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BOROUGH OF WALTHAMSTOW
Committee for Education

REPORT

of the

DIVISIONAL

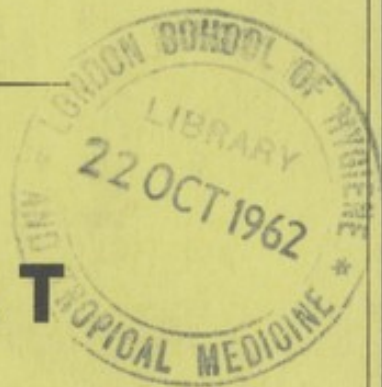
SCHOOL MEDICAL OFFICER

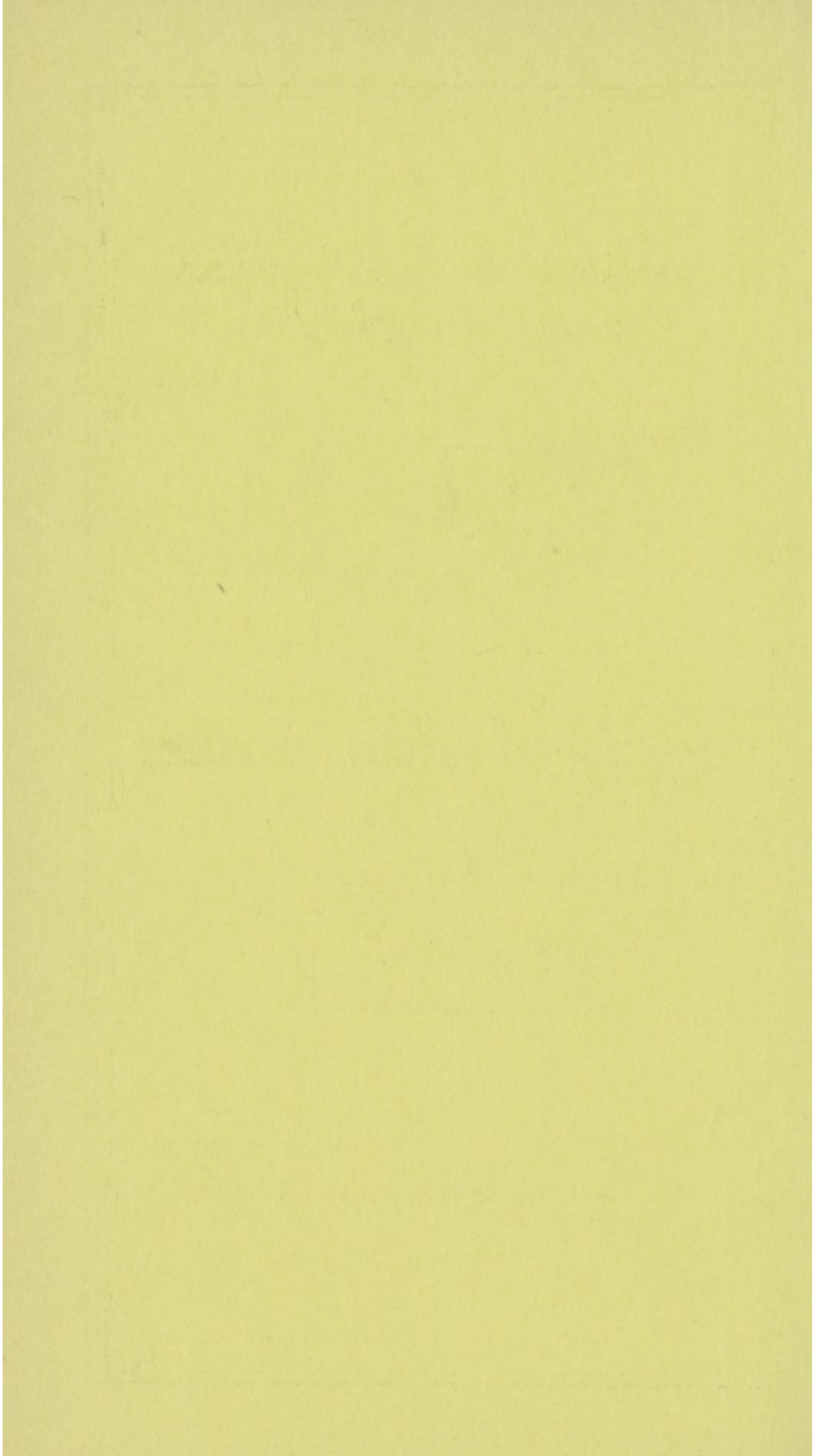
for the year

1961

MELVILLE WATKINS, M.R.C.S., L.R.C.P., D.P.H.

DIVISIONAL SCHOOL MEDICAL OFFICER





BOROUGH OF WALTHAMSTOW
Committee for Education

REPORT

of the

DIVISIONAL

SCHOOL MEDICAL OFFICER

for the year

1961

MELVILLE WATKINS, M.R.C.S., L.R.C.P., D.P.H.

DIVISIONAL SCHOOL MEDICAL OFFICER

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WALTHAMSTOW COMMITTEE FOR EDUCATION

1961 - 1962

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Miss D.E. WYLD

Borough Education Officer:

E.T. POTTER, B.Sc., J.P.

*To the Chairman and Members of the
Walthamstow Committee for Education.*

Mr. Chairman, Ladies and Gentlemen,

The reception accorded to my Report last year has encouraged me to repeat the same format, presenting again reviews and comments upon items of current interest in the School Health Service separately from the tabular and statistical section. I shall try, so far as possible, to deal in this way each year with some particular aspect of Child Health.

This year has been noticable for the growth which has been taking place in the upper branches of the tree of knowledge; the proposed University of Essex looks as though it will soon progress from a concrete proposal to a red brick foundation. Extensive plans are afoot for the establishment of colleges of advanced technology and for the expansion of existing technical colleges; grammar schools are carrying large numbers in their VIth forms and secondary modern schools are running extended courses. Education generally seems to be striding forward with seven-league boots and inevitably some will be left behind. These are the handicapped children who, because of poor physical or mental endowment or as a result of injury or disease are unable to keep pace with their fellows.

The more efficient an educational system becomes the higher are the aims and the swifter the pace. Also the more difficult it becomes for the very dull and the disabled to keep up. These latter have always been of special interest, and responsibility, to my department and for this report I have asked those of my colleagues chiefly concerned for contributions dealing with handicapped children. These follow and I would like to express my thanks to their authors for their clear and comprehensive expositions of the problems involved.

Dr. Poole and Mr. Williams have analysed the changes that have occurred over the years in the type of child now requiring special schooling and the reasons for this. Acquired disablements resulting from diseases have become rarer due to the advances made in preventive work. Children with congenital defects occupy most of the places nowadays thus presenting the teachers with far more formidable challenges than the special schools of old. The children often have dual defects. The defects are more resistant to treatment and the child is admitted at a much earlier age.

Education therefore, is more difficult and complex. Not only must formal education be given (a slow process at best under such circumstances) but the child must be taught to overcome and live with his handicap. Diligent search must be made for residual skills and their careful nurture in preparation for vocational training. It can therefore be seen that the responsibilities are great.

With all the devotion and skill given to these children there still remains a few areas of further development in this field. The future will see more concentration on earlier diagnosis and assessment of these children necessitating a skilled co-ordinated team made up of various disciplines.

I would endorse the observations made by Mr. Harvey and Dr. Poole upon the need for an integrated welfare service for the handicapped school leavers. Very many of these pupils will remain permanently and substantially handicapped for the rest of their lives and will continue to need informed medical supervision and help in managing their lives and work. Ten years or more of continuous observation and knowledge of the child's potential is lost when the welfare and responsibility for the child is relinquished when he leaves school.

STATISTICS. On page 45 will be found a comparison of the major defects discovered in the years 1951 to 1961. On the whole, there have been very little changes in incidence, but a few conditions show an increase and some a decrease. Skin defects are more than twice that of 1951 and defects of vision and squint increased from 8.3 to 14.8 per cent. The reason for the latter is that yearly eye tests have now been instituted and the increase is due simply to the greater numbers examined during the year. It will be noted with satisfaction that ear disease, orthopaedic and heart defects have been more than halved during this last decade, thanks to various immunisation procedures and the advent of more effective antibiotics.

I wish to express my thanks to the Chairman and Committee for Education for their encouragement and to all the staff for their loyal support during the year.

I am,

Your obedient Servant,

M. WATKINS

Divisional School Medical Officer.

STAFF OF THE SCHOOL HEALTH DEPARTMENT - 1961Divisional School Medical Officer and Medical Officer of Health:

M. WATKINS, M.R.C.S., L.R.C.P., D.P.H.

Deputy Medical Officer of Health and School Medical Officer:

G.H.G. POOLE, M.B., B.S., D.(Obst.) R.C.O.G., D.P.H.

School Medical Officers:

Miss C.P. Dooley, L.R.C.P., and S.I., D.P.H.

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Mrs. J.H.W. Newman, M.B., Ch. B., D.(Obst.) R.C.O.G.,
D.P.H. (Part-time)

Miss J.P. Werren, M.B., B.S., D.C.H., D. (Obst.) R.C.O.G.

Specialist Part-time Medical Officers (Appointed by
Regional Hospital Board):

Ear, Nose and Throat Surgeon: A.N. Cammock, M.B., B.Ch.,
D.L.O.

Ophthalmologist: Miss I.D.R. Gregory, M.B., Ch.B.,
F.R.C.S., D.O.M.S.

H. Ho, M.R.C.S., L.R.C.P., D.L.O.,
D.O.M.S.

Orthopaedic Surgeon: G. Rigby-Jones, M.C., T.D., M.A.,
M.B., B. Chir., F.R.C.S.

Paediatrician: E. Hinden, M.D., M.R.C.P.

Psychiatrists: Mrs. H. Gillespie, M.R.C.S., L.R.C.P.
Miss R. Hoffman, M.B. Ch.B., D.P.M.

Dental Surgeons:

Mr. G.P.L. Taylor, L.D.S. (Area Dental Officer from
7.7.61.)

Mr. R. Hyman, L.D.S.

Mr. F.B. Christie, L.D.S. (from 1.5.61) (c)

Mrs. A.M. Culloty, L.D.S. (from 16.3.61) (c)

Mr. W. Goldberg, L.D.S. (13.2.61 - 22.11.61) (c)

Mr. W. Landes, Stat. Exam. (Part-time)

Mr. R.V. Tait, L.D.S. Orthodontist (Part-time)

Mr. D.R. Minchom, L.D.S. (from 21.6.61) (c)

Mr. P.H. Vidler, L.D.S. (14.3.61 - 7.6.61) (c)

(c) Contractor.

Health Visitors/School Nurses (Part-time to School Health
Services):

Miss M. Smith (Superintendent) Miss D. Legg

Miss R.M. Adalian (Part-time) Mrs. E. Levis (Part-time)

Miss R. Boyd Miss M. Loughton

Miss E. DuRandt Miss C. Moseley (from 8.1.61)

Mrs. E.M. Geary Miss J.M. Palmer

Mrs. J.L. Haynes (Part-time) Mrs. M. Saywell (from 29.8.61.)
 Miss E.A. Kenny Miss M.E. Waghorn
 Mrs. D.E. Lambert (Part-time) Miss A.O. Wright

(All the above are S.R.N., S.C.M., H.V. Cert.)

School Nurses:

Mrs. A. Dunford, S.R.N. Mrs. J. Mountford, S.R.N.
 Mrs. B. Jones, S.R.N. C.M.B. (Part 1) Res. 3.4.61.
 Mrs. M. Leach, S.R.N. Miss I.E. Turner, S.R.N.

Clinic Nurse:

Mrs. J.A. Gwilliams, S.R.N.

Educational Psychologists:

Miss E.M. Smith, M.A. Miss A.M. Marshall, B.A.

Psychiatric Social Workers:

Miss M. Russell Miss J. Court, (Res. 2.6.61.)
 Miss A.M. Laquer Mrs. P.A. Pearmain
 Miss J.D. Ford

Speech Therapists:

Mrs. C.S. Yorke, L.C.S.T. Miss J.A. Rasor, L.C.S.T.

Orthoptist:

Mrs. J.A. Maddocks

Play Therapists (Part-time):

Mrs. J. Elkan Miss B. Seccomb
 Miss F. Salzberger

Physiotherapist:

*Miss H. Garratt, C.S.P.

* Appointed by Hospital Management Committee.

Dental Attendants (Part-time to School Health Service):

Mrs. D. Allen (Part-time) Miss N. Hutchinson
 Mrs. S. Dewey Mrs. M. Wright
 Miss G. Hutchins Miss E. Weatherill (Dental
 Clinic Clerk)

Dental Technicians (Part-time to School Health Service):

Mr. G.H. Higgins Mr. G. Allen

Administrative and Clerical Staff:

Mr. F.J. Aylward (Senior Administrative Assistant)

Mr. G.J. Bradley

Mr. R. Newman

Mrs. M. Crosier (Retired 31.5.61)

Mr. R.T. Prudden

Miss M. Game

Mr. A.T. Wade

Miss M.R. Guy From 10.7.61.

Mrs. P. Wells

Miss V. Jennings

Mrs. E. Wood

Mr. G.B. Martin

SCHOOL CLINICS*Aural -*

Monday	2 p.m. - 4 p.m.	Town Hall
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Child Guidance -

Monday to Friday	9 a.m. - 5 p.m.	Child Guidance Clinic, 263, High Street, E.17.
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Dental -

Monday to Friday	9 a.m. - 4.30 p.m.	Town Hall
Saturday	9 a.m. - 12 noon	Town Hall
Monday to Wed.	9 a.m. - 4.30 p.m.	Priory Court
Thursday & Friday	9 a.m. - 4.30 p.m.	Silverdale Road
Monday to Friday	9 a.m. - 4.30 p.m.	West Avenue

Chiropody -

Tuesday	By appointment	Town Hall, Low Hall Lane, Priory Court, West Avenue and Silverdale Road.
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Minor Ailments -

Monday, Wednesday, Friday, Saturday	9 a.m. - 12 noon	Town Hall
Tuesday	9 a.m. - 11 a.m.	Silverdale Road
Monday, Thursday	9 a.m. - 11 a.m.	Low Hall Lane

Massage & Sunlight -

Monday to Friday	9 a.m. - 5 p.m.	Wingfield House School
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Ophthalmic -

Monday (Alt.)	9 a.m. - 12 noon)	Town Hall
	2 p.m. - 4 p.m. }	
Tuesday	2 p.m. - 4 p.m. }	
Wednesday (Alt.)	9 a.m. - 12 noon)	
Thursday	2 p.m. - 4 p.m. }	
Friday	2 p.m. - 4 p.m. }	
Saturday (Alt.)	9 a.m. - 12 noon)	

Orthopaedic -

Monthly (Tuesday)	1.30 p.m. - 4 p.m.	Wingfield House School
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Orthoptic -

Monday	9 a.m. - 12 noon)	Town Hall
Wednesday	9 a.m. - 12 noon)	
	2 p.m. - 4 p.m. }	
Thursday	2 p.m. - 4 p.m. }	
Friday	9 a.m. - 12 noon)	

Paediatric -

Thursday (Alt.)	9 a.m. - 12 noon	Town Hall
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Speech Therapy -

By appointment		Old Monoux School and Wingfield House School
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Immunisation -

Wednesday	2 p.m. - 4 p.m.	Town Hall
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SQUARE PEGS

People who maintain that school days are the happiest in one's life have, one suspects, either conveniently selective memories or else have failed to fulfil their own early promise. However that may be, few would deny the immense importance of the school environment, atmosphere, tradition, teachers and friends, in moulding character and setting standards for the rest of one's life. Discounting the nonsense of the 'old school tie' it is significant that most of those who can afford to do so (of whatever political persuasion) take great care to send their children to the 'right' schools.

The proper placement of the handicapped child is at once a stimulating challenge and a great responsibility to the School Medical Officer. These are all exceptional children who cannot easily be fitted into a normal class and whose needs must be individually and comprehensively assessed. The extent and prognosis of the child's disability, its intelligence, the home conditions and the parent's attitude; most of all, perhaps, the personality structure of the child itself. All these, and other, factors must be weighed and a choice made from the schools available. When this choice is correct the result is soon gratifyingly apparent in the progress shown; when it is wrong the child with a disability already is further handicapped.

The policy of the Ministry of Education is to use every endeavour to place handicapped children in normal schools and most school medical officers endorse this view. The natural result of this is to concentrate in the special schools the most severely affected children - the squarest of square pegs. The gradual replacement, by schools built on spacious modern lines, of the multi-turreted Victorian edifices which contained more stairs than pupils, is making it possible for many handicapped children, even wheel-chair cases, to attend a school be it modern, technical or grammar, which will provide opportunities no special school can afford. This is a welcome contribution towards lessening the need for those necessary evils - the special schools.

Advances in therapeutics too, have removed diabetics from the handicapped category and have so improved the control of epilepsy that many of its victims can live virtually normal lives. A fit once or twice a term does not completely disorganise a class, indeed, the other children are usually quite unconcerned (not so the teachers, but the more stout-hearted of these learn to put up with it.)

The antibiotic drugs have played a major role in eliminating much disabling illness in children. Mastoid infection, a potent cause of deafness in the past, is now rare, as are chronic kidney disease and the permanently damaged hearts which used often to follow scarlet and rheumatic fevers. The 'antibiotic umbrella' together with the advances in surgical technique now permit operations to be undertaken to repair the damaged heart valves in rheumatic carditis and a whole series of repair and shunt operations for congenital heart defects. Children with permanent damage and chronic infection in the lungs can sometimes have the affected lobe or segment removed and, like many of the heart cases, can return to ordinary school life with little or no disability.

But a large share of the credit for reducing the incidence of disabling conditions is owed to preventive medicine. From the Ante-natal Clinic to the Youth Employment Service children's health is supervised as never before. Improved nutrition, housing, clothing and hygiene have all helped to raise the

standards of physical health of our children while the pasteurisation of milk has virtually eliminated tuberculous disease of bones and joints. The universal availability of free medical advice and treatment both by family doctors and at local authority clinics has reduced neglected medical conditions almost, but not quite, to vanishing point. It is impossible to over-emphasise the part played by immunisation. Since 1941 diphtheria (England and Wales) has been reduced from 55,000 cases (3,000 of them fatal) annually to less than 100 cases with a handful of deaths.. During the last ten years the incidence of whooping cough (with its too frequent aftermath of permanent lung damage) has fallen to one fifth and its mortality to one ninth of the 1950 figures. Vaccination against poliomyelitis has already shown a similar trend and it is expected that the proposed vaccination against measles will be equally effective.

It may seem surprising therefore, that Wingfield House, our School for the Physically Handicapped, is full and for the first time for many years has a waiting list for admission. Similarly the Joseph Clarke School for the Partially Sighted has increased its numbers from 43 to 58 in the past five years and the William Morris School for the Deaf from 46 to 53 over the same period. There are, of course, a number of explanations for this. The first is obvious; over forty per cent of the children at the Physically Handicapped School come from Leyton or the Forest Division; Leyton's open air school closed in July 1955 while the school population of the Forest Division has increased during the last ten years from 25,851 to 42,000. The schools for the deaf and the partially sighted serve even larger areas. At William Morris School only five of the fifty-three are Walthamstow children, others coming from as far away as Harlow and Purfleet, while at Joseph Clarke School the catchment area extends from Southgate to Rayleigh. Only eight of these children live in Walthamstow or Chingford.

The second reason is far more subtle; the rising proportion of long-stay cases. There is a progressive change in the kind of physical handicap requiring special school placement. Although the numbers of children suffering from the after-effects of infective conditions have steadily fallen they have been replaced by the children, few in number but individually presenting infinitely greater problems, who are suffering from some form of organic brain damage. Spasticity, athetosis, some forms of epilepsy, many serious eye defects, congenital deafness, inco-ordination and, as is now widely recognised, severe behaviour disorders, may all result from

damage to the brain or from interference with its blood supply before, during, or after birth.

It is well known that German measles contracted during the first four months of pregnancy is liable to cause congenital abnormalities in the child and extensive research is now going on into the effect of similar virus diseases. The Rhesus factor (incompatibility of blood group between mother and child), exposure of the pregnant woman to irradiation, and premature birth from a multitude of causes all tend to produce 'brain damaged' babies. Children of this type form an increasing proportion of those now attending special schools and constitute our greatest problem. Brain damage is irreversible - physiotherapy may prevent a spastic child becoming a bedridden cripple but can never cure it. The child with congenital perceptive deafness may be helped by a hearing aid but nothing can restore its normal hearing. Furthermore, brain damage tends to be multiple: typical is a boy with such severe athetosis that his whole body goes into writhing contortions in the effort to keep his hand steady enough to write his name; his vision is poor and he has to use a hearing aid. As one would expect, he is mentally retarded as well. It is difficult to see what sort of education could fit such a child to take his place in the world or what work he would be capable of. Clearly he is unemployable in the ordinary sense but the alternative of dragging out his days house-bound in idle loneliness on National Assistance does not bear thinking about.

There is a great need to create a few square holes for such children. The Club for the Physically Handicapped held on Monday evenings at the Margaret Brearley School goes some way in providing occupation and companionship but is a poor substitute for work. Could large employers of labour locally be persuaded to carry a passenger? One firm did. A girl paralysed from the waist down and confined to a wheelchair was given a job out of charity. She is now working full time on an assembly line besides doing the cooking and washing at home for her father who is a widower. She is happy, and proud of her job, but she might never have had the chance to try.

Nowadays it is fashionable to compare the relative importance of diseases not by the annual number of deaths they cause but by the 'number of years of useful life lost'. Thus, while 'strokes' account for 14.2 per cent of all deaths and congenital malformations with diseases of early infancy only 2.7 per cent the latter are more socially important since they

affect a whole life-time whereas strokes are largely confined to elderly people who have already completed most of their 'useful' lives. By the same token it is a hardship to become deaf at seventy but a disaster to be deafened e.g. by measles, in infancy. The expectation of life at birth is now 68 years (women as usual, have an extra six) compared with 59 before the war and 40 years a century ago. This does not mean that children now will live nine years longer than their parents and nearly thirty years longer than their great grandparents, but that practically all of them will reach three score years and ten. With a few notable exceptions, already marked for an early death, most of the children attending our special schools can look forward to a lifetime normal in length if not in breadth. Whether they will be seventy years of useful life depends very much upon early diagnosis, treatment and training and, as a necessary corollary, suitable placement in employment of some kind.

Children ascertained as handicapped are required to spend an extra year at school (until 16 plus) to compensate to some extent for the necessarily slower tempo at special schools. If the last two years could be biased (as in Technical Schools) towards some form of vocational training this might be of great benefit to them. One sixteen-year old whose damaged heart condemns him to a sedentary job, wants to become a television servicing technician but he has learned only elementary and some commercial arithmetic and no science whatever. How one could set about organising preliminary vocational training in such small schools I do not know, while with the present staffing position they are practically restricted to the 'three R's'. As it becomes possible to transfer more of the handicapped children to normal schools, so do those who remain tend increasingly to be the heavily and multiply handicapped children. For these the statutory maximum of twenty to a class is far too high to afford them the individual help they ought to have and there is a great need for more teachers to undertake this necessary and rewarding work. On leaving school all substantially handicapped children are notified to the County Welfare Officer at Chelmsford who assumes responsibility, with the Youth Employment Officer, for their future welfare. It is perhaps unfortunate that the Health Department cannot continue to supervise the welfare of these young people whose disability is, after all, due to a medical condition.

For the future I do not believe that the number of children needing special school placement will be much further reduced. Indeed, for the physically handicapped it may increase

and for the mentally handicapped it is certain to do so. Socio-economic conditions during the past twenty years have tended to encourage the least responsible parents to have the largest families. One Walthamstow family taken into care last year because of the father's fecklessness consisted of nine children ranging from 3 to 13 years of age. It has been shown that 'Problem Families' who need constant help and supervision by the Health and Welfare Departments to maintain even minimum standards have, on average, exactly twice as many children as their socially and economically self-reliant neighbours. Conversely many men and women whose lives have been of inestimable benefit to the community and whose qualities of mind have won them prominence and universal esteem, have no children or, at most, one or two. There is a progressive increase too, in the number of illegitimate births which now account for 5.4 per cent (more than one in nineteen) of live births throughout England and Wales. London, because of the facilities and anonymity provided by a great city, tends to import these problems and for 1960 the figure for the Administrative County was 6,530 illegitimate births, representing 11.4 per cent or one out of every nine babies born! These unfortunate children experience not only an increased mortality (in 1960 the Illegitimate Infant Mortality Rate in Walthamstow was 54.5 per thousand compared with 16.7 for legitimate infants) but also an increased liability to suffer from mental and physical defects. It is not surprising that this should be so; children are just as likely to inherit the mental and physical characteristics of their parents as to resemble them in appearance. Although individual psychologists and sociologists vary in their assessments of the degree to which intelligence is dependent upon heredity (and we can all think of exceptions) one generally accepted view is that parents' intelligence and environment together account for 80 per cent of the difference (above or below average) in the intelligence of the child and, in this context, heredity is four times as important as environment. It is significant that the Ministry of Education estimate an increase in the provision of special school places for the educationally subnormal from the present figure of 34,500 to 54,000 by 1965.

The trend is less clear with the primarily physically handicapped child but we are coming more and more to be concerned with hereditary and congenital conditions and little progress has been made in combating these. Techniques like exchange transfusion of the entire blood volume may save the life of a baby affected by Rhesus incompatibility and improvements in obstetric and paediatric techniques enable many infants

who would formerly have died to survive but, unfortunately, sometimes they only just survive and prove to be substantially handicapped. One would expect a reduction in the numbers of children suffering from familial defects such as haemophilia since the high mortality rate should make these conditions self-limiting but as many as 50 per cent of cases now arise, *de novo*, in previously normal families as a result of genetic mutations. The only known cause of mutation is ionizing radiation and there is little hope that the level of radioactivity will diminish.

Our provision of special schooling and of the employment and welfare services for handicapped school leavers ought to be designed with these problems clearly in view. There is a world of difference between a child whose legs are crippled by polio, but whose brain and body are normal and a cerebral palsied cripple whose whole body and brain and not merely his legs, are affected. The former is a child with a handicap while the latter is one example of that much greater problem, the multiply handicapped child. These are the unhappy few who need comprehensive and continuous help, not merely at school but throughout their lives.

GEOFFREY POOLE.

A SURVEY OF PHYSICALLY HANDICAPPED CHILDREN

For some years a progressive change has been noted in the types of defect leading to the placement of children in Open Air or Physically Handicapped Schools. Preventive medicine and improvements in nutrition with earlier and more effective treatment have greatly reduced the numbers disabled or debilitated by infective conditions while other factors (discussed elsewhere in the Report) have enabled many physically handicapped children to be accommodated in normal schools.

The stage has been reached where it appears necessary to review critically our provisions for the special educational treatment of physically handicapped children in the light of conditions now prevalent, as illustrated by a survey of the pupils at present attending our School for the Physically Handicapped at Wingfield House. This school has an establishment of 95 places and, at the end of the year, 94 children were in attendance arranged in five classes, as shown in Table I.

TABLE I

CLASS	GROUP 1 Acquired Physical Defects	GROUP 2 Hereditary and Congenital Conditions	GROUP 3 Psycho-somatic Disorders	GROUP 4 Miscellaneous	Brain Damaged Children in Groups:			
					1	2	3	4
I - 16 children, average age 6 yrs. 6 mnths. Range 4-8 to 8-9 1953 - 1957	Rheumatic heart 'P' ...1 Recurrent bronchitis...1	Epilepsy.....1 Malformation of limbs.....1 Heart Defect.....1 Arthrogryposis.....1 Pituitary deficiency.....1 Fragilitas Ossium.....1 Cerebral Palsy.....4	Asthma.....2 Asthma and Eczema 'P'.....1	Leukaemia.....1	-	1	-	-
Totals: 16	2	10	3	1	-	4	-	-
II- 19 children, Average age 8 yrs. 8 mnths. Range 7/4-11 1951 - 1954	Bronchiectasis.....1 Chronic Bronchitis.....1 'P'	Epilepsy.....1 Multiple Deformities.....1 Haemophilia.....2 Arthrogryposis.....1 Fragilitas ossium.....2 Renal malformation.....1 Heart Defects.....2 Cerebral Palsy.....4	Asthma.....1 Asthma and Eczema 'P'.....1	Maladjusted.....1	-	1	-	-
Totals: 19	2	14	2	1	-	4	-	-
III- 19 children, average age 9 yrs. 11 mnths. Range 7-6 to 12-11 1949-1954	paralytic Polio.....2 Recurrent Bronchitis...2 Cerebral Palsy (post meningitic)....1 Epilepsy (post encephalitic).....1 Bronchial Asthma.....1	Muscular Dystrophy.....1 Hirschsprung's Disease.....1 Hepatic Fibrosis.....1 Epilepsy.....1 Rhesus C. Palsy.....1 Asthma and Eczema ('P'1).....3	Asthma.....2	Delicate 'P'.....1 Enuresis 'P'.....1	1 1	1 1	- -	- -
Totals: 19	7	8	2	2	2	2	-	-
IV- 20 children, average age 12 yrs. 1 mnth. Range 9-8 to 16-1 1945 - 1952	Recurrent Bronchitis...1 Bronchiectasis 'P'.....1 T.B. Spine.....1	Multiple deformities.....1 Arthrogryposis and Epilepsy...1 Heart Defects.....2 Scoliosis.....1 Muscular Dystrophy.....1 Asthma etc. (1 'P').....5 Cerebral Palsy.....4		Delicate.....1 Immaturity.....1	-	1	-	-
Totals: 20	3	15	-	2	-	4	-	-
V - 20 children, average age 14 yrs. 6 mnths. Range 12-11 to 16-11 1945 - 1949	Rheumatic Heart.....1 Ileo Colitis.....1 Fractured femur.....1 Bronchitis and asthma..1	Epilepsy.....2 Heart Defect.....1 Spina bifida.....1 Malformation (absence of hands).....1 Asthma, etc.....3 Cerebral Palsy (one athetoid).....4 (one Rhesus).....1	Asthma.....2	Maladjusted.....1 (post meningitic) Delicate.....1	-	2 1	- -	- -
Totals: 20	4	12	2	2	-	4	-	-

NOTE: 'P' indicates that the child is one of a 'problem family' and that poor home environment is a significant factor in its retention at a special school.

The second table gives comparative totals for 1950 and 1961. (Percentages in Brackets).

TABLE II

Year	GROUP I	GROUP II	GROUP III	GROUP IV	TOTAL	Number with Brain Damage
1950	64(61.5%)	27(26%)	4(3.8%)	9(8.7%)	104	15(14.4%)
1961	18(19.2%)	59(62.7%)	9(9.6%)	8(8.5%)	94	26(27.7%)

These figures clearly show the increasing proportion of children admitted because of hereditary and congenital defects (which usually cannot be prevented and often are not capable of effective treatment). These, with the psycho-somatic disorders, now account for just over 72% of the children compared with 30% in 1950. During the same period the proportion suffering from acquired defects fell from 61.5% to 19.2, while the number of children suffering from brain damage has almost doubled. It follows naturally that a high percentage of intellectually impaired children are included and Table III gives the normal distribution of intelligence quotients contrasted with those estimated for the Wingfield House children in 1950 and 1961.

TABLE III

Intelligence Grading	E. S. N. (69 or less)	DULL (70-84)	BELOW AVERAGE (85-94)	AVERAGE (95-104)	ABOVE AVERAGE (105-114)	SUPERIOR (115 and above)
Normal Distribution %	1	14	20	24	22	19
Wingfield House 1950	11	13	34	32	6	4
Wingfield House 1961	12	38	17	22	2	9

This table shows a definite shift to the left: 50 per cent of the Wingfield House children now fall into the dull and E.S.N. categories compared with 24 per cent ten years ago and the 15 per cent of a normal population. This is associated with a higher proportion of brain damaged children. Thus the eighteen cerebral palsied children have an average I.Q. of 76.55 and the six epileptics average just below 66. The relatively high proportion of children in the 1950 school who scored 'below average' is probably mainly accounted for by loss of schooling due to physical illness - a factor which is now much less significant.

Table IV gives the numbers in each of the selected years grouped under their main disabilities and demonstrates the great reduction in preventable physical conditions.

TABLE IV

<i>Disability</i>	<i>1950</i>	<i>1961</i>	<i>Disability</i>	<i>1950</i>	<i>1961</i>
Anaemia	1	0	Malnutrition	2	0
Asthma	12	22	Muscular Dystrophy	3	2
Bronchitis and Lung Diseases	18	7	Poliomyelitis	5	2
Cerebral Palsy	6	18	Rheumatism	10	2
Congenital Malformations	4	23	Tuberculosis (incl. contacts)	19	1
Epilepsy	6	6	Miscellaneous	18	11

In Tables II and IV we have grouped children under their principal handicap but it is not possible to convey the true picture in this way since so many of them have two or more major disabilities. The position is further complicated by the existence of different causes for the same disabilities; with the asthmatics, for example, we have placed two children in the acquired group since their condition is secondary to lung infections while there are eleven children whose asthma is clearly hereditary and nine in whom the psycho-somatic factor predominates. The following examples may explain our recognition of different causes for the same symptom complex.

1. E.R. had two severe attacks of pneumonia in infancy and subsequently developed recurrent bronchitis and asthma. Because of very poor attendance at her infants' school she was admitted to Wingfield House at the age of seven. In the two years she has been with us she has grown $4\frac{1}{2}$ inches and gained $10\frac{1}{4}$ lbs. She has advanced two and a half years in educational progress and responded so well to physiotherapy that her chest is now clear and she will soon return to normal school. During the last term she has been absent for two days only.

2. M.B. on the other hand, is a typical case of the hereditary eczema/asthma complex. Infantile eczema appeared with teething followed later by acute attacks of asthma. He has had several admissions to hospital for broncho-pneumonia but now, at eleven, he is steadily improving. Eczema is still present and he is still liable to sharp attacks of asthma when exposed to any stress or anxiety as occurred when transfer to ordinary school was requested by the parents. After two years Michael is still not ready to leave us but his condition continues to improve slowly (there is a strong

tendency to asthma in his mother's family). He is of good average intelligence and school progress is entirely satisfactory.

3. In Brian's case there is no family history of a hereditary factor or of severe respiratory infection. He was perfectly healthy until his eighth birthday when father left home and Brian and his mother had to seek shelter with friends. His asthma attacks date from this time and are precipitated by any anxiety or stress. He is now thirteen and free from attacks at school but they occur most week-ends while at home. His intelligence is well above average, 133 on Performance Tests, but this falls to 104 on a verbal scale and his reading age is only eight and a half. His real ability is inhibited and his asthma provoked by psychological factors. He is receiving psychiatric treatment and still needs the security of the sheltered environment of the Special School.

The difficulties in classifying the multiply handicapped child are illustrated by the cases of Jean and Neville.

Jean, a perfectly normal child, developed tuberculous meningitis at six. This left her with a partial paralysis, her right arm and leg being practically useless, the latter being in irons. To add to her troubles severe epileptic fits developed as a result of the damage to her brain and her functional intelligence has steadily declined to its present I.Q. level of 53. She is partially deaf with a hearing loss (bilateral) for all frequencies of between 20 and 30 decibels. Jean is now fifteen, a tall, pleasant, docile girl, who walks with a marked limp holding her paralysed arm close to her side. Although drugs have reduced the frequency of her fits, when these do occur they are severe. She is now making very little academic progress but she is developing socially and emotionally. Her subsequent placement will be a problem as there is little likelihood of her ever being economically employable.

Neville is little better; at fourteen and a half he is a gentle, pleasant lad with strong glasses. All his movements are hampered by gross athetoid inco-ordination due to brain damage. He can walk, after a fashion, with his legs spread wide apart but he prefers to hold on to walls or furniture for support. He frequently falls to the ground because it is quite impossible for him to recover his balance, and he cannot go into the streets alone. His intellectual capacity is of low average standard and his

school work is consistent with this apart from his written work. Writing, like feeding himself, or any controlled movement, is extremely difficult for him.

Two more examples of the problems presented by handicapped children may be given.

1. David was severely deformed at birth, both hands were absent and both feet deformed. He was sent (in another area) to an ordinary school and at first did well enough. Later it became obvious that he was very unhappy and he came to us, where he has settled down and is making good progress within his limitations. Very young children are surprisingly unconcerned by gross deformity in themselves or in their companions but with the development of self consciousness which reaches its peak in adolescence these unfortunates must suffer great mental anguish in a community of normal children. From the first award of cardboard stars in the Baby Class, competition is one of the most valuable spurs to the normal school child but competition with normal children can be utterly demoralising to the heavily handicapped child.

2. Susan, at eight, was a very beautiful child; she was also a moderately severe spastic and the youngest, and the pet of a large family. She looked like a little princess and was quite content to sit in regal immobility while her parents, brothers, sisters, aunts and cousins delighted in anticipating her every need, waiting on her hand and foot. No amount of explanation or pleading prevailed: her family could not bring themselves to allow her to attempt, in her clumsy and awkward way, to do anything for herself. Gradually she was losing all initiative and her stiffened limbs were wasting from disuse. She had to be sent to a residential special school to protect her from the devotion of her family.

This survey attempts to show some of the difficulties now encountered in providing for severely handicapped children the 'type of education suited to their age, ability, and aptitude'. Even dealing with individual children the educational problems are bad enough; when dealing with groups of twenty they are very much greater. Thus the enormous scatter in physical and mental ability throughout the school has led to far too broad an age grouping in the classes, from seven and a half years to nearly thirteen in Class III and from under ten to over sixteen in Class IV. Even so, many very dull or severely handicapped children have had to be 'promoted' on age and size alone although they were incapable of more advanced work. Only with sufficient teacher time to allow of much individual and small

group tuition can education to any reasonable standard proceed in circumstances such as these. One of us has referred elsewhere to Special Schools as 'necessary evils'. That they are, and will continue to be, necessary, is clear but they are evils only in so far as they fail to provide their pupils with the opportunities for full educational and social development which would be offered by a normal school.

GEOFFREY POOLE and G.M. WILLIAMS

EMPLOYMENT OF HANDICAPPED PUPILS

Mr. Arthur Harvey, Youth Employment Officer, has kindly contributed the following observations on the employment of handicapped pupils.

When considering handicapped young people, the Youth Employment Service personnel, while conscious of their responsibility for the vocational guidance and successful placement in employment, are also aware of their own limitations. They are not specialists, trained to recognise the limitations of the physically, mentally or emotionally handicapped, and must, therefore, rely upon the specialists for a detailed assessment of the abilities and needs of the individual concerned, and use their own knowledge to interpret this in terms of the employment situation.

Two problems emerge: Firstly, the large number of specialists, who may have a legitimate interest in the young persons, plus a number of others who may be self-appointed. It is no exaggeration to say that in many cases there could be a dozen such professional and voluntary, social and welfare organisations (each passing the buck?). Where do the specialists draw their line? Where can they co-operate? Where do they overlap? How often does each feel the other is overstepping the mark? Secondly, the Youth Employment Service personnel have unrivalled experience of placing 'normal' young people in 'normal' employment - and that's a difficult enough specialism with heavy case loads, when one reflects on the many other duties - but in many cases of handicapped young people the employment has to be *devised* to suit the individual and an employer found who is prepared to do so. How often one hears the words 'employers are not in business as a charitable organisation'!

When all the resources of specialists have been called upon, it is still the responsibility of the Service to find, or create, employment for the young person, and to follow

this up by keeping them in employment. Obviously, in some cases, it is unable to create within normal industry, the right employment. Yet it is so important to *start* them right. A process of trial and error will only increase their handicaps. What then, if the Service fails? Some may go into sheltered communities, where it does not matter if they are not economically self-supporting, and where work is created for them. Certain handicaps have better organised facilities for this than others, but good as these are, the young people are being denied the privileges of normal society. Some welfare authorities are able to provide small units where a few people of varying handicaps may work together as a unit of production, while living at home. These are invaluable, but also extremely rare. In many places, the Welfare Officers are so thin on the ground that they count themselves fortunate if they can call twice a year upon each individual; of what value is this? Perhaps new equipment is needed and may even be replaced - but what care can be given? They are not even specialists in problems characteristic of normal youth. Can they, or the Youth Employment Service, go to work with the youngster for repeated spells to size up his problems and keep him at it? Can either really be the prop on which *at any time* he may lean? Can either, in other cases, take 'devised' work to the home, instruct and care for the young person? The Youth Employment Service and the Ministry of Labour, have, within their establishments, officers who do specialise to a great degree in assisting the handicapped, but can never go to such lengths as these. Some young people are, therefore, homebound, workless, draining in confidence and ability, virtually written off everything except the finances of the National Assistance Board. Fortunately, they are not many. They are still too many.

How can the situation be improved? Primarily, by making one person only responsible for the care of a youngster. A succession of callers asking for repetition of extremely personal and private case histories and leaving with a pat on the head and vague words of assurance is just not good enough. The one person must *care*, be able to spend as much time as the case needs, and in a sense, acting in loco parentis and as a mediator between the young person and all the assisting agencies. It follows that this should be a locally based person, well acquainted with the medical and/or psychological aspects of a case, able to educate the parents - of whom more presently - and to assist the young person to adjust himself to society directly, rather than through too many agencies.

In the opinion of the writer, just as in schooldays, the main influences outside the home were the School Medical Officer and the Head Teacher, after school life it should still be the School Medical Officer and a suitably qualified welfare officer on the Youth Employment Staff, or possibly continued (officially recognised as duty and allowable for staffing ratios) interest of a member of the school staff with exceptional freedom within the Youth Employment Service, youth service and further education generally. All others should 'stand-off', having confidence in these and assisting rather than negatively competing.

Parents, it is repeated, need to be educated. There is not space to dwell on this weighty problem; who can tell where springs the love in some apparently impossible cases? The protective sense may, however, be misguided. A little experience in Youth Employment Service would convince one, for example, that parents of some epileptic children are, collectively, the biggest set of liars in existence. But to gain their confidence and enlist their aid - indeed to be effective in the interests of the young person at all - one needs often to take on the whole family. Although much good can be done by voluntary effort and probably little without a 'calling', this is not really a job for an amateur, and into this classification most of us must fall. One is familiar with the activities of many worthy voluntary organisations and would not wish to decry their goodwill or efforts, but an annual bun-fight, concert or outing is not enough.

A section of young people who do not attend special schools, may not indeed attract notice during their school life as being anything other than normal, nevertheless appears in the first stages of employment as virtually a handicapped group. One suspects that many are emotionally handicapped. They are unable to cope with the work situation. Unable to adjust themselves to society. Our pattern of Youth Service, which includes the Youth Employment Service, is of great assistance to us in helping these, but here again the personnel are inadequately qualified and feel that many could have been 'straightened out' earlier, and could be now, except that only in extremely obvious cases are there powers to call in others who are qualified to do it. The remainder go by default. Success is achieved by experience through trial and error. Extreme cases prove the principle, e.g. when they are subsequently referred to the Service by a hospital almoner on their discharge from a mental hospital. What of the many minor cases? - those who flit from job to job, accumulating dozens in a very short time? Waste of manpower. Waste of

human beings. At a saving of how little?

This could, of course, be construed as a case for better training of Youth Employment staff. I would not quarrel with this, but it is also a case for more staff to carry out the job more comprehensively, or alternatively for someone else to do so.

No case histories have been given here. The School Medical Officer has referred to one case which no one would have blamed the Youth Employment Service for writing off as impossible. It was solved by the Service, only by more exhaustive efforts and invaluable time, but most important of all, by *caring*. Time, however, is dearly bought at the expense of others needing guidance.

The Youth Employment Service receives these handicapped school leavers when they are sixteen. The special school, having carried a heavy burden, could not be blamed if it took no further action, but in fact the staff continue to take a great personal interest. Likewise, the Youth Employment Service must pass them on at 18 years of age. They too would be no less than human if occasionally they didn't breath a sigh of relief that the responsibility was now with someone else, but in fact they, like the school, are concerned. Education and welfare must be continuous in these cases. One cannot put time limits on caring for human need. What moral right have we to deny the dignity of labour and acceptance into normal society of those on the fringes? How dare we presume to say we have done all we can? Who knows the solutions which lie just around the corner? A final word; there are some who receive considerable public acclamation of their goodwill and work for a few handicapped youngsters. While not underestimating the value of such work, let us also recognise that it is too easy to rest ones conscience, that because of it all is well. Let us examine, more closely what is *not* done, and put it right; what is done wrongly, and put that right too.

THE WALTHAMSTOW SPECIAL CLASSES

AN EXPERIMENT IN REMEDIAL EDUCATION

THE NEED

Throughout the country there is a shortage of Special School places for children who are mentally or emotionally retarded, and in Walthamstow the disparity between places available (at the Margaret Brearley School) and the number of children found to need such special help has increased steadily during the past few years. Because of the long waiting list (approximately 40 for a 100 place school) priorities had to be determined by the School Medical Officer in consultation with the Educational Psychologist and Head Teacher to fill the few vacancies which arose each term. Consideration had to be divided between the need on the one hand to offer early admission to the worst cases, the relatively low grade children, who would be utterly out of place in a normal school, and on the other, to admit for remedial treatment those children who would benefit most and, after a year or two of carefully graduated study, be fit to return and hold their own in a normal school. Consequently we had the depressing task once or twice each term, of combing through the waiting list to select those children whom we considered to have the highest priority, to fill the half dozen vacancies. Those assessed at lower priority were put off for consideration the next term, and some spent several years on the waiting list until finally removed as too old to benefit.

Many of the children brought to our notice for conspicuous failure to learn proved to have intelligence quotients above that usually regarded as educationally subnormal (about 75) but were, for various reason, incapable of making educational progress without the special help which could not be afforded them in a normal class of up to 40 pupils. It was for children of this type, the potentially remedial cases, that we had long wished to set up small classes in ordinary schools where they could receive individual attention suited to their particular disability from a teacher keen and able to concentrate on remedial work.

The remedial class started at Markhouse Secondary School in 1952 had to be terminated after two years because of the then increasing pressure on available accommodation, but with the transfer of the 'bulge' to the secondary schools in 1958 came the possibility of setting up one or two small special classes, this time in junior schools. The Borough Education Officer, with the willing co-operation of the head teachers

concerned, was able to provide a classroom and a suitable teacher at both Mission Grove and Woodside Junior Schools. The location of these vacant classrooms, resulting from the changing density of the school population, determined the age range for admission to these special classes, i.e. 7-11 years, but this coincided with our opinion of the optimum, that is when children were old enough to co-operate in formal learning yet young enough to secure full benefit from it. To avoid too wide an age range the children were divided so that the younger ones went to Mission Grove and the older to Woodside, irrespective of place of residence. Thus in some cases transport was required and this the Education Committee kindly authorised.

The results obtained by these two classes were so encouraging that a third class was started the next year (September 1959) at Blackhorse Junior School taking mainly children from the middle of the age range, i.e. 8-9 years, allowing a better age grading throughout the three classes, all of which have continued to function excellently and, by diverting the remedial cases, have reduced the waiting list at Margaret Brearley to manageable numbers.

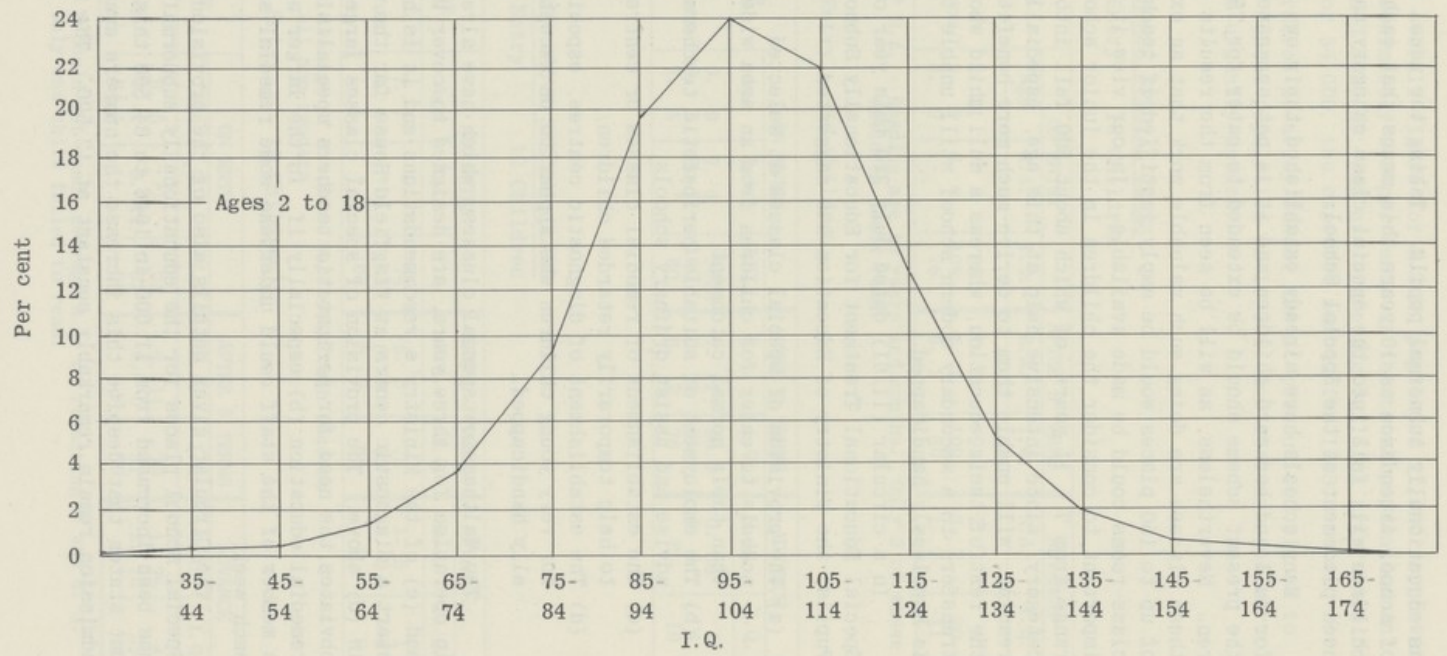
THE SIZE OF THE PROBLEM

Intelligence quotients, mental age expressed as percentage of chronological age, as measured on the Terman Merrill Scale, range from 30 to 170 with a mean value (mode) of 100.

24 per cent. of all children fall within the range (I.Q. 95 - 104) of average intelligence. A further 20 per cent. have I.Q's. of 85-94 and 22 per cent between 105 and 114. Thus two thirds of all children fall within the normal class category from rather bright to rather dull.

Above and below this range the numbers fall off sharply. Only 12 per cent. have I.Q's. of 115 - 124 and only 5 per cent. score 125 - 134. Two per cent. have I.Q's. of 135 - 144 and less than one per cent. are above this. These children (approx. 20%) are the potential grammar school candidates. There remain about 14 - 15 per cent. of children who are below 85 and of these 9 per cent. score between 75 - 84 and should make slow progress in normal schools. We are more concerned with the lowest ranges; the 5 per cent. 65 - 74, many of whom need E.S.N. placement, and the one per cent. below 65 who are frankly E.S.N. including, perhaps, 0.2 per cent. below 50 who are ineducable. For Walthamstow, with a school population of about 15,000 (after deducting 3,000 out-area children attending grammar and technical schools) this means that 750 children (5%) will be so dull as to need some special help, and 150 (1%) will need Special School placement

NORMAL DISTRIBUTION CURVE OF I. Q.'S



as educationally subnormal pupils. Taking the usual duration of school attendance as 10 years this means that each year 75 children will fall into the special class category and 15 will need placement at the Special School.

Many schools have already established their own classes for dull and backward children and it is not suggested that the present scheme should be extended to cater for 750 children. Nevertheless, as will be seen from the results achieved, these classes are doing such valuable work that an extension of up to 150 places would be amply justified if teachers and class-rooms could be made available. In our view it is most important to consider the children in the junior school age range from 7 - 11 years, of which about 300 fall into this category, since intensive help at this age, especially in reading, will enable them to derive much more benefit from the rest of their education, whereas a dull child who transfers to a secondary modern school still unable to read, is hopelessly handicapped.

In a circular (11/61) dated July 3rd this year on Special Educational Treatment for Educationally Subnormal Pupils, the Ministry of Education has suggested:

- (a) The provision of special classes at selected schools to cater for children from an area wider than their normal catchment,
- (b) The employment of suitable peripatetic teachers to advise and assist ordinary schools,
- (c) The establishment of remedial classes or centres to help temporarily retarded children,
- (d) The establishment of diagnostic centres, especially for very young children who appear to be exceptionally handicapped.

The Walthamstow special classes, which have already been in operation for three years, are designed to cover both (a) and (c) of the Ministry's recommendations and it is hoped to start a diagnostic centre at Wingfield House for the purpose in (d) above. The provision of special classes largely obviates the need for peripatetic teachers specialising in remedial education (b) especially if, in the larger schools, a member of the staff could undertake some remedial sessions each week.

The Circular gives details also of the provision of Special School places for the educationally subnormal which has been increased from 11,000 in 1946 to 34,500 this year but states that despite this increase the numbers awaiting admission remain remarkably constant at 12,500. The Ministry

gave an overall figure for E.S.N. pupils of 52,000 representing approximately 0.8 per cent. of the total population in maintained schools, and are approving building programmes to cater for 54,000, the expected number for 1965.

Margaret Brearley School has at present 110 places to serve a school population of 15,000, and at least one more class is urgently needed.

Results

BLACKHORSE SPECIAL CLASS

1959 Entry 16 Children

FACTOR	ON ENTRY			AFTER 3 TERMS		ADVANCE	
	Age	R. A.	I. Q.	R. A.	I. Q.	R. A.	I. Q.
Average	8. 11	*	86	7. 6	91	2. 2	5
Range From/	9. 9	6. 0	108	8. 7	100	3. 7	20
To	8. 0	-	76	6. 2	80	1. 2	-11

* R. A. - Reading age in years and months. Only 3 of these children could read.

1960 Entry 16 Children

FACTOR	ON ENTRY			AFTER 3 TERMS		ADVANCE	
	Age	R. A.	I. Q.	R. A.	I. Q.	R. A.	I. Q.
Average	9. 9	7. 4	90.6	7. 11	96.5	0. 6½	1
Range From/	10. 7	8. 7	100	9. 0	101	3. 0	4
To	8. 5	-	80	6. 2	76	0	-10

MISSION GROVE SPECIAL CLASS

1958 Entry 12 Children

FACTOR	ON ENTRY			AFTER 3 TERMS		ADVANCE	
	Age	R. A.	I. Q.	R. A.	I. Q.	R. A.	I. Q.
Average	7. 7	*	74	/6. 5	75	1. 5	1
Range From/	8. 4	*	83	8. 0	83	3. 0	6
To	7. 1	*	63	5. 9	63	0	0

/ Average of 7. Five were still non-readers

* All non-readers

1959 Entry 15 Children

FACTOR	ON ENTRY			AFTER 3 TERMS		ADVANCE	
	Age	R. A.	I. Q.	R. A.	I. Q.	R. A.	I. Q.
Average	8. 5	*	75	6. 11	78	1. 2½	4
Range From/	9. 1	6. 11	83	9. 0	91	2. 10	22
To	8. 1	-	63	- /	69	-	-4

* 9 could not read, average R.A. of remaining 6 was 6. 4.

/ Only one child failed to read.

1960 Entry 15 Children

FACTOR	ON ENTRY			AFTER 3 TERMS		ADVANCE	
	Age	R. A.	I. Q.	R. A.	I. Q.	R. A.	I. Q.
Average	8. 1	*	80	6. 11	81	1. 4	1
Range From/	9. 4	7. 4	90	8. 3	88	2. 2	7
To	7. 0	-	69	6. 0	69	2	-7

* Only four children could read. Average R.A. of these was 6.8.

WOODSIDE SPECIAL CLASS

1958 Entry 12 Children

FACTOR	ON ENTRY			AFTER 3 TERMS		ADVANCE	
	Age	R. A.	I. Q.	R. A.	I. Q.	R. A.	I. Q.
Average	9. 8	*	75	/6. 4	76	1. 6	1
Range From/	10. 2	6	80	7. 11	80	2. 6	3
To	9. 4	-	63	-	65	0	0

* Only five children could read, their average R.A. was 5. 5.
/ Average of 11. One child failed to read.

1959 Entry 17 Children

FACTOR	ON ENTRY			AFTER 3 TERMS		ADVANCE	
	Age	R. A.	I. Q.	R. A.	I. Q.	R. A.	I. Q.
Average	10. 1	*	74	7. 3	81	1. 1	7
Range From/	11. 0	7. 11	80	8. 8	98	2. 0	18
To	9. 3	5. 9	66	5. 10	71	-6	-6

* Only 12 could read, their average R.A. was 6. 8.

1960 Entry 15 Children

FACTOR	ON ENTRY			AFTER 3 TERMS		ADVANCE	
	Age	R. A.	I. Q.	R. A.	I. Q.	R. A.	I. Q.
Average	9. 10	6. 6*	80	7. 10	81	1. 7	1
Range From/	11. 8	7. 9	88	8. 6	101	2. 11/	20
To	8. 10	-	72	6. 9	70	3	-6

* Excludes 2 non-readers. / Six children made more than 2 years advance.

CONCLUSIONS

These results, remarkably consistent in some ways, show striking differences also. Thus the *average* progress achieved per year at Blackhorse (2 classes), Mission Grove and Woodside (three classes each) was 16.25, 16.16 and 16.66 months respectively. The lower average gain during the second year in all three classes is due to retaining the slower developers for a further year.

It is with individual children that the marked differences occur. One child made $3\frac{1}{2}$ years progress in a single year, a large number advanced by 2 years or more, while some made a few months' progress only. Each class had similar experiences with the best children making advances of between 24 and 43 months (average 34 months) while one or two made no significant progress. Obviously we are dealing with two distinct types of retarded children, the true remedial cases whose performance in the normal school situation and in tests was depressed by inhibitory factors and who, after their confidence had been built up by carefully graduated work, were able to transfer to ordinary classes and hold their own with their age group. Twenty-three children were so placed, thirteen of them after two years in a special class. Most of the remaining children proved to be uniformly dull and remained within the special classes making slow progress within their limitations. Six who were so dull as to need special education permanently were transferred to the E.S.N. School.

These should not be regarded as failures since although they proved unsuitable for remedial education and, with the larger number of dull children who made slow progress above the E.S.N. level, have unduly depressed the progress averages, they have individually benefitted very much from the patient and kindly skill of their teachers in the remedial classes. Nor should it be thought that our inability to determine with certainty beforehand which children will be able to obtain full benefit from remedial methods, is wasteful of special class places. Although we have contrasted two distinct types these are really the extremes of a continuous series. In other words the capacity of these children to learn varies from black to white through all the intermediate shades of grey. The initial I.Q. test, although as independent and comprehensive as possible, is inevitably biased by the child's scholastic attainment and ability to give of its best. Thus a very dull child performing to the maximum of its limited capacity may obtain a higher score than a much more intelligent but very timid child whose response is seriously inhibited. Billy B's I.Q. was 63 when he joined the Mission Grove Special Class in September 1959; a year later it was 85, while Jane P. who started in the same class with an I.Q. ten points higher scored only 69 at the end of the year. The following three examples serve to illustrate the different kinds of problems and response.

1. Richard had always been slow but at the age of seven his development came to a full stop. Father's whereabouts were unknown, and in turn his mother, grandmother and grandfather had died. The intimate family group atmosphere of a special class restored his confidence and, although his I.Q. remained at 74,

he made eighteen months' progress in reading. He also developed a keen interest in figures and used to make up model radio and T.V. programmes, correctly timed and titled, and could talk with interest about them. After a year it was possible to return Richard to normal school ('C' stream). He was, and always will be dull, but he is now well stabilized and working to capacity.

2. Alan was the 'odd man out' at his infants' school; he appeared afraid of everything, including the sound of his own voice, speaking, when he had to, in reluctant whispers. He would not join the other children in work or play. At seven when he was transferred to the Special Class he was an unhappy-looking child, speaking to no-one, and had to be given a non-verbal test, in which he scored only 70. After two terms he would speak a little to his teacher, trusting her enough to begin to join in P.E. It was a major triumph to see him gingerly walking along a form, tightly holding the teacher's hand, instead of remaining pressed against a wall terrified while the other children ran about. Rapid progress was not expected but in two years he had managed to make one and a half years' advance in reading, and his I.Q. rose to 83. His parents, opposed at first to special placement, are now delighted, but Alan still needs to remain in the Special Class for at least another year.

3. At the age of 9 Catherine was still having great difficulty in reading at a 6 year-old level. She was a tense child, thin and over-anxious, who would not stay for school dinners. Considerable persuasion was needed before mother (who in some ways resembled her daughter) would consent to Catherine's transfer to a special class, where almost immediately she began to blossom. So keen did she become that she refused to stay away when unwell and she cheerfully stayed to dinner. She threw herself into the work with enthusiasm and in a single year advanced nearly three years (to 8. 10) in reading age and was returned to her normal school with an entirely different attitude.

We should like to acknowledge the co-operation and encouragement we have received from the Walthamstow Committee for Education, from the Borough Education Officer and his staff and from the head teachers of the schools concerned. The Special Class teachers, all of whom volunteered for the work, have shown endless patience and sympathy in dealing with these handicapped children, and to their skill and devotion is due the success of this experiment.

E.M. SMITH

GEOFFREY POOLE

SPECIAL SCHOOLS

Wm. Morris School for the Deaf. - Mr. K.S. Pegg, Headmaster, reports as follows:-

"The school re-opened in January 1961 with 58 children on roll. During the year five partially deaf and three profoundly deaf children were admitted and 17 left. The children who left were placed as follows:-

Employment	Further training	Residential Deaf Schools	P.D. Units	Hearing Schools
8	1	2	2	4

"The children on roll at the end of the year were classified as follows:-

		Under 5	5-11	Over 11	Totals
Deaf	Boys	-	7	4	11
	Girls	3	3	4	10
Partially Deaf	Boys	-	6	7	13
	Girls	-	8	7	15
Totals		3	24	22	49

CATCHMENT AREA

Barking	2	(2)	S. Essex	1
Leyton	9	(2)	Romford	6 (1)
S.E. Essex	1		Ilford	11 (1)
Forest	14	(3)	Walthamstow	5

(Figures in brackets indicate children travelling by public transport)

Average number on roll .. 54 Average Attendance .. 50

"Children continue to attend the Audiology Unit, Gray's Inn Road, so that impressions may be taken for hearing aid inserts, and during the year children took part in an experiment concerned with binaural speech audiometry tests. Following these tests a number of children were issued with two individual hearing aids in an attempt to prove the value of binaural listening, especially for children with a dissimilar hearing loss in each ear.

"In March, Dr. Dooley visited the school to re-examine children referred from the general medical inspection, and in June Mr. Taylor conducted a full dental inspection. Miss Smith, the Educational Psychologist, has made a number of visits to test children.

"During October each child was issued with an O.L.57 individual hearing aid with a special case - there were six types of case each made from a different material - in an

attempt to find the most suitable case material. The trial was arranged by the Ministry of Health and the Post Office Engineers.

"Four new group hearing aids have been purchased. Two are in full use and the others will be used when the extra classrooms which have been made available to the school are ready for occupation."

Margaret Brearley School for the Educationally Sub-normal. -
Mr. L.F. Green, B. Sc., Headmaster, reports as follows:-

"The accommodation of the school has been greatly improved during the year. An annexe was opened for the two reception classes in the grounds of the Thomas Gamuel Infants' School. This move, along with the moving of a partition to make one classroom where previously there had been two, has given more space for the older boys and girls. In December new toilets were completed.

"A full scale medical and dental inspection was carried out during the year. Mrs. Leach, S.R.N., has continued her valuable visits for checks on hygiene etc. Miss Moseley, Health Visitor, has given regular lessons to the senior girls on hygiene and child care. The clinic staff have been unfailing in their help and understanding of our children's needs.

"A club for the older boys and girls meets one day a week after school. Socials have been held, at which those who have left the school in the past have been made welcome. The sympathy of Mrs. Dowling at the Leyton Baths has enabled many pupils to learn to swim and help the timid ones to have no fear of the water.

"Every effort has been made to get closer co-operation with parents. Many parents attended a meeting to explain what is being attempted for the younger children at the Thomas Gamuel Annexe. Two news letters have also been sent.

"Many visitors have been made welcome: from Training Colleges, from other schools, midwives in training and two students from overseas. Many visits have been made by our own pupils: to London and Whipsnade Zoos, Epping Forest, Hitchman's Dairy, Waltham Abbey, Electric House, Fords, Windsor and the Circus at Olympia.

"Miss Smith, the School Psychologist, has continued with the testing of those pupils who needed review and prior to leaving school.

"At the end of the year 99 children were on roll. During the year, seven children were transferred to Junior Training Centre and one pupil was transferred to a Secondary

Modern School. There were nine leavers placed as follows:-

Factory work ..	4	Shop assistants ..	2
Garage hand ..	1	Machinist ..	1
Occupation Centre	1		

"An 8 m.m. film of various outdoor activities was made as an experiment. It has helped with our observations of the general co-ordination of the pupils, and has given them much enjoyment at seeing themselves on the screen.

"During the year Mr. Bowling was transferred to Wingfield House School. His work and that of all my colleagues has been greatly appreciated by me."

The Joseph Clark School for the Partially Sighted. - Mr. G.M. Williams, Headmaster, reports as follows:-

"At the end of the year the school had 56 children on roll, the increase over the previous year being due to an extension of the catchment area. During the year, children from the following areas were on the school roll.

Essex -

Barking	1	Ilford	3
Basildon.. .. .	1	Leyton	2
Chigwell.. .. .	1	Loughton	4
Chingford	1	Pitsea	1
Dagenham.. .. .	13	Rayleigh	1
Harlow	3	Romford.. .. .	4
Hatfield Heath	1	S. Ockenden.. .. .	3
Hornchurch	1	Walthamstow.. .. .	8
Hutton	2	Woodford	2

Middlesex -

Edmonton.. .. .	5	Southgate	1
Finsbury Park	1	Tottenham	2
Hornsey	1	Wood Green	1

"The wide area represents almost the limit of travel, especially for young children, many of whom are spending almost two hours a day in coming to and from school. There are now 15 children of secondary school age who travel independently by public transport.

"The visual acuity (Snellen) after correction in the school was as follows:-

5 children	had acuity of less than 6/60
17	do. 6/60
14	do. 6/36
23	do. 6/24 or more.

"There were three young children whose visual acuity had not been accurately ascertained. Monocular vision only existed in 21 children.

"The ophthalmic conditions on entry were as follows:-

Albinism	9	Detached retina	2
Optic atrophy.. .. .	6	Cerebral defect of visual pathways	1
Corneal opacities.. .. .	1	Anisometropia	1
Cataracts.. .. .	20	Coloboma	2
Rubella cataract	2	Macular degeneration.. .. .	1
Nystagmus.. .. .	3	Iridocyclitis	1
Retinal degeneration	3	Ectopia Lentis	2
Choroiditis	1	Anitidia	1
High myopia	7		

"Of the children on the school roll during this year it is estimated that there were eight children whose intellectual abilities were above average: 30 were of average ability, 8 were below average, 10 were dull and 6 were within the E.S.N. range.

"As in previous years, ophthalmic care and clinical supervision have been well maintained. In addition to many children being seen by their own ophthalmic specialists, Dr. I. Gregory, M.B., D.O.M.S., made visits in June and November, seeing all new admissions, all potential leavers or transfers, and gave much helpful advice on special problems.

"Dr. Ho and the Eye Clinic staff have also made regular clinical ophthalmic examinations of selected children, and Mrs. Suckling has given a very ready and efficient service in the supply and repair of spectacles. The willing help of all at the Eye Clinic has been much appreciated.

"Dr. Werren medically examined all children at the school during the months of July and October. In November, Mr. Taylor made a full school dental inspection of all children on roll and subsequent treatment was accepted by almost all the children referred. Miss Rasor of the Wingfield House Speech Therapy Clinic made four visits and four children received speech therapy during the year.

"Visitors to the school during the year included Dr. Huss from the Ministry of Education, School Medical Officers from Barking and Romford, a Research Assistant of the London Medical School Dental Department, Student Paediatricians, Training College Students, Pupil Midwives from Essex and Middlesex, Students from Dr. Barnardo's Staff Training College, Youth Employment Officers, Blind Welfare Officers, and a qualified teacher from Australia.

"A small party under the care of Mr. Crosbie spent a week at Weymouth in company with the Woodside School Camp Party. The valuable contacts made between normal and handicapped children were again of value and acknowledgement must once more be made to the Woodside School who so generously allowed us the opportunity.

" In September, Mr. J. Bloomfield took up his appointment at the school with a newly created fourth class, covering the 11-13 age group.

" The school participated for the third consecutive year in the London Partially Sighted Schools' Sports at North House, Wimbledon. The school finished in fourth position, its best performance so far.

" During the summer term a new toilet block was erected and has replaced previous toilet facilities since September.

" There are now 15 senior children who travel to school independently by public transport, eight of these making journeys involving change of buses or trains.

" The average number on roll during the year was 54.7 with an average attendance of 47.96. During the year 12 children were admitted and 7 were taken off roll, as follows:-

2 transferred to residential partially sighted school
 1 transferred to partially sighted grammar school
 4 to employment - 2 boys as laboratory assistant and shop assistant, and 2 girls, one of whom secured an apprenticeship in hairdressing and the other employment in a cereal factory.

" I have to express my thanks to all my colleagues, teaching, welfare and transport for their continuing efforts on behalf of the children."

Wingfield House School for the Physically Handicapped. -

Mr. G.M. Williams, Headmaster, reports as follows:-

" At the end of the year the school had 95 children on roll, drawn from the following areas -

Walthamstow	Wanstead & Woodford	Waltham Abbey
Leyton	Chigwell	Epping
Chingford	Harlow	Middlesex
Loughton	Hornchurch	

" This represents an increase in numbers over the past few years. The average number on roll during the year was 87.5 with an average attendance of 71.9. In this period 38 children were admitted, and 32 were discharged, of which 15 were transferred to other schools. The average length of stay of these children was 2 yrs. 3 mths. Of the 9 children leaving to employment all were placed in employment. Of the children on roll during the year 46 received treatment at the orthopaedic clinic and 12 received speech therapy. There were two non-ambulant children on roll and three who were only partially ambulant.

"Visitors to the school during the year included post graduate medical students from Whipps Cross Hospital, Student Health Visitors, District Nurses, Teacher Training College Students and H.M. Inspectors.

"The school has benefitted greatly from the valued co-operation of Miss Garratt of the Orthopaedic Clinic, and of Miss Razor of the Speech Clinic. Miss Smith, the Educational Psychologist has made visits for the purpose of examination and guidance, and Mr. Harvey, the Youth Employment Officer, and his staff have interviewed all school leavers.

"Dr. Poole, who is in clinical charge of the school has made regular weekly visits and his ready help and advice has been greatly appreciated. Dr. Werren also made four visits for additional inspections.

"Mrs. Leach, S.R.N., has attended daily and has assisted in the general care and management of the children, and has carried out audiometric testing and re-testing on selected children. A total of 516 minor treatments have been given.

"Three staff changes have to be noted - Mr. Ellis and Mrs. Wilson resigned their teaching posts during the year and Mr. Bowling and Miss Young joined the staff in their places. Mrs. Crosling, Senior Welfare Worker, who died after a short illness just before Christmas was greatly missed. She had rendered incomparable service to the school.

"The children on roll at the end of the year were classified as follows:-

Delicate (Category 'j').. .. .	27
Physically Handicapped (Category 'h') ..	65
Epileptic (Category 'f')	3

"I would put on record my thanks to all my colleagues for their continued and steadfast effort on behalf of the school."

CHILD GUIDANCE

Dr. Helen Gillespie, Consultant Psychiatrist, reports as follows on the work of the Child Guidance Clinic:-

GENERAL COMMENTS. -

The psychiatric sessions continued at the same level, that is 11 per week, but 8 play therapy sessions are now worked, instead of 7, as in the previous year.

STAFFING. -

Miss Court, Psychiatric Social Worker at the clinic, left on June 2nd to take up work in a research project for the University of Cambridge. We welcome to the clinic two new Psychiatric Social Workers, Mrs. P.A. Pearmain and Miss J.D. Ford. Miss Ford received her practical training in the Mental Health Course at this clinic. Mrs. J. Elkan was appointed as child psychotherapist last March for two sessions per week. (The total number of sessions now worked by the child psychotherapists is eight out of a total of ten.)

TRAINING OF STUDENTS. -

Two student psychologists in the Walthamstow area have worked at our clinic as part of their practical training, and two students training to be Educational Psychologists at the Tavistock Clinic, did their practical work here.

Four students in the L.S.E. Mental Health course sent to us for part of their practical training 1959/60 have since been qualified, and four more students will be supervised during this academic year.

A teacher training in work with maladjusted children at the University of London Institute of Education, came to our clinic for practical work for a year.

ACTIVITIES OF STAFF OUTSIDE THE CLINIC. -

One discussion group for Health Visitors in Leyton continues, participants numbering 68. The other one, originally taken by Miss Court, will re-start as soon as the newly appointed Psychiatric Social Worker has gained sufficient experience in the field. In addition, case work is being done by the Psychiatric Social Workers with the children at Lea Bridge Road Day School for Maladjusted Children, and at Nazeing Park School, such work mostly necessitating visits to the parents' homes which are scattered over a wide area. With an increase of Psychiatric Social Worker staff, we are glad to record that many more home visits have been made during the year when, for various reasons, the parents were not able to attend the clinic premises. 49 such visits were paid during the year.

Dr. Hoffman gave two talks to the National Association of Probation Officers at their week-end conference on Adolescence, and another talk to the Magistrates at Chingford Town Hall.

An open meeting for all Head Teachers of the Forest Division was held to meet all the Child Guidance teams for Harlow and Walthamstow. This was followed by questions and discussions of our work and its ramifications.

During the year Miss Smith, the Educational Psychologist, gave five lectures to Parent-Teacher Associations, and three informal talks to a Young Wives' Organisation.

LEA BRIDGE DAY SCHOOL. -

Our contact continues with the children placed at Lea Bridge School, and the Psychiatric Social Workers continue to attend case conferences with the school staff, and to visit the parents concerned.

CHILDREN UNDER 5. -

Far too few of these are still referred for consultation. As stressed in my previous reports, work with children under 5 has definite prophylactic value, in preventing more serious difficulties at a later stage of development.

Miss E.M. Smith, Educational Psychologist, reports as follows: -

This year, a great deal of the psychologist's work has been concerned with children at Special schools and in Special classes. The majority of children at the Margaret Brearley school have been re-tested for intelligence and reading attainment. The selection of children for the three Special classes, with later re-assessment of I.Q. and attainment levels, and interviews with parents, is necessarily a time consuming job, though rewarding. Obviously those children are selected who are in greatest need of special help, whose pace of learning and emotional inhibitions cannot be adequately dealt with in the normal sized class. But there remains a quite considerable number of children in normal schools, both at Primary and Secondary levels, who need a limited curriculum and a slower pace. These children are handicapped equally with those who have some diminishing of sight or hearing, though not in such degree as to need to attend special schools. A course of lectures to teachers on the problems of such children was proposed during the Spring term, but this had to be abandoned because of lack of support.

Parents, perhaps more than teachers, need to be enlightened on the educational problems of such handicapped children, and I feel that a series of talks to parents (could they be arranged) would be helpful. Parent-teacher associations often ask for talks of this kind, but many parents who might benefit do not attend such functions, nor has every school a P.T.A. During the year 5 lectures were given to P.T.A.'s and 3 informal talks to a Young Wives organisation.

In general the requests for help about individual children came from Primary schools, but during the year the psychologist has seen children from all types of school, from Nursery to Grammar and Technical schools.

definite recessive mutants (such as cystic fibrosis of the pancreas) when the risk is $\frac{1}{4}$, in the great majority of cases the parents should be encouraged to try again. This is true even when it is known that the defect (such as spina bifida, or cleft palate) tends to occur in families; for the *added* risk caused by this factor is small in comparison to the overall risk of 1:40, and hardly increases it. True, the spina bifida might occur again; but congenital heart disease could occur instead, or a limb deformity, and the total hazard is much the same, as though there had never been a defective baby.

The increased awareness of congenital defect has inspired a fresh assessment of the causes of illness in neonates. During the last 30 years, the idea that cerebral palsy is due to brain injury at birth - generally anoxic - has been steadily gaining ground and is widely accepted. Nowadays many paediatricians are wondering more and more whether in fact such babies were not abnormal before they were born? It is commonplace to find a 'spastic' child after what was apparently a perfectly normal, non-traumatic birth; and it is possible that abnormal labour (such as prematurity, or unusual presentation) might be due to some flaw in the foetus. In other words, the abnormal labour may be caused by 'cerebral palsy' present before birth, rather than be a cause of this condition. Certainly the increased prevalence of congenital deformity (especially of the central nervous system) in the sibs of spastic children is a hint against the theory of acquired injury.

I should like to thank the School Health Officers who sent the children to me, and the family doctors who permitted the referral. I should also like to thank Dr. P. Tettmar, radiologist, and Dr. W. Walther, pathologist, at Whipps Cross Hospital, for kindly allowing me the use of their facilities.

DENTAL CLINIC

Mr. G.P.L. Taylor submits the following report on the work of the School Dental Services:-

During 1961 only two full time dental surgeons were employed but we have received valuable help from a number of part time surgeons. This has enabled the department to inspect and offer dental treatment to considerably more children than in the preceding year.

The staffing difficulty seems likely to continue, and one of the problems involved is to find a part time dental attendant

who is available for the same sessions as the part time dental officer, at the same time that a surgery is free for their use. This means, of course, that a fresh programme has to be arranged each week.

As there seems no prospect of recruiting any full time dental officers, owing to the comparatively low starting salary, we must hope that more part time surgeons will come to help us.

STATISTICAL SUMMARY

SCHOOL POPULATION

	No. of schools	No. on roll (22.12.61)
Secondary	17	9,262
Junior	19	4,959
Infant	20	2,980
Special	4	300
Nursery	1	83

PERCENTAGE ATTENDANCE

	Jan.	Feb.	Mar.	Apr.	May	Jun.	Jul.	Sep.	Oct.	Nov.	Dec.
Secondary	96.7	89.8	93.0	95.4	92.8	91.8	85.7	93.3	93.8	93.2	90.7
Junior	92.2	88.5	91.5	94.3	92.1	91.4	88.0	92.7	93.3	91.7	89.8
Infant	86.9	78.0	80.0	89.6	86.1	86.2	82.4	89.1	87.1	85.5	82.8
Special	84.5	81.4	85.6	89.0	88.0	86.8	82.4	86.8	87.1	84.8	85.1
Nursery	65.0	73.3	81.9	84.9	66.9	79.5	76.8	83.4	77.6	74.8	77.7
Totals	93.3	87.1	90.0	93.8	91.1	90.5	85.6	92.3	92.3	91.2	88.9

MEDICAL INSPECTION

Periodic Medical Inspections -

5 years age group	...	1,279
10-12 year age group	...	1,640
14 years age group	...	2,200
Others	...	825
Total		<u>5,944</u>

Other Inspections -

Special Inspections	...	1,417
Re-inspections	...	1,701
Total		<u>3,118</u>

(i) Individual Children found to require treatment -

Age Groups Inspected (by year of birth)	For defective vision (excluding squint)		For any of the other conditions recorded		Total
1957 and later	-	(-)	3	(2)	3 (2)
1956	20	(12)	137	(52)	144 (59)
1955	27	(17)	133	(56)	149 (71)
1954	12	(4)	37	(16)	46 (19)
1953	13	(7)	13	(6)	21 (12)
1952	12	(8)	15	(7)	20 (10)
1951	111	(82)	130	(57)	210 (136)
1950	95	(68)	113	(42)	182 (105)
1949	31	(18)	33	(15)	58 (32)
1948	45	(35)	32	(18)	71 (46)
1947	29	(22)	27	(9)	56 (31)
1946 and earlier	399	(328)	248	(126)	585 (429)
Totals	794	(601)	921	(406)	1545 (952)

Figures in brackets indicate those children, included in the totals who were already under treatment.

(ii) Physical condition of children inspected -

Age Groups Inspected (by year of birth)	No. of pupils inspected	No. whose condition was classified	
		Satisfactory	Unsatisfactory
1957 and later	4	4	-
1956	655	653	2
1955	620	620	-
1954	192	192	-
1953	88	88	-
1952	65	65	-
1951	773	772	1
1950	613	613	-
1949	297	297	-
1948	260	259	1
1947	177	177	-
1946 and earlier	2200	2200	-
Totals	5944	5940	4

(iii) Defects found at medical inspections -

PERCENTAGE OF DEFECTS TO NUMBERS EXAMINED: -

	1951	1952	1953	1954	1955	1956	1957	1958	1959	1960	1961
Skin	1.9	2.2	3.1	3.9	1.9	3.1	6.1	4.7	4.6	3.8	4.2
Vision and Squint	8.3	8.9	9.0	10.0	11.9	15.2	14.1	15.7	17.1	11.1	14.8
Other Eye	0.7	1.1	1.2	0.6	0.7	1.4	1.1	1.1	1.1	1.0	0.8
E.N.T.	6.1	6.2	6.4	5.4	3.3	5.9	6.7	4.7	4.1	3.6	2.4
Orthopaedic	8.6	7.8	4.0	4.1	3.9	4.1	4.9	5.0	6.4	3.1	2.9
Heart	0.7	0.5	0.4	0.3	0.3	0.4	0.3	0.2	0.3	0.3	0.3
Bronchitis etc.	1.0	1.9	1.2	0.7	0.5	1.0	2.2	1.9	1.3	1.1	1.0
Other defects	3.4	4.8	5.7	3.3	3.8	5.3	5.1	4.4	5.1	4.4	3.6

PERIODIC INSPECTIONS										
	Entrants		Leavers		Others		Totals		Special Inspections	
	Treatm't	Obs:	Treatm't	Obs:	Treatm't	Obs:	Treatm't	Obs:	Treatm't	Obs:
Skin	37	25	103	27	111	64	251	116	26	48
Eyes - (a) Vision	47	62	399	51	348	89	794	202	9	26
(b) Squint	47	16	6	1	37	21	90	38	6	4
(c) Other	16	11	6	13	27	46	49	70	9	10
Ears - (a) Hearing	7	53	2	7	8	62	17	122	14	4
(b) Otitis Media	5	38	5	16	6	27	16	81	1	2
(c) Other	2	6	6	4	5	5	13	15	6	8
Nose and Throat	40	113	17	20	42	90	99	223	34	32
Speech	32	43	1	6	18	18	51	67	18	10
Lymphatic Glands	4	53	3	3	2	50	9	106	1	-
Heart	4	49	10	23	7	83	21	155	-	1
Lungs	36	29	4	9	19	55	59	93	9	9
Developmental - (a) Hernia	-	6	-	-	1	9	1	15	-	-
(b) Other	19	77	34	62	31	165	84	304	3	25
Orthopaedic - (a) Posture	-	27	14	30	25	143	39	200	4	7
(b) Feet	1	7	3	12	10	55	14	74	3	5
(c) Other	30	52	33	28	56	85	119	165	21	34
Nervous System - (a) Epilepsy	-	2	-	2	6	4	6	8	-	1
(b) Other	2	7	13	9	10	24	25	40	4	24
Psychological - (a) Development	5	36	1	1	1	43	7	80	6	10
(b) Stability	8	57	-	6	14	95	22	158	16	12
Abdomen	4	7	1	2	1	15	6	24	3	1
Other	1	1	-	-	4	1	5	2	41	46

(iv) Pupils found to have undergone tonsillectomy -

Age Group	Number Inspected		No. found to have undergone tonsillectomy	
	Boys	Girls	Boys	Girls
5 years	667	612	44	27
10-12 years	790	850	38	38
14 years	1079	1121	170	212
Other	459	366	67	59
Totals	2995	2949	319	336

(v) Pupils found to have defects of colour vision

	Intermediate inspections	Leaver inspections	Others
Tested for colour vision	1572	2200	526
Found to have defect of colour vision ..	18	69	17

(vi) Vaccinal condition of children inspected -

Number inspected			Prophylaxis									
			S.P.		Diph:		Wh.C.		Polio		B.C.G.	
			No.	%	No.	%	No.	%	No.	%	No.	%
5 years Boys	667	389	58.3	603	90.4	492	73.8	488	73.2	43	6.4	
Girls	612	339	55.4	549	89.7	444	72.6	513	83.8	34	5.6	
10-12 years												
Boys	790	335	42.4	680	86.1	432	54.7	594	75.2	30	3.8	
Girls	850	392	46.1	741	87.2	481	56.6	689	81.1	44	5.2	
14 years												
Boys	1079	507	46.9	764	70.8	281	26.0	639	59.2	381	35.3	
Girls	1121	533	47.5	971	86.6	322	28.7	759	67.7	470	41.9	
Others Boys	459	199	43.4	368	80.2	236	51.4	304	66.2	47	10.2	
Girls	366	152	41.5	307	83.9	190	51.9	254	69.4	29	7.9	

(vii) Parents present at medical inspections -

		Number inspected	Number of parents present	Per Cent
5 years	Boys	667	626	93.9
	Girls	612	567	92.7
10-12 years	Boys	790	598	75.7
	Girls	850	707	83.2
14 years	Boys	1079	155	14.4
	Girls	1121	314	28.0
Others	Boys	459	274	59.8
	Girls	366	230	62.8

(viii) Employment of Children - No. of children examined	...	206
(ix) Employment of Children in Public Entertainment	...	Nil
(x) Examinations in School by School Nurses -		
(a) Uncleanliness - No. examined		16,317
No. found unclean		104
(b) Vision - No. tested		9,993
No. referred for treatment		301
(c) Feet - No. examined		4,055
No. referred for treatment		85

TREATMENT

(i) <u>CHIROPODY</u> -	1961	1960
New Cases ...	550	507
Attendances ...	2660	2567

(ii) MINOR AILMENTS -

	New Cases		Re-attendances	
	Boys	Girls	Boys	Girls
Ringworm Head	1	-	-	-
Body	-	-	-	-
Scabies	4	-	-	-
Impetigo	3	1	11	1
Other skin diseases	49	45	353	381
Defective vision and squint ..	26	27	-	3
Other eye disease	17	18	1	4
Ear, Nose and Throat conditions..	111	83	60	42
Speech	26	14	6	1
Lymphatic Glands	1	-	1	1
Heart and circulation	1	1	-	2
Respiratory diseases	11	14	7	7
Developmental defects	56	52	120	149
Postural defects	25	27	12	14
Flat foot	11	5	6	1
Other orthopaedic conditions ..	69	32	32	28
Nervous disorders	34	18	28	23
Psychological disorders.. .. .	36	34	30	24
Various	92	70	104	179
Totals	573	441	771	860

Tonics - Parrishes Food	Cod Liver Oil and Malt	C.L.O. & Malt with Parrishes Food
159 lbs.	44 lbs.	324 lbs.

(iii) DENTAL INSPECTION AND TREATMENT -

Number of pupils inspected - Periodic	age groups	..	..	6601
Specials	..	..	..	1477
Found to require treatment	..	..	..	4524
Number actually treated	..	..	..	4117
Number offered treatment	..	..	..	3707
Attendances for treatment	..	..	..	9477
Half days devoted to inspection	..	..	..	53
- do - treatment	..	..	..	1712
Fillings - Permanent teeth	..	..	..	6048
Temporary teeth	..	..	..	1541
Teeth filled - Permanent teeth	..	..	..	4578
Temporary teeth	..	..	..	1310
Extractions - Permanent teeth	..	..	..	687
Temporary teeth	..	..	..	1837
Anaesthetics - General	..	..	..	512
Local	..	..	..	1244
Pupils supplied with artificial dentures	..	..	..	48
Other operations - Permanent teeth	..	..	..	1285
Temporary teeth	..	..	..	569

Orthodontic treatment	Orthodontic Surgeon	Dental Officers
Cases commenced during year	62	38
Cases brought forward	255	281
Cases completed	116	27
Cases discontinued	17	10
Removable appliances fitted	113	12
Fixed appliances fitted	5	-
Number of sessions	132	45
Total attendances	1203	289
Cases seen in consultation with Dental Officers	105	
Oral Hygiene (to 30.6.61) - Attendances		44
Scalings		17
Polishings		42
Gum treatments		5

(iv) SPECIALIST CLINICS -(a) *Eye Clinic*

New Cases	Under 7 yrs.		7-11 yrs.		Over 11 yrs		Total	
	Boys	Girls	Boys	Girls	Boys	Girls	Boys	Girls
Hypermetropia	4	11	10	11	7	5	21	27
Astigmatism	21	14	29	33	38	23	88	70
Myopia	5	1	20	35	65	46	90	82
Other eye defects ..	38	33	37	29	25	22	100	84
Totals	68	59	96	108	135	96	299	263

Total attendances 3854

Glasses obtained (a) through the Hospital Service Optician 848

(b) through outside opticians 74

(b) *Orthoptic Clinic* -

New cases 76

Total attendances 905

(c) *Ear, Nose and Throat Clinic* -

New Cases						Boys	Girls
Tonsils and adenoids	..	..	..	..	..	14	5
Nasal obstruction	..	..	..	..	..	8	5
Otitis media	..	..	..	..	..	2	3
Cervical adenitis	..	..	..	..	..	3	-
V.M. Rhinitis	..	..	..	..	..	2	-
Hay Fever	..	..	..	..	..	2	-
Frequent colds	..	..	..	..	..	1	-
Post-nasal tumour	..	..	..	..	..	1	-
Recurrent boils	..	..	..	..	..	-	1
Sore throat/tonsillitis	..	..	..	..	..	1	2
Epistaxis	..	..	..	..	..	4	-
Wax	..	..	..	..	..	1	1
Bifid uvula	..	..	..	..	..	1	-
Eustachian obstruction	..	..	..	..	..	6	1
Catarrh	..	..	..	..	..	-	1
Speech	..	..	..	..	..	1	-
Polyp left ear	..	..	..	..	..	1	-
No defect	..	..	..	..	..	7	2
Defective hearing due to:-							
Otitis media						15	18
Wax						5	-
Cervical adenitis						2	3
Following measles/S.F.						1	2
Eustachian obstruction						-	3
Nasal catarrh						2	-
Upper respiratory infection						2	1
Nasal obstruction						7	1
Deviated Septum						-	1
Cause unknown						7	2
Totals..						96	52

Attendances - New cases	148
Old cases	187
Total	335

Cases referred to Hospital -

Tonsillectomy	42
Removal tumour	1
Cauterisation	1
Exploration mastoid	1
Polypectomy	1
Xray	2

No. of sessions	45
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(d) Orthopaedic Clinic -

	Boys			Girls		
	5-16 yrs	Under 5 yrs	16-18 yrs	5-16 yrs	Under 5 yrs	16-18 yrs
Anterior poliomyelitis ..	15	-	1	7	-	1
Surgical tuberculosis ..	-	-	-	1	-	-
Scoliosis, Lordosis, Kyphosis ..	89	2	-	104	1	-
Genu Valgum	3	-	-	6	1	-
Genu Varum	1	-	-	2	-	-
Pes Valgus and Valgus ankles	45	7	1	24	2	-
Cerebral palsy	10	1	-	15	1	-
Schlatters Disease	-	-	-	1	-	-
Progressive muscular atrophy	5	-	-	2	-	-
Osteogenesis imperfecta	1	-	-	1	-	-
Talipes (a) Equino varus	5	1	-	3	-	-
(b) Pes cavus ..	2	-	-	-	-	-
(c) Metatarsus varus	1	1	-	1	1	-
Torticollis	-	1	-	2	-	-
Congenital dislocation of hip ..	-	-	-	4	1	-
Hallux rigidus	1	-	-	1	-	-
Spina bifida	2	-	-	1	-	-
Hallux valgus	1	-	-	3	-	-
Perthes disease	3	-	-	1	-	-
Overlapping toes	3	1	-	1	-	-
Hammer toes	5	-	-	-	-	-
Claw toes	5	-	-	-	-	-
Arthrogryposis multiplex congenitae	3	-	-	-	-	-
Transverse myelitis	-	-	-	-	-	1
Taut hamstrings and tendo achilles ..	14	-	-	10	-	-
Post meningitis paralysis	2	-	-	-	-	-
Rotation of tibiae	3	5	-	6	7	-
Other congenital defects	6	3	-	2	1	-
Miscellaneous (including chest conditions) ..	71	6	-	51	7	-
Totals.	296	28	2	249	22	2

New cases seen by Surgeon - School age	86
Under School age	18
Total	104

No. of cases seen by Surgeon - From Physically Defective School	29
From other schools	382
Under school age	41
Total	452

Total number of examinations made by surgeon ..	556
Total number of cases discharged by surgeon ..	101
Average number of examinations per session ..	42.7
Number of treatments given	7971
Number of attendances for after care	1384
Number of sessions held - treatment	441
inspection	13
Number of visits by instrument maker	44
Operations performed	10
Children transferred from Connaught Hospital ..	4
Total number of treatments	9533
Attendances for ultra-violet light treatment ..	178

(e) *Child Guidance Centre -*

Tables I and II

Analysis of Problems Referred and Cases Diagnosed

(WALTHAMSTOW CASES ONLY)

	Referred	Diagnosed
1. Nervous disorders, e.g. fears, depressions, apathy, excitability ..	17	34
2. Habit disorders and physical symptoms e.g. enuresis, speech disorders, sleep disturbances, tics, fits, etc.	15	6
3. Behaviour disorders, e.g. unmanageable, lying, tempers, stealing, sex problems, etc.	42	11
4. Educational e.g. backwardness, failure to concentrate	5	4
5. No basic disturbance of child, i.e. mainly parental overanxiety		5

Table III - Analysis of Cases Closed during 1961

1. Improved and recovered after treatment	27
2. Improved after partial service, i.e. before diagnosis	5
3. Diagnosis and advice only	11
4. Interrupted, e.g. on parents' or adolescent patient's initiative	25

5. Closed for miscellaneous causes (removal from area, placement at E.S.N. school, etc.)	18
6. Spontaneous improvement	4
7. No change	3

(f) *Paediatric Clinic* -

New Cases	Over 5 yrs.		Under 5 yrs.	
	Boys	Girls	Boys	Girls
Circulatory disfunction	1	-	-	-
Pseudosomatic DaCostas Syndrome	1	-	-	-
Heart	12	2	1	1
Syncope	1	-	-	-
Enuresis.. .. .	5	3	1	1
Migraine.. .. .	2	-	1	-
Anxiety Complex	-	1	-	-
Habit Spasm	1	-	-	-
Nightmares	-	1	-	-
Obesity	2	1	-	-
Hernia	1	-	1	1
Persistent vomiting	-	-	1	-
Coeliac disease	-	-	1	-
Undescended testes	13	-	-	-
Varicocele	2	-	-	-
Epilepsy	2	-	1	-
Asthma	1	-	-	-
Bronchiectasis	1	-	-	-
Development	5	2	4	2
Paralysis	-	1	-	-
Shortened fraenum	-	-	1	-
Eczema	-	-	1	-
Swelling in Chest	-	-	1	-
At request of Court	-	1	-	-
Totals.. .. .	50	12	14	5

Total attendances	220
No. of sessions	24
Referred to Hospital	20

(v) *SPEECH THERAPY -*

	High St. Clinic	Wingfield House Clinic
Number in attendance at beginning of year	77	61
Number under observation at beginning of year	27	18
New cases	42	54
Re-admitted	3	3
Transfers from other clinics - Within County	3	7
Cases discharged - cured	28	35
improved	1	7
defaulted	4	1
transferred to other clinics	9	10
left district	3	2
left school.. .. .	1	1
Cases in attendance at end of year.. .. .	79	69
Cases under observation at end of year.. .. .	30	27
Total attendances during year	2108	2160

Analysis of Defects

Stammering and cluttering	42	19
Dyslalia	101	56
Stammering and dyslalia	3	13
Delayed language development	7	26
Cleft palate speech	-	5
Voice defects	2	5
Speech defect due to deafness	1	-
Defects of neurological origin.. .. .	1	12
Probable mental deficiency.. .. .	1	7

(vi) *CONVALESCENT HOME TREATMENT -*

Number of children sent away for convalescent holidays	24
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(vii) *TUBERCULOSIS -*

	Girls	Boys
No. examined for the first time at the Chest Clinic:-		
Referred by School Medical Officers	15	27
Referred by private practitioners	50	46
Examined as contacts	21	22

IMMUNISATION

(a) *Diphtheria* -

Primary immunisations (children of school age)	200
Booster doses (do.)	1283

(b) *Whooping Cough* -

No. of school children immunised	42
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(c) *Poliomyelitis* -

No. of children vaccinated (0 - 17 yrs.)	1844
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(d) *B.C.G.* -

	1961	1960
No. invited	2462	1704
No. accepted.. .. .	1586	986
Acceptance rate	64.4	57.8
Number of Heaf positive	220	116
Percentage positive	14.5	11.7
Number of Heaf negative	1291	859
Number absent	75	11
B.C.G. given	1291	859
Absent or not done	-	1
Conversion tests - positive	761	555
negative	-	2

INFECTIOUS DISEASES

Notifications - 5-14 years

	1961	1960
Measles	625	83
Whooping Cough	14	119
Scarlet Fever	82	116
Pneumonia	1	7
Dysentery	20	64
Tuberculosis.. .. .	3	2
Food Poisoning	1	17
Poliomyelitis	-	1
Diphtheria	-	4
Meningitis	1	-

SCHOOL MEALS SERVICE

Inspections by Public Health Inspectors - Schools ..	34
Kitchens..	88
No. of milk samples taken (all satisfactory) ..	8

NATIONAL SOCIETY FOR THE PREVENTION OF CRUELTY TO CHILDREN

<i>Nature of Offence</i>		<i>How dealt with</i>	
Neglect	25	Warned	42
Ill-treatment	8	In Juvenile Court	2
Beyond control	1	Prosecuted	1
Advice sought	13	Dropped.. .. .	2

No. of children dealt with - Boys 88, Girls 82 (63 under 5 years of age).

HANDICAPPED PUPILS

	<i>No. examined</i>
(a) Blind	-
(b) Partially Sighted	-
(c) Deaf	-
(d) Partially Deaf	-
(e) Educationally Sub-normal	35
(f) Epileptic	-
(g) Maladjusted	13
(h) Physically Handicapped.. .. .	2
(i) Speech	-
(j) Delicate	13

CHILDREN ATTENDING THE SPECIAL SCHOOLS

	<i>Partially Sighted</i>	<i>Deaf</i>	<i>Open Air School</i>	<i>Educationally Subnormal</i>
Walthamstow ..	8	5	48	98
Forest ..	10	14	27	1
South Essex ..	8	2	-	-
Barking ..	2	3	-	-
Dagenham ..	11	-	-	-
Ilford ..	2	7	-	-
Leyton ..	2	9	18	-
Romford ..	4	6	-	1
Middlesex ..	8	-	1	-
Hertfordshire..	-	-	-	-
Mid Essex ..	-	-	-	-
Chadwell Heath	-	2	-	-
Hornchurch ..	1	1	1	-

WALTHAMSTOW CHILDREN IN RESIDENTIAL SCHOOLS

Blind	3	Epileptic	6
Deaf	2	Maladjusted	13
Delicate	4	Physically Handicapped	7*
Educationally Subnormal	5		

* In addition there are two physically handicapped children having home tuition.

MISCELLANEOUS

Staff Medical Examinations - County Council Staff	154
Other Staff	333
Prospective Teachers	75
Entrants to Teaching Profession	37