284	56	50	693	9.96
1931	70,560	1018	14.43	456	6.46	35	321	62	61	742	10.52
1932	70,640	970	13.70	486	6.88	29	302	60	62	786	11.11
1933	70,300	886	12.60	492	6.99	31	329	41	46	788	11.20
1934	69,472	943	13.57	454	6.50	24	297	39	41	727	10.46
1935	68,960	868	12.60	417	6.04	41	328	51	60	704	10.20

TABLE III. *AGES AT DEATH, AND WARD DISTRIBUTION OF DEATHS IN 1935.*

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.
Enteric Fever	1	—	—	—	—	—	—	—	1	1	—	—	—
Whooping Cough	3	2	—	1	—	—	—	—	—	—	—	—	3
Diphtheria	8	—	—	3	4	1	—	—	—	1	1	3	3
Influenza	8	—	—	—	—	—	—	4	4	3	3	—	2
Cerebro-spinal Fever	1	—	—	—	1	—	—	—	—	1	—	—	—
Phthisis	32	—	—	—	—	5	18	5	4	6	5	9	12
Other forms of Tuberculosis	9	—	—	2	2	2	—	1	2	3	2	1	3
Syphilis	2	1	—	—	—	—	—	1	—	—	2	—	—
G.P.I. & Tabes Dorsalis	3	—	—	—	—	—	—	2	1	—	2	—	1
Cancer	94	—	—	—	—	—	4	49	41	31	24	18	21
Diabetes	11	—	—	—	—	—	—	3	8	3	3	1	4
Rheumatic Fever	1	—	—	—	—	1	—	—	—	—	—	—	1
Cerebral Haemorrhage, &c.	67	—	—	—	—	—	2	20	45	21	22	11	13
Heart Disease	133	—	—	—	2	2	9	25	95	40	27	29	37
Other Circulatory Diseases	24	—	—	—	—	—	—	5	19	9	5	3	7
Bronchitis	21	—	—	—	—	—	—	9	12	7	5	5	4
Pneumonia	29	3	1	2	1	2	2	10	8	12	5	5	7
Other Respiratory Diseases	3	—	—	—	—	—	2	1	—	1	2	—	—
Peptic Ulcer	11	—	—	—	—	—	—	5	6	4	1	5	1
Diarrhoea	11	11	—	—	—	—	—	—	—	1	2	3	5
Appendicitis	8	—	—	—	—	1	2	4	1	—	1	4	3
Cirrhosis of Liver	1	—	—	—	—	—	—	1	—	—	1	—	—
Other diseases of Liver	7	—	—	—	—	—	—	1	6	1	3	3	—
Other Digestive Diseases	1	—	—	—	—	—	—	—	1	—	—	—	1
Nephritis	21	—	—	—	—	—	4	7	10	5	7	5	4
Puerperal Sepsis	2	—	—	—	—	1	1	—	—	1	1	—	—
Other diseases, &c. of Parturition	2	—	—	—	—	—	2	—	—	1	—	1	—
Congenital debility, Prematurity, &c.	25	25	—	—	—	—	—	—	—	12	6	3	4
Senility	62	—	—	—	—	—	—	1	61	18	13	16	15
Suicide	9	—	—	—	—	—	2	6	1	4	4	—	1
Other deaths from violence	27	—	—	1	2	3	5	6	10	11	5	2	9
Other defined diseases	67	9	1	1	6	4	6	19	21	25	13	13	16
TOTALS	704	51	2	10	18	22	59	185	357	223	164	140	177

TABLE IV.

INFANTILE MORTALITY, 1935.

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
Whooping Cough	2	—	—	—	—	—	1	1	—	—	—	—	2
Congenital Syphilis	1	—	—	—	—	1	—	—	—	—	1	—	—
Pneumonia	3	—	—	—	—	1	2	—	—	—	1	—	2
Diarrhoea	11	—	1	1	1	4	4	—	—	1	2	3	5
Prematurity	13	12	—	—	1	—	—	—	—	7	2	2	2
Congenital Debility	2	1	1	—	—	—	—	—	—	—	1	1	—
Congenital Heart Disease	2	—	—	—	—	—	—	1	1	2	—	—	—
Spina Bifida	3	—	2	1	—	—	—	—	—	1	1	—	1
Anencephalus	1	1	—	—	—	—	—	—	—	1	—	—	—
Marasmus	2	—	1	—	1	—	—	—	—	—	1	1	—
Injury at birth	5	4	—	1	—	—	—	—	—	3	1	—	1
Convulsions	1	—	—	—	—	—	—	—	1	1	—	—	—
Intussusception	1	—	—	—	—	—	1	—	—	—	—	—	1
Hiorschspring's Disease	1	—	—	—	—	—	1	—	—	—	—	—	1
Otitis Media	2	—	—	—	—	1	—	—	1	1	—	—	1
Renal Neoplasm	1	—	—	—	—	—	1	—	—	—	—	1	—
TOTALS	51	18	5	3	3	7	10	2	3	17	10	8	16

TABLE V.

CASES OF INFECTIOUS DISEASE NOTIFIED DURING THE YEAR, 1935.

Notifiable Disease.	Cases notified in whole District. At Ages—Years.								Ward Distribution.			
	At all Ages	under 1	1 to 5	5 to 15	15 to 25	25 to 45	45 to 65	Over 65	North East	North West	South East	South West
Scarlet Fever	103	—	40	46	8	7	2	—	31	39	20	13
Diphtheria	80	1	23	49	7	—	—	—	28	29	8	15
Pneumonia	29	—	5	4	2	9	5	4	3	8	5	13
Erysipelas	22	—	1	1	2	4	10	4	9	5	1	8
Puerperal Pyrexia	3	—	—	—	2	1	—	—	2	1	1	—
Ophthalmia Neonatorum	2	2	—	—	—	—	—	—	1	—	1	1
Paratyphoid	2	—	1	1	—	—	—	—	1	1	—	—
Tuberculosis (resp)	27	1	2	8	4	4	6	2	5	5	10	6
Tuberculosis (other)	19	1	1	3	4	4	4	2	5	5	3	6
TOTALS	337	3	72	111	51	55	31	14	101	104	47	85

OPHTHALMIA NEONATORUM.

Cases.			Vision unimpaired.	Vision impaired.	Total Blindness.	Deaths.
Notified.	Treated.					
	At home.	In hospital.				
2	1	1	2	—	—	—

CASES REMOVED TO HOSPITAL.

TABLE 6.

	Total Notified.
Scarlet Fever	82	103
Diphtheria	78	80
Pneumonia	13	29
Puerperal Pyrexia	3	3
Erysipelas	16	22
Ophthalmia Neonatorum	1	2
Paratyphoid	2	2

TABLE 7. **BIRTHS.**

	Male	*Female.*	*Total.*
LIVE BIRTHS.			
Total	461	407	868
Legitimate	436	387	823
Illegitimate	25	20	45
STILL BIRTHS.			
Total	19	15	34
Legitimate	18	13	31
Illegitimate	1	2	3

NOTIFIED LIVE BIRTHS. **Ward Distribution.**

	Total.	N. East.	N. West.	S. East.	S. West.
Total Births notified in the district	407	136	63	45	163
Notifications received from other districts	442	156	121	60	105

NOTIFIED STILL BIRTHS.

Inside 5 Outside 18 Total 23

NOTIFICATIONS WERE RECEIVED FROM :—

Doctors and Parents	701
Midwives	171

Table 8. **INFANT WELFARE CENTRES, 1935.**

Number of Centres provided and maintained by the Council	4
Total number of attendances at all centres during the year :—	
(*a*) by children under 1 year of age	10,295
(*b*) by children between 1 and 5 years of age	7,817

Average attendance of children per session	
Number of children who attended for the first time during the year :—	
(*a*) under 1 year of age	689
(*b*) between 1 and 5 years of age	202
Percentage of notified live births represented by number of children who attended a centre for the first time during the year	81.15
Children treated at Dental Clinic	142
Children treated at Ophthalmic Clinic	7
Mothers treated at Ophthalmic Clinic	3
Children operated on for enlarged tonsils and adenoids	2
Children operated on with X-Ray for Ringworm	—

TABLE 9. ANTE-NATAL CLINIC.

Number of Expectant Mothers who attended	335
Number of attendances made by Expectant Mothers	373
Mothers referred for Dental treatment at the Clinic	85
Mothers supplied with Dentures	19
Expectant Mothers to whom Dried Milk was supplied	24
Number of packets of Dried Milk supplied	196

TABLE 10. INQUESTS.

Inquests — 38

Killed by a Motor Vehicle	11	Fall downstairs	1
Suicide	9	Accidental fall	1
Death under anaesthetic	5	Accidental drowning	1
Senility accelerated by accident	2	Found drowned	1
Fall out of window	1	Fall from roof	1
Fall when drunk	1	Fall from pedal cycle	1
Alcoholic poisoning	1	Dog-bite	1
		Pneumonia	1

CORONER'S CERTIFICATE AFTER POST MORTEM WITHOUT AN INQUEST—28.

Heart Disease	11	Want of attention at birth	1
Cerebral Haemorrhage	5	Influenza	1
Atheroma	3	Cancer	1
Nephritis	3	Bronchitis	1
Acute Pancreatitis	1	Septic Meningitis	1

FACTORIES, WORKSHOPS AND WORKPLACES.

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

Premises.	Inspections	Written Notices
(1)	(2)	(3)
Factories .... (Including Factory Laundries)	72	12
Workshops .... (Including Workshop Laundries)	396	6
Workplaces .... (Other than Outworkers' Premises)	14	Nil
Total	482	18

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

Nuisances under the Public Health Acts :—

Particulars.	Found	Remedied
(1)	(2)	(3)
Want of Cleanliness	31	31
Want of Ventilation	Nil	Nil
Overcrowding	Nil	Nil
Want of drainage of Floors	2	2
Other Nuisances	6	6
Sanitary Accommodation :—		
Insufficient	4	4
Unsuitable or defective	33	33
Not separate for sexes	Nil	Nil
Offences under the Factory and Workshop Acts :—		
Illegal Occupation of underground Bakehouses	Nil	Nil
Other offences	Nil	Nil
Total	76	76

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

ELSIE MADELEY, M.B., Ch.B., D.P.H., Assistant Medical Officer of Health and School Medical Officer.

P. H. SLATER, L.D.S., School Dentist.

M. W. KINCH, M.R.San.I., Cert of 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 Misdescription 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. M. COOKSEY, A.R.San.I., 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 School Nurse.

Miss A. WOOSNAM, S.R.N., C.M.B., Health Visitor and School Nurse.

Miss M. I. GREENWOOD, S.R.N., Certificate of Royal Sanitary Institute, C.M.B., Health Visitor and School Nurse.

H. L. HACKER,* Chief Clerk.

Miss G. OVERALL*	Clerk. (Resigned 31/8/35)
Miss V. E. ARNOLD*	Clerk.
Miss D. E. BEACON.	Clerk.
Miss A. KENT*	Clerk.
Miss V. SLACK*	Clerk. (Appointed 11/11/35).

Miss M. J. GILFILLAN,* S.R.N., C.M.B., Matron, Isolation Hospital.

Miss F. A. CAVENDISH, Matron, Day Nursery.

G. BAKER,* Disinfector.

A. C. MEPHAM,* Asst. Disinfector and Mortuary Keeper.

NOTE.—To the salaries of all the above officials excepting those marked with an asterisk, contribution is made under the Local Government Act, 1929.

I have again to express my appreciation and thanks to all the members of my staff for their excellent co-operation during the year.

I am,

Your obedient Servant,

D. J. THOMAS,

Medical Officer of Health.

ANNUAL REPORT

OF THE

School Medical Officer

FOR THE YEAR 1935.

MUNICIPAL OFFICES,

ACTON, W.3.

To the Chairman and Members of
the Acton Education Committee.

LADIES AND GENTLEMEN,

We beg to submit the following report upon the schools and school children of Acton for the year 1935.

Changes in the staff occurred during the year. In May, Dr. Howell resigned to take up an important post with the Welsh Board of Health after over three years devoted service to the Committee, and Dr. Madeley has succeeded her. In June Miss Broughton was appointed a Health Visitor and School Nurse to the Brentford and Chiswick Council; she had served here in a similar capacity with quiet efficiency for 2½ years. Miss Greenwood was appointed to succeed her in July of last year.

As in former years the subject matter has been arranged as far as possible in tabular form. The tables at the end of the Report are those issued by the Board of Education.

In last year's report the question of Health Education and the teaching of Hygiene was introduced, and some misunderstanding was created regarding the purport of our remarks. Our object was to bring into prominence the necessity of teaching Hygiene so that every boy and girl would take a pride in their physical fitness, and that cleanliness, care of the teeth, &c., would be inculcated as habits with them. We did not underestimate the difficulties, and as a result of a conference with the head teachers, the Director of Education and the Chairman of the Education Committee, when a frank interchange of views took place, a syllabus was agreed upon and a place given to the definite teaching of hygiene.

PUBLIC ELEMENTARY SCHOOLS WITHIN THE DISTRICT WITH ACCOMMODATION.

Name of School.	*Dept.*	*Accommodation.*	*Avge. monthly No. on Registers*	*Average attendance*
Acton Wells	Senior	320	263	236
.....	Junior	364	417	378
	Infants'	364	373	309
Beaumont Park	Senior Girls'	450	191	172
	Junior Girls'	450	237	218
	Infants'	400	231	196
Berrymede	Junior Boys'	640	468	417
	Junior Girls'	542	395	357
	Infants'	450	314	266
Central		480	439	411
Derwentwater	Junior Mixed	441	407	379
	Infants'	350	298	257
John Perryn	Senior	360	247	224
	Junior Mixed	288	278	254
	Infants'	336	289	254
Priory	Senior Boys'	500	334	302
	Senior Girls'	499	363	312
	Infants'	400	288	252
Rothschild	Junior Boys'	450	218	201
	Infants'	400	274	235
Southfield	Senior Boys'	415	207	189
	Junior Mixed	382	327	301
	Infants'	350	242	196
Turnham Green R.C.	Mixed	327	237	207
Special	(M.D.)	68	44	37
		10026	7381	6560

AVERAGE HEIGHT WITHOUT SHOES AND AVERAGE WEIGHT WITHOUT CLOTHES.

ANTHROPOMETRIC COMMITTEE, 1929.

	MALES.		*FEMALES.*	
Age last birthday.	*Height in ins.*	*Weight in lbs.*	*Height in ins.*	*Weight in lbs.*
3	36.9	32.9	36.6	31.5
4	39.2	35.9	38.4	33.7
5	41.4	38.7	41.1	37.5
6	43.	41.3	42.8	40.1
7	45.4	45.4	45.1	44.1
8	47.8	51.	47.5	49.4
9	49.2	54.8	48.9	52.6
10	51.3	59.6	51.2	59.8
11	52.7	64.6	52.8	63.9
12	55.	71.6	55.6	73.9
13	56.2	76.5	56.9	79.
14	58.	86.1	58.9	88.2
15	61.8	99.3	62.3	106.8

TABLE SHOWING HEIGHTS AND WEIGHTS AT DIFFERENT AGES

LEAVERS (BOYS)	No. Examined.	YEARS OF AGE. 12—13 No.	12—13 Height ins.	12—13 Weight lbs.	13—14 No.	13—14 Height ins.	13—14 Weight lbs.	14—15 No.	14—15 Height ins.	14—15 Weight lbs.
Acton Wells Senior	39	38	57.5	83.2	1	57.5	79	.....	.....	.....
Central	37	37	59.1	89	.....	.....	.....	.....	.....	.....
John Perryn Senior	49	45	58	81.2	4	59.8	87.6	.....	.....	.....
Priory	117	116	57.2	82.7	1	56	72	.....	.....	.....
Southfield Snr. Boys'	63	59	56.8	77.6	4	58	84.5	.....	.....	.....
Roman Catholic	17	12	59	86.4	4	61.3	96.6	1	61	88.5
	322	307			14			1		
(GIRLS)										
Acton Wells Snr.	40	39	58.3	83.1	1	64.5	98.5	.....	.....	.....
Beaum't Pk. Snr.	67	67	58.1	81.8	.....	.....	.....	.....	.....	.....
Central	42	42	59	82.1	.....	.....	.....	.....	.....	.....
John Perryn Snr.	48	48	58.9	85.1	.....	.....	.....	.....	.....	.....
Priory	146	142	57.6	79.4	4	60.4	85.6	.....	.....	.....
Roman Catholic	19	17	58.9	84.2	2	62.2	92.5	.....	.....	.....
	362	355			7					

TABLE SHOWING HEIGHTS AND WEIGHTS AT DIFFERENT AGES.

INTERMEDIATES (BOYS)	No. Examined.	Years of Age. 7—8			8—9			9—10		
		No.	Height ins.	Weight lbs.	No.	Height ins.	Weight lbs.	No.	Height ins.	Weight lbs.
Acton Wells Junior	16	8	49.2	53.4	7	50.3	56	1	54.5	73.5
Acton Wells Infts.'	41	25	49	54.1	16	50	55.5	.....	.....	.....
Beaumont Pk. Infts.'	7	7	47.1	50	.....	.....	.....	.....	.....	.....
Berrymede Jnr.	86	40	48.6	53	45	48.7	54.8	1	53	72.5
Berrymede Infants'	5	5	49.6	55.4	.....	.....	.....	.....	.....	.....
Derwentwater Jnr.	34	20	49.1	54.6	14	51.4	59.4	.....	.....	.....
Derwentwater Infts.'	5	5	47.8	51.1	.....	.....	.....	.....	.....	.....
John Perryn Junior	1	.....	.....	.....	1	50	54.5	.....	.....	.....
John Perryn Infts.	40	20	49.1	53.9	20	49.5	54.5	.....	.....	.....
Priory Infants'	4	4	48	51.6	.....	.....	.....	.....	.....	.....
Rothschild Junior	50	13	48.9	54.5	36	49.2	56	1	53.8	57
Rothschild Infants'	8	8	49.5	55.5	.....	.....	.....	.....	.....	.....
Southfield Junior	27	20	49.2	56.1	7	48.4	56.9	.....	.....	.....
Southfield Infants'	8	8	47.9	51.9	.....	.....	.....	.....	.....	.....
Roman Catholic	21	6	48.8	52.5	11	51.5	57.2	4	50.9	57.5
	353	189			157			7		

TABLE SHOWING HEIGHTS AND WEIGHTS AT DIFFERENT AGES

INTERMEDIATES (GIRLS)	No. Examined.	Years of Age. 7—8			8—9			9—10		
		No.	Height ins.	Weight lbs.	No.	Height ins.	Weight lbs.	No.	Height ins.	Weight lbs.
Acton Wells Junior	21	12	49.4	54.3	9	49.5	56	.....	.....	.....
Acton Wells Infants'	37	14	48	49.8	23	48.8	52.8	.....	.....	.....
Beaumont Park Jnr.	42	28	48.4	50.3	14	48.9	52.2	.....	.....	.....
Beaumont Park Infts.	4	4	48.8	56	—	—	.....	.....	.....	.....
Berrymede Jnr.	89	61	48.7	53.9	28	48.4	53.9	.....	.....	.....
Berrymede Infts.	2	2	49.6	51.2	.....	.....	.....	.....	.....	.....
Derwentwater Jnr.	28	14	49.9	52.3	14	50.6	55.8	.....	.....	.....
Derwentwater Infts.'	3	3	51.6	57.5	.....	.....	.....	.....	.....	.....
John Perryn Jnr.	5	.....	.....	.....	4	47.4	46.7	1	53.8	62
John Perryn Infts.'	38	16	47.5	50.6	22	48.7	53.7	.....	.....	.....
Priory Infants'	8	8	48.1	51	.....	.....	.....	.....	.....	.....
Rothschild Infants'	7	7	47.6	48.8	.....	.....	.....	.....	.....	.....
Southfield Junior	39	28	46.8	53.9	9	48	50.1	2	51	70.1
Southfield Infants'	2	2	51.1	56	.....	.....	.....	.....	.....	.....
Roman Catholic	18	4	48.4	50.5	11	49.1	51.1	3	53.1	60.9
	343	203			134	.....	.....	6	.....	—

TABLE SHOWING HEIGHTS AND WEIGHTS AT DIFFERENT AGES.

ENTRANTS (BOYS)	No. Examined.	Years of Age. 3—4			4—5			5—6			6—7		
		No.	Height ins.	Weight lbs.	No.	Height ins.	Weight lbs.	No.	Height ins.	Weight lbs.	No.	Height No.	Weight lbs.
Acton Wells Infants'	86			.....	42	40.8	38.5	36	43	41.5	8	45.6	46.3
Beaumont Park Infants'	62	10	38.3	34.9	15	40.8	40.1	28	42.5	42.2	9	44.7	45.5
Berrymede Infants'	67	26	37.2	33.9	19	39.6	36.6	19	42.8	43.2	3	45.6	48.8
Derwentwater Infants'	62	.....	.....	.....	37	40.9	38.6	20	43.8	44	5	45.1	45.7
John Perryn Infants'	41	.....	.....	.....	15	40.8	39.2	23	43	42.1	3	45.7	48.8
Priory Infants'	58	.....	.....	.....	25	41.2	38.9	26	43.8	43.3	7	45.3	45.8
Rothschild Infants'	42	10	38.7	35.5	14	41.5	39.4	15	43.5	42	4	44.4	46
Southfield Infants'	66	.....	.....	.....	30	41.6	40.3	30	43.3	41.8	6	47.3	48
Roman Catholic	17	.....	.....	.....	9	42	38.3	5	43.4	40.9	3	45.9	44.4
	501	46			206			202			47		
(GIRLS)													
Acton Wells Infants'	55	.....	.....	.....	22	40.1	36.3	27	42.9	41.3	6	43.9	42.5
Beaumont Park Infants'	69	16	36.6	32.5	18	40.2	37	29	41.8	40	6	45.9	46.4
Berrymede Infants'	57	15	36.2	31.9	15	40.4	38.2	19	42.5	42	8	44.5	45.7
Derwentwater Infants'	66	.....	.....	.....	27	41.1	37.9	32	42.4	39.6	7	45.1	43.9
John Perryn Infants'	52	.....	.....	.....	22	40.9	38.4	24	43.	41.9	6	45.5	46
Priory Infants'	51	.....	.....	.....	19	40.6	36.8	20	42.5	40	12	44.8	44.2
Rothschild Infants'	45	9	37.5	31.9	15	40.1	36.1	17	43.4	42.8	4	48	52.8
Southfield Infants'	61	.....	.....	.....	19	41.8	38.4	37	43.9	42.7	5	46.9	46.6
Roman Catholic	11	.....	.....	.....	7	41.3	36.2	3	41.8	39.2	1	45.3	43.8
	467	40			164			208			55		

TONSILS AND ADENOIDS.

77 Children were operated upon during the year under the Authority's scheme for removal of tonsils and adenoids.

65 of these were operated upon because of repeated attacks of tonsillitis and repeated and constant head and throat colds accompanied by obstruction to the breathing, and enlargement of the glands in the neck.

3 children were operated upon because it was considered that their septic tonsils were the source of infection for their rheumatic condition.

9 children were operated upon because of some ear condition, either deafness, discharging ears, or recurring earache coinciding with sore throat.

PROVISION OF MEALS.

At December 31st, 1934, there were 283 children on the feeding list—at the end of December, 1935, this number had increased to 304. It will be seen that there is an increase in the number at the end of last year, but it must be remembered that the free meal population is a floating one, and that children are stopping and starting free meals all the time. These numbers are not therefore strictly comparable and on analysis of actual meals taken it will be seen that actually the first quarter of 1935 provided more free meals than the last one. During the first 3 months of 1935, the number of free meals supplied was 11,571 while in the last quarter it was 11,146—a slight drop. These quarters are strictly comparable, consisting each of 13 weeks and in each there was one week's holiday. The two intermediate quarters show a considerable drop, the second quarter's meals numbering only 8,650 and the third 6,451. In the second quarter there were 2 weeks holiday, and in the third 4 weeks.

A grand total of 37,820 meals was supplied during the year, 227 children receiving meals and milk, 3 children receiving meals only, and 74 children receiving milk only.

94,169 bottles of milk were provided during the year. From this it will be seen that advantage is being taken of the facilities provided for necessitous and undernourished children and it is hoped that increasingly the general health of the children will improve with it.

Each child, before being provided with free meals or milk is examined, weighed and measured, and over and over again we

were struck with the fact that the " junior," *i.e.*, the child aged 7-11, seemed to be more underweight and generally more puny than his older and younger brother or sister. Where a whole family were examined, it would be noted that the " infant " or " senior " would show less evidence of malnutrition than the intermediate member of the family. Accordingly, out of curiosity, 80 " infants " who had been put on free meals and milk, were chosen at random and their height and weight averaged out, and also their average age calculated. It was found that their average height was 41.6-in. and the correct height for the average age was 41.5-in. There was thus practically no discrepancy. Their average weight was 38.9-lbs. and the correct weight should have been 40.5-lbs. Their average underweight for height was therefore 1.6-lbs. This was not a very big difference and it bore out what had been noted, that the entrant is a fairly good specimen on the whole.

It was not possible to get 80 " seniors " who were seniors when put on the feeding list, but a similar deduction was made for 47. It was found in these that the average height was 55.1-ins. and the average weight 70.7-lbs. For their average age they should have measured 54.7-ins. and weighed 73.9-lbs. There was thus again very little difference in height but the average underweight for age was 3.2-lbs.

When for the " juniors " a comparable calculation was made for 80 chosen at random, it was found that their average height and weight was 49.3-ins. and 53.7-lbs. For their average age the correct figures are 51.6-ins. and 63.5-lbs. There is thus a much greater discrepancy between these figures—the average underweight being 9.8-lbs. and underheight 2.3-ins. These figures bore out what we had observed, that the " junior " who comes up to be examined for free meals is a poorer specimen than his older or younger brother.

Seeking a reason for this, it is certain that there is no single factor at work. The fact that no distinction as regards sex was made, would account in part for the " seniors " showing so little difference as it is well known that about the age of 12, girls tend to put on weight. At this period also it is common for boys to earn a little money for themselves by delivering newspapers, &c. Lack of rest in " juniors " is probably one of the main contributing causes. It is found that very frequently the " junior " does not go to bed any earlier than his " senior " brother, 9-10 o'clock and even later being a very common answer to an enquiry as to the regular bedtime. Also " be won't go to bed until his brothers and sisters go," is a very usual reply. The " infant " is still considered more or

less as a baby and is put to bed earlier, although sometimes not nearly as early as he ought to be.

Following the introduction of the Summer Time Act in 1921, an investigation was made into the effect of this Act on the health of the school child and on the amount of rest and sleep which the children got in the Winter and Summer. The amount of sleep required at different ages is stated to be as follows :—

Four to seven years	—	12 hours.
Seven to eleven	—	11 hours.
Eleven to thirteen	—	10 hours.
Thirteen to fifteen	.....	10 hours.
Fifteen to seventeen	—	9½ hours.
Seventeen to nineteen	—	9 hours.

In Acton it was found that up to the age of 7 there was no great deficiency in the amount of sleep which the children got. In children aged 11-14 also the bulk of the children were having approximately correct periods of rest. By far the greater number of children who were not having adequate rest fell in the age groups 7-11. These figures were of course drawn from all the school children in Acton, not only from those whose home circumstances required that extra nourishment should be granted them, but it is most surprising to find that where the results of poverty are apparent in malnutrition in childhood these effects should be aggravated in the age group where lack of rest is an additional factor.

The figures quoted for rest sleep for Acton were, of course, got out some few years ago, but it is unlikely that human nature has changed so much in the interval as to make the results no longer applicable. They are, moreover, borne out by observation and by statistics, that the " junior " who comes for examination for free meals is a poorer specimen than his older brother and sister.

It is not an easy matter to impress on the average mother that her child needs more sleep, it is so much easier to let the children run about until they voluntarily seek their beds, than to have to break them into a new habit of going early to bed.

AURAL REPORT.

The frequency of discharging ears is not a bad index of the efficiency of medical care in any community, and in a recent number of the " Lancet " an incident is related which shows the frequency of the condition in former years. Some twenty years ago a mother brought one of her children to an out-patient department in a poor

district in London, complaining that, although the child was teething, there was no discharge from the ears as had been the case with all her other children.

It is of interest to look through our school reports and in the earlier ones we find the same sort of story. In 1908 we were complaining that treatment was difficult, as the children had suffered for years from the complaint and it was hard to convince the mothers that the disease was not a necessary accompaniment of teething and bronchitis.

Frequently the smell was so objectionable that the teachers requested us to exclude the children from school attendance, and occasionally this was adopted, but we found this of little service as no complaint led to such a prolonged absence from school.

One of our difficulties in those early days arose from lack of co-operation from the mothers, and their diffidence in obtaining treatment. The first step to improve matters was taken in 1910 when a school nurse was appointed, but we soon found that the mothers did not carry out the instructions of the nurse, and the nurse herself could only carry out a part of the treatment. A second nurse was apointed in 1913, and arrangements were made for the children to come to the office daily to have their ears syringed. In 1914, the Minor Ailment treatment centre was opened, and since then a great improvement has occurred. Arrangements were subsequently made for the examination and treatment of cases by a specialist, and our cases showed a welcome diminution in the number.

The same method of running the Ear Clinic has been followed this year as previously, and the results have well repaid the labour which has gone to making the work a success. As will be seen from the subsequent analysis of cases, children are being sent for examination on the slightest suspicion of ear trouble, as it will be noted that many who are referred to the Clinic are found not to be suffering from ear disease at all. Those who are found to be so suffering are examined, treated, visited and not lost sight of until they are either well or are referred to a specialist, if it is found that success is not attending the efforts of the Clinic to cure the complaint.

There are two types of cases which constitute a problem to any Ear Clinic. The first is the intermittent discharge which clears up completely but begins again when the child gets a head cold with infection extending to the middle ear. It is not always easy to convince the patient and its parent that the nose treatment advised is as important a part of the cure as the local treatment to

the ear. These children may have attack after attack of ear discharge until they come to treat the ear discharge almost with indifference, although each attack means added risk of impaired hearing.

The other type of case is the chronic ear discharge where all the treatment of the case is left to the Clinic. The parent is urged to co-operate, shown how to do so, but apathy and indifference win the day and no effort is made. Such cases are the despair of any Clinic, but fortunately in Acton they are few.

Last year at the Clinic, the total number of cases referred for examination was 127, but not all of these were found to be suffering from ear disease.

35 children were referred complaining of deafness, and investigation provided the following figures :—

28 were suffering from wax in their ears and were cured on its removal.

4 were deaf after bad head colds and got better on suitable treatment as their colds improved.

2 were due to abnormalities in the formation of their ears, one had thickened ear drums and the other a congenitally narrowed meatus.

1 showed no obvious cause for deafness and was referred to an ear specialist.

30 Children came to the Ear Clinic complaining of earache, a complaint which, curiously enough, analysis showed to be in the main due to things other than ear inflammation.

12 only had genuine earache and all subsided on appropriate treatment without developing otorrhoea.

6 complained of earache but the pain was from decayed back teeth.

8 were getting pain from impacted plugs of wax,

2 had mumps,

1 had furunculosis of the external auditory meatus and,

1 showed nothing to substantiate the claim to earache.

34 cases of otorrhoea have been treated and cured during 1935.

27 of these were acute cases, ears discharging when first seen, and they responded to treatment. All were discharged from the Clinic with healed drums and normal hearing.

4 cases of intermittent ear discharge were cured, three of these showed a perforation in the drum with a certain interference with hearing but one had a healed drum head and normal hearing.

2 cases of old standing otorrhoea where a mastoid operation and a double mastoid operation had been performed were cured, in both cases with intact drums and good hearing.

1 case of intermittent ear discharge cleared up after removal of Tonsils and Adenoids.

11 cases of otorrhoea which were not showing signs of improvement were referred to Hospital for further advice or treatment.

3 had mastoidectomy performed, two are cured but the third operation is too recent to know the result.

1 was put on special treatment and is to be operated upon in 2 months time if the local treatment is unavailing.

2 were cured without operation.

4 are still attending Hospital with discharging ears.

1 child ceased to attend hospital and is now being looked after by his own doctor.

3 children left the district while attending the Clinic and before their ear discharge had ceased.

1 died, not as a result of ear trouble.

4 children left school and so passed out of our hands, while still incompletely cured of ear discharge.

2 of these had mastoid operations and their ear discharge was much less.

1 was attending another Clinic.

1 had suffered from intermittent ear discharge for some time and was much better. All these children had been taught to keep their ears clean by themselves and should therefore have been able to carry on the work of the clinic even if they no longer attended school.

At the end of 1935, the ear clinic was left with 8 children still suffering from otorrhoea.

3 of these were cases of intermittent otorrhoea and 3 were recent cases. 1 was a child who had been treated at the clinic, his parents had then left Acton and had later returned when the child was found to have very profuse double ear discharge. His routine treatment at the clinic is again having its effect and he is clearing up, but this case makes one realise how totally inadequate the home treatment of such cases is, and how very valuable and necessary is the regular supervision that our Nurses exercise on these cases. One child's parents refused treatment at the clinic as they objected to his lessons being missed, and are having the child treated out of school hours by their own doctor.

STAMMERING AND SPEECH DEFECTS.

Stammering is generally classified as a Speech Defect, although in reality this is a misnomer. The stammerer has nothing organically wrong with his vocal apparatus, neither has he any defect of the speech itself. This may be proved by the fact that he can sing or speak in chorus perfectly and can speak quite well if he is in a room by himself. The stammer is due to muscular tension and inability to co-ordinate the vocal and mental apparatus caused by psychological inhibition.

The stammerer will usually tell you of some shock, illness or accident which happened to him when he was four or five, which he explains was the cause of the stammer. This may or may not be true, but the fact is that there is a predisposition to stammer which usually comes out at about that age. The child goes to school and meets new companions, discipline is forced upon him probably for the first time and he is suddenly plunged into a new atmosphere which is completely alien to him, and he begins to stammer.

A shy, self-conscious child will stammer first from fear' a more precocious child will stammer out of self-defence. In the first case the child will be afraid of stammering a second time and the fear will make him do it again. In the second case the child will find it pays, people will sympathise and give in to him rather than hear his stammer. In both cases it grows into a habit which soon becomes difficult to eradicate.

There have been stammerers from time immemorial and there have always been people ready to cure them. Everyone knows

the familiar story of Demosthenes, the Greek orator, who is said to have cured his stammer by standing on the sea-shore shouting to the waves with a pebble on his tongue. A few weeks ago I heard of a small boy who had cured his stammer in the same way. Less than fifty years ago it was a comparatively common occurrence for surgeons to operate for a stammer. Everyone has his own pet theory, and every stammerer we meet has been told to breath deeply or hit the table or click his fingers. When we hear of a successful cure of this description there is only one answer to it . . . . where there's a will there's a way. There is always a type of person who intends to get cured and one who subconsciously prefers not to do so. It is the job of the Speech Therapist to get at the root of this subconscious preference and help the stammerer to find out the cause of his stammer and so get rid of it.

Every stammerer is different and it is soon found out that it is necessary to treat the stammerer and not the stammer. As there is no speech defect it is no good attacking the speech itself and more harm than good can be done by countless vocal exercises producing perfect vowel and consonant sounds which only draw the attention of the stammerer to his own difficulty. When the stammerer is perfectly relaxed physically and mentally he can talk freely. It is necessary to get rid of all muscular tension by exercises and daily practice in relaxation, at the same time strengthening the self-confidence of the stammerer by talking to him, taking an interest in his life, and explaining the cause and effect of the stammer to him. Breathing exercises are important as they help to develop control and establish confidence in the stammerer's power over his own voice. Recitation and reading are practiced sparingly and only in order to convince the stammerer of his progress. The essential part of the cure is to get rid of the feeling of inferiority and incompetence which is inherent in every stammerer and to build up instead a feeling of confidence and assurance. The great thing is to get the whole-hearted support not only of the stammerer himself but of his parents and friends, school teachers and companions. The difficulties that he is up against in daily life cannot be too clearly realised ; if he is a nervous type he should not be forced to read aloud in class, to take messages or to do shopping. On the other hand the stammerer nearly always has a high standard of intelligence and he should not be treated differently from other children or passed over because he is difficult to teach. I had a case of a boy of fourteen who could not read, because when he was younger his teacher passed him by because his stammer prevented him from speaking quickly. Every case can be cured eventually, the time depends entirely on the individual. The complete cure may take from 3 months to 3 years or more, according to the

personality of the stammerer and the depth to which the habit has grown.

There are 5 boy stammerers to every girl, but other speech defects are divided more fairly among the sexes. Stammering is by far the most prevalent of all speech defects. The next more usual is that known as Lalling or baby talk. This is found generally amongst only children, or youngest members of a grown-up family who continue to talk at the age of 6 or 8 as they did at 3 years old. This form of bad articulation, which has no organic defect sometimes prevails to an older age and is commonly met with amongst older children and adults of a low mental status. It can be cured by re-education of the speech by mouth, lip and tongue exercises, and mimicry. A young child of average intelligence will soon learn to speak well while with an older person the cure may take longer. A lisp is sometimes due to faulty dentition and more often to a thick and inflexible tongue. Word-deafness and blindness are forms of speech and hearing defects whnch are not so common although quite frequently a case of inability to speak clearly which appears at first sight to be lack of intelligence is found to be caused by deafness.

The most difficult form of speech-defect is that known as cleft-palate speech. The patient is born with a cleft palate which may be operated on in various ways according to the position of the cleft. But the operation cannot be performed until the child is 2 or 3 years old so that he learns to speak badly. After the operation it is necessary to teach the child to breath through the mouth and nose, to exercise the uvula and soft palate which has become stiff through the operation, and to re-educate the speech. The child finds the exercises hard work, and unfortunately soon tires of the practice and very often does not realise the necessity for the cure. However, modern surgery has discovered better ways of mending the broken mouth than those used in the past, and the job of learning to speak well afterwards will be made correspondingly easier for the children.

E. P. B. CLARK,
Speech Training Therapist.

Report on Speech Training Classes.

Classes for stammering children were held twice a week, on Mondays and Thursdays from January to December. In January, 1935, 31 children were attending these classes and during the year :—

10 left school,
3 left the district,
13 were discharged as cured,
2 were removed from the classes,
1 was re-admitted, and
9 new cases were admitted.

Apart from the 13 discharged as cured, the majority of those attending the classes show improvement. Two of those discharged as cured were bad stammerers and 4 bad stammerers still attending the class show marked improvement. At the end of 1935, 12 children were still attending the classes for stammering children, one being a child who had relapsed into a slight stammer.

In addition to providing classes for that most common and most disturbing speech defect, *i.e.*, stammering, it was decided to extend the scope of the Speech Training Classes to include all forms of speech defects, and in October, 1935, classes for this purpose were instituted. 33 children were selected as suitable for speech training, and in October the classes for these were formed according to age. As there were fewer stammerers at this time, it was found possible to deal with them in the mornings on Monday and Thursday from 10-12 o'clock in 3 classes of 40 minutes duration. This left the afternoons free for other speech defects, and accordingly the 33 children were divided into two classes, that of children aged 5-7 from 2—2.45 p.m., and that of children 8-12 from 2.45-3.30 p.m. Three older children were given individual attention for a quarter of an hour each from 3.30-4.15 p.m. on Mondays and Thursdays.

The commonest defects noted and dealt with was lalling or baby speech, found mostly in young children from the Infants' department. Other defects were due to faulty dentition, to malformation of the mouth or to some degree of deafness.

Some cases were referred from the Special School, backward, sluggish or slovenly speech, and it is hoped that speech training in their cases may encourage their power of concentration and mental attitude generally.

At the end of 1935, there were 36 children attending the Speech Training Classes as distinct from stammerers. Progress is naturally slow, but some improvement may be reported in the majority of those attending the classes.

RETURN OF EXCEPTIONAL CHILDREN.

On Table 3 will be found a return of all the exceptional children in the district.

Partially Sighted Children.

There are 5 cases in all. One attends an elementary school but goes to hospital regularly. Three children go to Kingwood Road School and one is at White Oak Ophthalmic Convalescent Hospital at Swanley.

Deaf Children.

Two boys and a girl attend Ackmar Road School and one girl is at Oak Lodge Residential School.

Mentally Defective Children.

45 children are attending the Acton Special School for Mental Defectives, 25 boys and 20 girls.

Epileptic Children.

Of 5 children suffering from Epilepsy, 3 are in institutions, one boy and one girl at Lingfield Colony, and one girl whose parents moved recently into Acton, at Moneyhull Colony, Birmingham. The other two are at home, one having been withdrawn from Lingfield, and one attending Maida Vale Hospital.

Tuberculous Children.

One child suffering from tuberculosis of the lung has been discharged from Harefield Sanatorium and is meantime at home. Two boys, one suffering from tubercular enteritis, and one from tuberculous osteomyelitis of the right ilium, are at the Royal Sea Bathing Home at Margate; two children, one boy and one girl are in the Victoria Home, Margate, and the Rob Roy Home, Margate, respectively, suffering from tuberculous hip disease. Another girl suffering from the same disease has come out of their Stanmore branch and is attending as an out-patient at the Royal National Orthopaedic Hospital. One girl who has a tubercular spine is at Warkworth House, Isleworth, and a boy with tuberculous disease of his sternum is at Alton.

Crippled Children.

One girl is attending the Queensmill Road School for Physical Defectives, one boy attends Brook Green School and another girl is at a similar school in Faroe Road. One girl is at the St. Vincent's Home, Pinner, and arrangements were made to send a boy

to the Shaftesbury Home, Hastings, but his father declined. He has been attending an ordinary elementary school.

Heart Disease.

One girl is at an ordinary elementary school, one boy is in the West Middlesex Hospital and two girls are attending Hospital and are excluded from school.

Delicate Children.

There are 8 children who may be so classed. One boy whose parents have recently moved into Acton, was attending Wood Lane Open Air School, and is continuing to do so. A girl has been discharged as cured from Harefield Sanatorium where she was sent suffering from tuberculosis of the lung, she is meantime at an elementary school. A boy who suffers from Asthma, was attending Guy's Hospital, is much improved and is at present attending an elementary school. One girl who suffers from rheumatism is at present at the Chenies Convalescent Home, Seaford, while two other children a boy and a girl, who suffer from the effects of rheumatism are at present at home. One boy who had suffered from tubercular adenitis, has had an accident and has been in Hospital, but is to attend an Open Air school on his recovery. One girl was in St. Vincent's Hospital, Pinner, was discharged and is at present at home, pending arrangements for her attending an Open Air school.

Multiple Defects.

One boy, who is mentally defective and crippled was at Stoke Park Colony, was sent from there to Harefield, and is now at home.

SCHOOL OCULIST'S REPORT. 1935.

During the period covered by this report, 435 children were referred to the Ophthalmic Clinic for examination.

Of this number, 60 refused treatment or left the district, four obtained glasses privately, and glasses were prescribed in 296 cases.

In addition, 17 boys from the Junior Technical and County Schools were examined. 6 were found to require no treatment and 11 were provided with glasses.

From the Welfare Centres, 4 mothers and 19 children were seen. 3 mothers and 7 children were provided with spectacles. 3 were cases of external eye disease and 6 were children with squints who are being kept under observation at the Clinic.

23 cases of external disease of the eye were treated at the Clinic. These were not severe in character, for the most part, and not of such a nature as to result in permanent diminution of visual acuity, save in one or two instances.

75 children referred for examination were found to require no treatment. This figure illustrates the care with which the children are examined prior to their appearance in the ophthalmic clinic, since all presented symptoms or signs which might have been due to ocular defects.

Certain practical difficulties arise in all clinics in cases in which prolonged treatment is indicated. Especially is this so, when children are referred on account of squint. These cases require early and prolonged treatment and observation extending over a period of years, together with the goodwill and active co-operation of patient, parent, and school teacher.

It is found that many parents do not realise the seriousness of the condition. Some consider that the mere prescription of glasses for the child relieves them of all further responsibility in the matter. Though the prescription of correcting lenses, where necessary, is the foundation upon which further treatment is based, it frequently happens that the degree of squint is not materially reduced thereby. It is not perhaps surprising therefore, that parents are apt to conclude that their children are not receiving any benefit from the fact of wearing spectacles, &c., and the children of such parents are often inadequately supervised at home as regards occlusion and so forth.

The fact remains, that in default of treatment, most squinting eyes suffer a great reduction in visual acuity, which may fall to 6/60 of normal or even lower. Further, this reduction of acuity will, in untreated cases, become permanent.

Every opportunity, therefore, is taken to bring these facts to the parents' notice, and it is pointed out that apart from the handicap under which these children labour, in virtue of their personal appearance, they are automatically debarred from employment in most branches of the Navy, Army, Air Force, Police, Railways, and engineering and transport generally.

In recent years, there has been a great improvement in the technique of treatment of cases both of manifest squint and in cases of smaller defects of muscle balance,

In 1935, seven children were referred to hospital for the correction of defects of muscle balance causing eye strain. These cases were relieved of symptoms after completion of a course of orthoptic exercises. Care in the selection of cases is required, not all being suitable for this form of treatment.

The recommendations of the Committee on Partially Sighted Children are noted. Very similar standards to those laid down in the report would appear to have been employed in the Clinic for a number of years.

The accurate fitting of glasses and the maintenance of frames in correct adjustment is of great importance. The Clinic is fortunate in possessing the services of an Optician in attendance, since this ensures that the maximum of benefit is obtained from the correction of errors of refraction.

F. CLIFTON.

Partially Sighted Children.

This is the term suggested by the Committee appointed to inquire into the problems relating to the condition, in preference to the old term of partially blind children.

For educational purposes the definition of blindness is a much wider one than that adopted for the purposes of the Blind Persons Act. For the purposes of the Education Act, 1921, there are included not only those children whose vision after correction by glasses does not enable them to read ordinary school books, but also those whose vision after correction does not enable them to read such books without risk or detriment to their eyesight.

Children certified as blind under the Education Act, may be grouped in 3 catagories.

(1)—Those who having extremely defective vision, cannot be taught by methods involving the use of sight.

(2)—Those whose vision is so defective that they cannot follow the ordinary school curriculum, but can be taught by special methods involving the use of sight.

(3)—Those who are suffering from conditions such as myopia which may be aggravated by following the ordinary school curriculum.

Cases in categories (2) and (3) are the partially sighted for whom special provision is necessary. Myopia is by far the most

important and frequent single condition which leads to an admission to a special school, and it is the different interpretations given concerning this condition which mainly affect the number of partially sighted children in different districts. In deciding which cases should be sent to a special school, factors such as degeneration of the fundus, rate of progress of myopia, degree of myopia present, age, family history and visual acuity must all be carefully weighed and assessed, and certain general principles were laid down by the Committee which should be observed in the selection of the cases.

There are certain other cases of defective vision due in most cases to sequelae of inflammation, such as corneal ulcer, Keratitis, and cataract which may require consideration. Here the question of sight saving does not arise as it does in the case of myopia, for the conditions are permanent and will not progress.

The question of admitting cases of optic atrophy to a special school is controversial. The majority of such cases are progressive and eventually become blind. Some argue that while they have sight they should be educated as sighted children, while others hold that they should have at the earliest possible stage the benefits of methods of education applicable to the blind.

At the present time we have no one in a Blind School, but there are certain abnormal children who will in course of time probably be blind.

(1)—A girl who was at a Blind School before her parents moved into Acton. She has double optic atrophy. Her mental condition deteriorated so seriously that she was removed from the school and notified as ineducable. She is now in hospital and is over 16 years of age.

(2)—A boy of 8 who has a cataract in right eye and good vision in the left eye.

(3)—A girl who had an accident to the right eye, and at present wears glasses of 13 dioptres for that eye. She has good sight in the left eye with a glass of 2 dioptres.

(4)—A girl of 13 who has been at Mayfield for prolonged treatment to an old phlyctenular conjunctivitis. She still attends hospital for treatment.

(5)—A boy of 13 with corneal ulcers. He attends irregularly at an Ophthalmic hospital.

(6, 7 and 8)—Three boys at Kingwood Road Special School. The 2 younger boys, aged 8 and 9 probably have optic atrophy.

The elder, aged 12, was in Kingwood Road School when the parents moved into Acton and is still there.

There are 11 cases of high myopia under observation by the Ophthalmic Surgeon. They are examined periodically, in most of them near work is prohibited and the question of a special school will depend upon the progress of the condition, and any other factor which the Ophthalmic Surgeon will deem of importance.

There are 2 others who may be mentioned here ; one is a boy who used to attend Kingwood Road School, but the parents objected and withdrew him. He was educated at a private school and left at the age of 14 at December. The other is a girl of 11 years who attends an Ophthalmic hospital for nystagmus and hypermetropia, and is under observation in an ordinary school.

There are two methods in this country by which the partially sighted children are educated—(a) the " segregation " method in special schools, and (b) the " non-segregation " method in ordinary schools.

The bulk of the evidence indicates a preponderating opinion in this country in favour of the segregation system of educating partially sighted children, but the dominating factor in forming current opinion on the education of the partially sighted, has been the pioneer work of the London County Council.

By reason of its large and concentrated population, London was in a peculiarly favourable position for isolating partially sighted children and studying their special needs.

Outside London, the Committee which investigated the problem came to tc conclusion that the education of partially sighted children should be conducted where possible in special classes attached to, and forming an integral part of, the ordinary school.

DENTAL REPORT.

This year saw the commencement of inspection and treatment at the Junior Technical and County Schools, also for a period, the part-time assistance of Mr. J. V. Goldie.

I am able therefore, to record a further and substantial increase in the number of cases treated. A factor which has also contributed to the increase is the much greater dependability of the attendance of the older boys, thus reducing the number of wasted appointments to a minimum for these schools.

The problem of oral hygiene still remains a big one. I was very interested to find that one or two classes which have adopted Gibbs' Ivory Castle League idea showed a really great improvement in this direction.

It is, I think, only by such constant and continuous methods that much impression can be made, and I am hoping that the scheme will be extended, and that teachers will not find the extra work and supervision entailed to be too great. They will certainly be doing a very excellent work.

We are treating many more Welfare cases, mothers and infants, and this should have a beneficial effect upon the school children of the future.

The figures for the elementary schools are given in the Tables at the end of the Report, but below will be found a summary of the work carried out for the Technical and Secondary Schools and for the Welfare Clinics.

	Schools.		*Welfare cases*
Number of cases examined	535	Mothers	126
		Children	176
Referred for treatment	426	Mothers	126
		Children	155
Treated	165	Mothers	85
		Children	142
Number of fillings	371	Fillings	116
Number of extractions	116	Extractions	1043
Number of dressings	39	Dressings	93
Number of attendances	421	Attendances	458
		Dentures	19

P. H. SLATER.

School Dental Surgeon.

INFECTIOUS DISEASES.

80 cases of Diphtheria were notified in the Borough during 1935, and there were 8 deaths. All these deaths were in non-immunised persons. Every endeavour is still being made to keep up the level of immunity which was attained in 1932-1933, and in this connection it may be of interest to compare the percentage immunised in the Infant departments of our schools at the end of

December in the years 1933, 1934 and 1935, and to note that on the whole the level of immunity at the early ages is at any rate being maintained.

Comparing 1934 with 1935, in only two infants departments has the level dropped and that very slightly, while in all the others the percentage rate is higher.

School.	1933	1934	1935
Acton Wells Infant	24.3%	44.6%	72.4%
Beaumont Park Infant	64.7	52.9	50.4
Berrymede Infant	37.6	24.9	24.6
Derwentwater Infants	75.3	51.4	56.3
John Perryn Infant	63.1	58	71.6
Priory Infant	43.1	50	65.03
Rothschild Infant.....	35.5	33.8	35.8
Southfield	58.8	52.3	61.07

It is now three years since immunisation on a large scale was begun in Acton. In a recent paper published in one of the medical journals, results were given showing that 5% of children rendered Schick negative by immunisation had relapsed into being Schick positive from 1 to 7 years after inoculation. In the late summer of 1935 there had been notified two cases of Diphtheria in immunised children. Both these children had mild attacks and devloped no complications, but because of this experience, and the published figures, it was decided to re-test all children who had been immunised 3 years ago, and to re-immunise all who were found to have relapsed and to be showing Schick positive reactions. Accordingly, all these children were circularised and up to the end of the year 235 of these children had been tested. The results are set out in the following Table :—

	Years of Age.											*Total.*
	4	5	6	7	8	9	10	11	12	13	14	
No. of children tested	5	14	14	14	18	23	10	29	46	56	6	235
Negative	5	14	13	11	17	21	8	24	40	46	5	204
Pseudo reactions			1				1	1	2	6	1	12
Positive reactions				3	1	2	1	4	4	4		19

It will be noted that 19 children out of 235, *i.e.*.., 8.1% had relapsed into being Schick positive. It has been said, and with some proof, that the very small amount of toxin necessary to test

these cases, is sufficient in itself to stir up the blood immunity and to render the person again Schick negative, but it was decided to give each child another injection and so make assurance doubly sure. This has been done. The work is still proceeding and so these children's protection is being continued together with the fresh relays of children who are being immunised.

In this connection it may here be mentioned that the Schick test as used hitherto is not an infallible guide to the protection of the individual. It is not unknown that Diphtheria, true in a mild and uncomplicated form, has attacked an immunised person, and it is equally true that in a natural Schick negative reactor the disease has been found.

There is now being offered for use therefore, a stronger Schick toxin which it is hoped will pick out these persons who must have developed only a threshold immunity. This toxin, used in conjunction with the ordinary Schick toxin, picks out a greatly increased percentage of positive reactors and these will be given additional doses of protective material until they are Schick negative to the stronger toxin. It is too soon to give figures or results of the work done, and time alone will show whether the use of this stronger toxin will eliminate all danger of an immunised person developing Diphtheria, however mild the attack.

There were 46 cases of Diphtheria in our schools in 1935, as against 58 in 1934. Of these, nearly 50% occurred in one school, and on swabbing the contacts, three Diphtheria carriers were isolated and treated, when the outbreak ceased. The schools affected were as follows :—

Acton Wells	.....	3	Priory	.....	7
Beaumont Park	.....	1	Roman Catholic		1
Berrymede	.....	5	Central	.....	—
Derwentwater	.....	22	Rothschild	.....	—
John Perryn	.....	7	Southfield	.....	—

It will be noted that 3 schools were entirely free from Diphtheria for the whole year.

41 Diphtheria patients and 88 contacts were seen at the Office before they returned to school.

Below is attached a Table giving the immunisation figures from January to December, 1935, in the various schools.

Immunisation Figures—JAN. to DEC. 1935.

School	Schick Tested.	Positive re-actors.	Number of attendances for 1st dose.	2nd.	3rd.
A.W.S.	2	1	1	1	1
A.W.J.	22	7	14	16	19
A.W.I.	4	1	53	83	84
B.P.S.G.	—	—	—	—	—
B.P.J.G.	1	1	1	1	1
B.P.I.	—	—	22	19	18
B.J.B.	3	1	5	3	3
B.J.G.	1	—	1	1	2
B.I.	3	3	17	13	14
Central	4	4	5	4	6
D.J.	3	2	3	4	4
D.I.	1	1	63	59	55
J.P.S.	2	1	2	2	2
J.P.J.	6	5	8	12	10
J.P.I.	3	—	81	85	89
P.B.	—	—	1	—	—
P.G.	1	1	1	1	—
P.I.	—	—	52	50	48
R.J.	1	1	3	3	4
R.I.	—	—	7	6	12
S.S.B.	—	—	—	—	—
S.J.	15	12	9	3	3
S.I.	—	—	64	52	51
R.C.	8	6	9	9	5
Other Schools	20	16	22	21	24
Welfare	—	—	317	294	284
Total	100	63	761	742	739

In addition 620 children were Schick tested after six months. 615 were negative, while 5 who were still positive were again inoculated.

Scarlet Fever.

There were 48 cases of Scarlet Fever in the various schools during 1935. This is a marked decrease over 1934 when there were 122 cases. They occurred as under :—

Acton Wells	12	John Perryn	7
Beaumont Park	7	Priory	6
Berrymede	3	Southfield	10
Central	1	Rothschild	—
Derwentwater	2	Roman Catholic	—

It will be noted that again two schools are entirely free In fact, Rothschild School has been free of Scarlet Fever and Diphtheria for the whole of 1935.

37 Scarlet Fever patients and 69 contacts were examined before their return to school.

TABLE SHOWING THE NUMBER OF CHILDREN ATTENDING ACTON SCHOOLS EMPLOYED IN THE VARIOUS REGISTERED OCCUPATIONS ON 31ST DECEMBER, 1935.

SCHOOL.	Delivering Newspapers.		Delivering milk.		Delivering goods or parcels.		TOTALS.	
	Boys.	Girls.	Boys.	Girls.	Boys.	Girls.	Boys.	Girls.
Acton Wells	4	—	—	—	2	—	6	—
John Perryn	2	—	1	—	1	—	4	—
Central	4	—	2	—	6	—	12	—
County	4	—	2	—	7	—	13	—
Southfield	12	—	3	—	9	—	24	—
Priory	17	—	4	—	24	—	45	—
Roman Catholic	1	—	1	—	5	—	7	—
Beaumont Park	—	—	—	—	—	1	—	1
TOTALS	44	—	13	—	54	1	111	1

TABLE SHOWING THE DISTRIBUTION OF ALL CHILDREN EMPLOYED DURING THE PERIOD 1st JANUARY, 1935 TO 31st DECEMBER, 1935.

SCHOOL.	BOYS.									GIRLS.		
	Acton Wells	John Perryn	Central	County	Southfield	Priory	Roman Catholic	Others	Totals	Beaumont Park	Acton Wells	Totals
1. REGISTERED OCCUPATIONS :—												
(*a*) Delivering Newspapers	26	4	18	8	25	49	2	4	136	.....	.....	.....
(*b*) Delivering Milk	6	2	5	5	7	10	3	3	41	.....	.....	.....
(*c*) Carrying or Delivering goods or parcels	7	4	11	15	26	67	9	6	145	1	.....	1
TOTALS	39	10	34	28	58	126	14	13	322	1	.....	1
CORRESPONDING FIGURES FOR 1934	42	8	39	20	64	148	9	19	349	1	2	3

SWIMMING INSTRUCTION,—Season, 1935.

The School Swimming Season opened on Monday, 13th May, 1935, and provision was made for 54 classes at the Public Baths, 32 for boys and 22 for girls. Of these, 49 classes were held in school hours whilst one class for boys and four classes for girls were held in periods immediately before or after normal school periods. All the instructions was given by the teaching staff of the Schools concerned.

The season normally closes on the 30th September, but, as in previous years, one or two small classes continue to attend the Baths during the winter months for instruction and practice in life-saving.

Acton Education Committee continues to award certificates to boys and girls who can swim twenty-five yards down the length of the bath, without interruption, pause or rest, and Acton scholars also compete for the certificates of the London Schools Swimming Association and the Royal Life Saving Association as under :—

Swimming—1st class 100 yards—Condition as for Acton
2nd class 50 certificates.

Life Saving—Elementary and Advanced.

There are in the Schools at the present time 1318 scholars (695 boys and 623 girls) who can swim (as against 1307 at the end of last season) and 327 boys and 251 girls now in schools learned to swim during the 1935 season (against 634 last year). It should be borne in mind, however, that a great number of the scholars who left the elementary schools at the summer vacation to enter secondary schools had learned to swim by that date.

The following is a statistical return relating to the season's work, with comparative figures for last year. Details giving statistics for the individual schools are in the hands of the Director of Education.

	Year.	*Boys*	*Girls*	*Total.*
No. of classes per week allocated	1935	32	22	54
	1934	32	22	54

Total No. of attendances made	1935	10938	6943	17881*
	1934	12375	7911	20286

*NOTE–Season opened one week later, owing to Jubilee celebrations and consequent school closures.

Certificates gained.	*Year* 1935			*Year* 1934		
	Boys	*Girls*	*Total*	*Boys*	*Girls*	*Total*
Acton Education Committee	253	225	478	264	204	468
L.S.S.A. 1st Class	134	134	268	145	118	263
2nd Class	175	173	356	184	149	333
Life Saving, Elem.	—	28	26	20	14	34
Advd.	—	27	27	23	—	23

CHILDREN'S COUNTRY HOLIDAYS.

In 1935, Miss Stevens, Head Mistress of Berrymede Infant School, approached the Headquarters of the Children's Country Holidays Fund and asked if it were possible that some of the Acton children might benefit by the arrangements of the Association and have a holiday in the country or by the seaside. The Association sent a representative down to Acton and it was decided to open a local branch and Miss Stevens was made local Secretary.

Head quarters of the Fund made a grant of £188, and from the parents of the children who were to go on holiday £138 was collected. By this means 294 children (161 boys and 133 girls) were sent for a fortnight's holiday, 24 of these stayed a month. These

children were sent to Folkestone, Weston-Super-Mare, and to 20 other places in Herefordshire, Worcestershire, Wiltshire, Somerset, Warwickshire, Gloucestershire and Norfolk. The cost of sending a child away for a fortnight is approximately 30s. and the average amount paid by the parents of these children was 8s. 9d. Only one child paid the full amount.

The ages of the children varied from 7-14 and it is gratifying to have to report that the Country correspondents of the Society have reported excellent conduct of the part of the children, and in several instances they were spoken of as " an exceptionally nice set of children." That the children benefited by the holiday is the unanimous opinion of the Head Teacher of all the schools concerned. A day in the country often is not of benefit to the children concerned as the exhaustion of the excitement and long hours far outweighs the benefit of a breath of sea or country air, and it is the opinion of the Holiday Fund that a month is too long for any but delicate children and there is a tendency to get bored and tiresome towards the end of the time. A fortnight, however, sends the children back refreshed and exhilarated from their holiday, and the effects of healthy surroundings, good food and change of air should enable these children to face the coming winter with more hope of good health through the cold and sunless weather.

The Country Holidays Fund is most particular about the cleanliness and freedom from infection of the children who are sent away. Each child must be medically examined a few days before going away and each child must be examined for uncleanliness at least 3 times before departure.

This meant 882 examinations, but in reality nearly 1000 were seen by the school nurses, as those who were found to be un-clean had to be examined again and again until they could be certfied as clean and allowed to go on holiday. Several of these children were not only examined by one of the school nurses, but actually cleansed by her, so that they should not lose their holiday through the carelessness or incompetence of their home guardians.

The organisation and carrying out of these 294 holidays meant a very great deal of work. Miss Stevens, by whose enterprise and thought, the whole scheme was made possible, acted as local Secretary and the children of Acton who enjoyed a holiday last summer have her to thank, for without her no such scheme would be in existence and without the enormous amount of work she voluntarily did for it, the arrangements of these holidays would not have proceeded, as they did, without a hitch.

VISITS PAID BY SCHOOL NURSES.

The following Table gives the number of home visits paid by the Nurses during the year. The visits have been divided into school distribution.

Acton Wells	123	Priory	192
Beaumont Park	168	Rothschild	147
Berrymede	423	Southfield	208
Central	3	Roman Catholic	10
Derwentwater	105	Special School	1
John Perryn	97		
		Total	1477

CONVALESCENT HOMES AND COUNTRY HOLIDAYS.

One boy and one girl were sent to the Winter School of Recovery, Bexhill, for a perid of 3 months each.

In the Summer, 6 girls paid for a fortnight, and 3 boys and 3 girls were sent away for a fortnight's holiday free of charge.

MOTHERCRAFT CLASSES.

The following table shows the number of classes sent from each school to the Day Nursery.

Beaumont Park	4	Central	7
Acton Wells	6	Priory	5
John Perryn	5	Roman Catholic	1
			28

RETURN OF MEDICAL INSPECTIONS.

TABLE I.

A.—Routine Medical Inspections.

Number of Inspections in the prescribed Groups :—

Entrants	968
Second Age Group	696
Third Age Group	684
Total	2348

Number of other Routine Inspections —

B.—Other Inspections.

Number of Special Inspections	1906
Number of Re-Inspections	1577
Total	3483

C.—Children Found to Require Treatment.

Prescribed Groups :—

Entrants	61
Second Age Group	90
Third Age Group	62
Total (Prescribed Groups)	213
Other Routine Inspections	—
Total	213

TABLE II.

A.—Return of Defects found by Medical Inspection in the Year ended 31st December, 1935.

Defect or Disease.	Routine Inspections. No. of Defects. Requiring Treatment	Routine Inspections. No. of Defects. Requiring to be kept under observation, but not requiring Treatment.	Special Inspections. No. of Defects. Requiring Treatment	Special Inspections. No. of Defects. Requiring to be kept under observation, but not requiring Treatment.
(1)	(2)	(3)	(4)	(5)
Skin :—				
Ringworm :				
Scalp	—	—	7	—
Body	—	—	26	—
Scabies	1	—	18	—
Impetigo	4	—	252	—
Other Diseases (Non-Tuberculous)	10	2	128	—
Total	15	2	431	—
Eye :				
Blepharitis	15	—	79	—
Conjunctivitis	2	—	25	—
Keratitis	—	—	1	—
Corneal Opacities	—	1	4	—
Other Conditions (excluding Squint)	—	—	58	—
Total	17	1	167	—
Defective Vision	98	2	116	—
Squint	13	7	7	—
Ear :				
Defective Hearing	1	27	7	2
Otitis Media	11	2	17	1
Other Ear Diseases	11	4	113	—
Nose and Throat :				
Chronic Tonsillitis only	—	1	—	—
Adenoids only	—	—	3	—
Chronic Tonsillitis and Adenoids	45	15	9	—
Other Conditions	—	4	—	1
Enlarged Cervical Glands (Non-Tuberculous)	—	416	—	70
Defective Speech	1	3	25	—

Defect or Disease.	Routine Inspections.		Special Inspections.	
	No. of Defects.		No. of Defects.	
	Requiring Treatment	Requiring to be kept under observation, but *not* requiring Treatment	Requiring Treatment.	Requiring to be kept under observation, but *not* requiring Treatment.
(1)	(2)	(3)	(4)	(5)
Heart and Circulation :				
Heart Disease :				
Organic	—	10	—	—
Functional	—	16	1	—
Anaemia	—	5	—	—
Lungs :				
Bronchitis	—	6	—	—
Other Non-Tuberculous Diseases	—	4	—	—
Tuberculosis :				
Pulmonary :				
Definite	—	—	1	—
Suspected	—	2	—	—
Non-Pulmonary :				
Glands	—	1	1	—
Bones and Joints	—	—	4	—
Skin	—	—	—	—
Other Forms	—	—	1	—
Total	—	1	6	—
Nervous System :				
Epilepsy	—	—	—	—
Chorea	—	—	3	—
Other Conditions	—	1	—	—
Deformities :				
Rickets	1	28	1	—
Spinal Curvature	—	—	—	—
Other Forms	1	1	—	—
Other Defects and Diseases (excluding Uncleanliness and Dental Diseases)	—	41	618	8
Total	214	599	1525	82

B.—Classification of the Nutrition of Children Inspected during the Year in the Routine Age Groups.

Age-groups	Number of Children Inspected	A (Excellent)		B (Normal)		C (Slightly submormal)		D (Bad)	
		No.	%	No.	%	No.	%	No.	%
Entrants	968	410	42.3%	473	48.8%	77	7.9%	8	.8%
Second Age-group	696	293	42.09	347	49.8%	46	6.6%	10	1.4%
Third Age-group	684	213	31.02	446	65.2%	23	3.36	2	.29
Other Routine Inspections	—								
TOTAL	2348	916	39.01	1266	53.9%	146	6.2%	20	.85

TABLE III.

Return of all Exceptional Children in the Area.

BLIND CHILDREN.

At Certified Schools for the Blind.	At Public Elementary Schools.	At Other Institutions.	At no School or Institution.	Total.
—	—	—	—	—

PARTIALLY SIGHTED CHILDREN.

At Certifed Schools for the Blind.	At Certified Schools for the partially Sighted.	At Public Elementary Schools.	At other Institutions.	At no School or Institution.	Total.
—	3	1	1	—	5

DEAF CHILDREN.

At Certified Schools for the Deaf.	At Public Elementary Schools.	At other Institutions.	At no School or Institution.	Total.
4	—	—	—	4

PARTIALLY DEAF CHILDREN.

At Certified Schools for the Deaf.	At Certified Schools for the Partially Deaf.	At Public Elementary Schools.	At other Institutions.	At no School or Institution.	Total.
—	—	—	—	—	—

MENTALLY DEFECTIVE CHILDREN.

Feeble-Minded Children.

At Certified Schools for Mentally Defective Children.	At Public Elementary Schools.	At other Institutions.	At no School or Institution.	Total.
45	—	—	—	45

EPILEPTIC CHILDREN.

Children suffering from severe Epilepsy.

At Certified Special Schools.	At Public Elementary Schools.	At other Institutions.	At no School or Institution.	Total.
3	—	—	2	5

PHYSICALLY DEFECTIVE CHILDREN.

A TUBERCULOUS CHILDREN.

1.—CHILDREN SUFFERING FROM PULMONARY TUBERCULOSIS,

(Including pleura and intra-thoracic glands)

At Certified Special Schools.	At Public Elementary Schools.	At other Institutions.	At no School or Institution.	Total.
—	—	1	—	1

II.—CHILDREN SUFFERING FROM NON-PULMONARY TUBERCULOSIS

At Certified Special Schools.	At Public Elementary Schools.	At other Institutions.	At no School or Institution.	Total.
—	—	7	—	7

B. DELICATE CHILDREN.

(ie) Whose general health renders it desirable that they should be specially selected for admission to an Open Air School.

At Certified Special Schools.	At Public Elementary Schools.	At other Institutions.	At no School or Institution.	Total.
1	2	1	4	8

C. CRIPPLED CHILDREN.

(ie) (Other than those diagnosed as tuberculous and in need of treatment for that disease) who are suffering from a degree of crippling sufficiently severe to interfere materially with a child's normal mode of life.

At Certified Special Schools.	At Public Elementary Schools.	At other Institutions.	At no School or Institution.	Total.
4	1	—	—	5

D. CHILDREN WITH HEART DISEASE.

(ie) Children whose defect is so severe as to necessitate the provision of educational facilities other than those of the Public Elementary School.

At Certified Special Schools.	At Public Elementary Schools.	At other Institutions.	At no School or Institution.	Total.
—	1	2	1	4

CHILDREN SUFFERING FROM MULTIPLE DEFECTS.

Combination of Defect.	At Certified Special Schools.	At Public Elementary Schools.	At other Institutions.	At no School or Institution.	Total
Mental Deficiency & Crippling				1	1

TABLE IV.

RETURN OF DEFECTS TREATED DURING THE YEAR ENDED 31ST DECEMBER, 1935.

Treatment Table.

GROUP I—MINOR AILMENTS (excluding Uncleanliness, for which see Group VI.)

DISEASE OR DEFECT. (1)	Number of Defects treated, or under treatment during the year. Under the Authority's Scheme. (2)	Otherwise (3)	Total. (4)
SKIN :			
Ringworm-Scalp—			
(i.) X-Ray Treatment.	4	—	4
(ii.) Other Treatment.	—	3	3
Ringworm-Body	26	—	26
Scabies	18	—	18
Impetigo	252	—	252
Other skin disease	128	—	128
MINOR EYE DEFECTS : (External and other, but excluding cases falling in Group II.)	166	—	166
MINOR EAR DEFECTS	125	9	134
MISCELLANEOUS (*e.g.*, minor injuries, bruises, sores, chilblains, &c.)	618	—	618
TOTAL	1337	12	1349

GROUP II.—DEFECTIVE VISION AND SQUINT (excluding Minor Eye Defects treated as Minor Ailments—Group I.)

DEFECT OR DISEASE.	No. of Defects dealt with.		
	Under the Authority's Scheme	Otherwise	Total.
(1)	(2)	(4)	(5)
Errors of Refraction (including Squint)	435	4	439
Other Defect or Disease of the Eyes (excluding those recorded in Group I.)	23	—	23
Total	458	4	462

Total number of children for whom spectacles were prescribed—

(*a*) Under the Authority's Scheme	296	4	300
(*b*) Otherwise	296	4	300

GROUP III.—TREATMENT OF DEFECTS OF NOSE AND THROAT.

NUMBER OF DEFECTS.

Received Operative Treatment.										Received other forms of Treatment	Total number treated
Under the Authority's Scheme, in Clinic or Hospital				By Private Practitioner or Hospital, apart from the Authority's Scheme				Total			
(1)				(2)				(3)		(4)	(5)
1.	2.	3.	4.	1.	2.	3.	4.	1.	2. 3. 4.		
11	2	64	–	–	–	5	1	11	2 69 1	—	83

(1)—Tonsils only. (2)—Adenoids only. (3)—Tonsils and Adenoids.
(4)—Other defects of the Nose and Throat.

GROUP IV.—ORTHOPAEDIC AND POSTURAL DEFECTS.

	(1) Under the Authority's Scheme.			(2) Otherwise.			Total No. Treated.
	Residential Treatment with Education. (i)	Residential Treatment without Education. (ii)	Non-Residential Treatment at an Orthopaedic Clinic. (iii)	Residential Treatment with Education. (i)	Residential Treatment without Education. (ii)	Non-Residential Treatment at an Orthopaedic Clinic. (iii)	
No. of Children Treated.	—	2	—	—	1	2	5

Group V.—Dental Defects.

(1) Number of Children who were :—

(a) Inspected by the Dentist :

Routine Age Groups	Aged : 5—	705
	6—	733
	7—	613
	8—	723
	9—	764
	10—	756
	11—	818
	12—	621
	13—	687
	14—	131
	Total	6551
Specials		520
	Grand Total	7071
(2) Found to require treatment		4965
(3) Actually treated		3152
(4) Attendances made by children for treatment		4349
(5) Half-days devoted to :—		
Inspection		41
Treatment		472
	Total	513
(6) Fillings :—		
Permanent teeth		2020
Temporary teeth		68
	Total	2088
(7) Extractions :—		
Permanent teeth		850
Temporary teeth		4638
	Total	5488
(8) Administrations of general anaesthetics for extractions		2249
(9) Other operations :—		
Permanent teeth		229
Temporary teeth		78
	Total	307

Group VI.—Uncleanliness and Verminous Conditions.

Average number of visits per school made during the year by the School Nurses	14
Total number of examinations of children in the Schools by School Nurses	21909
Number of individual children found unclean :—	
Vermin and Nits	87
Slightly infested	449
Number of children cleansed under arrangements made by the Local Education Authority	14
Number of cases in which legal proceedings were taken :—	
(a) Under the Education Act, 1921	—
(b) Under School Attendance Byelaws	1

STATEMENT OF THE NUMBER OF CHILDREN NOTIFIED DURING THE YEAR ENDED 31ST DECEMBER, 1935, BY THE LOCAL EDUCATION AUTHORITY TO THE LOCAL MENTAL DEFICIENCY AUTHORITY.

Total number of children notified 5

Analysis of the above Total.

	Diagnosis.	*Boys.*	*Girls.*
1.	(i) Children incapable of receiving benefit or further benefit from instruction in a Special School :		
	(*a*) Idiots	—	—
	(*b*) Imbeciles	—	3
	(*c*) Others	—	—
	(ii) Children unable to be instructed in a Special School without detriment to the interests of other children :		
	(*a*) Moral defectives	—	—
	(*b*) Others	—	—
2.	Feeble-minded children notified on leaving a Special School on or before attaining the age of 16	2	—
3.	Feeble-minded children notified under Article 3, *i.e.*, "special circumstances" cases	—	—
4.	Children who in addition to being mentally defective were blind or deaf	—	—
	Grand Total	2	3

We are,

Your Obedient Servants,

D. J. THOMAS.

E. MADELEY.