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CUMBERLAND COUNTY COUNCIL

(Education Committee)

ANNUAL REPORT

on the

SCHOOL HEALTH SERVICE

FOR THE YEAR 1961

JOHN LEIPER, M.B.E., T.D., M.B., Ch.B., M.R.C.S.,
L.R.C.P., D.P.H.

PRINCIPAL SCHOOL MEDICAL OFFICER

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PREFACE

To the Chairman and Members of the Education Committee:

Mr. Chairman, Ladies and Gentlemen,

I have the honour to present the Annual Report on the School Health Service for 1961. The general state of fitness of the school children in the county continues at a now familiar high level.

The maintenance of a comprehensive pattern of vaccination and immunisation injections for school children has again occupied a prominent place in the work of the School Health Service during the year. Additional work was involved in launching the arrangements for introducing tetanus vaccination since many children who would normally have been receiving a reinforcement injection against diphtheria in school were now in fact commencing a series of injections to protect against tetanus as well. The additional visits to schools, together with the summer campaign for the completion of fourth poliomyelitis injections for children aged 5 to 12, inevitably combined to occupy so much of the doctors' and nurses' time that both the routine school medical inspections and the diphtheria immunisation programme itself suffered to a certain extent in consequence. I hope that the deficits in these fields will be eliminated in the coming year.

Two cases of paralytic poliomyelitis were notified in school children during the year, part of a small outbreak in the Maryport area. One of these children had not been protected against the disease and the point is again sombrely illustrated that only as near as possible to 100% protection of the groups eligible for poliomyelitis vaccination will eliminate this serious risk of outbreaks.

I mentioned last year in my Annual Report that the secondment of health visitor/school nurses to general practitioners had been begun and this was further extended during 1961. The school health aspect of this arrangement will, I

feel sure, be in no way behind the other aspects in importance It has always been difficult to achieve as close a link with the family doctor as is desirable in school health work and already the seconded health visitor/school nurses have shown that their new pattern of work is a real step forward in this direction. An interesting account is given in the body of the report by one of the seconded nurses.

I am at present giving some thought to the possible introduction of a greater variety of approach to the medical inspection of school children. It may be that a pilot scheme would be appropriate for certain areas involving a more selective examination of the children after their initial "entrant" medical inspection. I will be discussing this question fully with the School Medical Officers in the present year.

In connection with the all-important work amongst handicapped pupils, particular consideration was given during the year to the handicapped school leaver and fresh and important links forged with the rapidly developing Mental Health Service in the case of educationally subnormal leavers, and in the case of physically handicapped leavers with the new Welfare Section of this department, with its important resources for the support and guidance of handicapped people in the community.

Those children whose "handicap" is primarily social, namely those from problem families, have also continued to receive special consideration. Here again the key position of the school nurse, especially when seconded to the family doctor, is of the greatest value in helping to mobilise all the help possible for the child in the school environment.

The problem of staffing, particularly in the field of medical auxiliary workers, has once again shown its all too familiar chequered form. I have been very fortunate in securing during the year a full establishment of three full time speech therapists, and I do hope that this will be maintained in the interests of this extremely important service for school children. Unfortunately at the time of writing, the orthoptist who

commenced at the beginning of 1961 has resigned and I have no immediate prospect of filling her post. The services of these workers are very difficult to obtain and even more difficult to retain.

The post of Assistant Superintendent Nursing Officer with special responsibility in health education remains vacant but I am most anxious to secure a really first class incumbent for this post. Meantime, the field work in health education has gone ahead quite steadily and an account of this is given in the report.

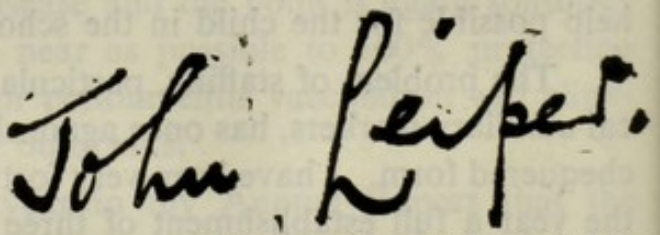
Although a few gaps appeared in the ranks of the Dental Officers in the latter part of 1961, I am glad to be able to report that at the present there is every likelihood of the establishment being filled again in the very near future, leaving Cumberland still in the very happy position of having one dental officer to 3.400 school children. Mr. Martin's departure during 1961 has been very much felt throughout the service and I was glad to welcome Mr. Neal as an extremely able and forward-looking successor.

From colleagues in general and hospital practice, I have once again received much co-operation, and of particular continuing value is the link with Dr. Platt, Consultant Paediatrician.

I wish to thank all who helped in the preparation of this report. The high standard of work of all members of the Health Department has continued to be invaluable.

I am, Mr. Chairman, Ladies and Gentlemen,

Your obedient servant,



Principal School Medical Officer

County Health Department,
11, Portland Square,
Carlisle.
May, 1962.

SCHOOL HEALTH SERVICE

STAFF AS AT 31.12.61.

SCHOOL MEDICAL AND DENTAL STAFF

Principal School Medical Officer—

*John Leiper, M.B.E., T.D., M.B., Ch.B., M.R.C.S., L.R.C.P., D.P.H.

Deputy Principal School Medical Officer—

*J. D. Terrell, M.B., Ch.B., D.P.H., D.C.H.

School Medical Officers—

*John Neil Dobson, M.B., Ch.B., D.P.H.
John R. Hassan, M.B., Ch.B., D.R.C.O.G. (Part-time General Practitioner).
*James L. Hunter, M.B., Ch.B., D.P.H.
*Thomas F. M. Jackson, L.R.C.P., L.R.C.S., L.R.F.P.S., D.P.H.
*Isaac S. Jones, M.R.C.S., L.R.C.P., D.P.H. Resigned 30.4.61.
*Harry C. T. Smith, M.B., Ch.B., D.P.H., D.P.A. Commenced 1.5.61.
*John Patterson, M.B., B.Ch., B.A.O., D.P.H.
*Kenmure J. Thomson, M.B., Ch.B., D.P.H.

The above are also District Medical Officers of Health and Assistant County Medical Officers.

*Gordon G. W. Bennet, M.B., Ch.B., D.P.H. Resigned 11.12.61.
Alix B. C. Halliday, M.B., Ch.B. Commenced 13.11.61.
*Enid M. O. Campbell, M.B., Ch.B., D.P.H.
*Catherine Helen Mair, L.R.C.P., L.R.C.S. (Ed.), D.P.H.
Elizabeth M. Spencer, M.B., Ch.B. Commenced 1.2.61.

*Approved for the ascertainment of educationally subnormal pupils.

Principal School Dental Officer—

A. C. S. Martin, L.D.S. Resigned 31.8.61.
R. B. Neal, M.B.E., L.D.S. Commenced 1.9.61.

School Dental Officers:—

I. R. C. Crabb, L.D.S.
D. H. Hayes, L.D.S.
Mrs. M. Hayes, B.D.S.
F. H. Jacobs, L.D.S.
A. MacDonald, L.D.S.
R. B. Neal, M.B.E., L.D.S. Appointed Principal School Dental Officer 1.9.61.
A. R. Peck, L.D.S.
J. G. Potter, L.D.S.
A. M. Scott, L.D.S.
J. Watson, B.D.S., L.D.S.

MEDICAL AUXILIARY STAFF

Orthoptist:—

Miss Joan Modlin, D.B.O. Commenced 3.1.61.

Orthopaedic Physiotherapists:—

Miss J. A. Fraser, M.C.S.P., O.N.C.
Miss J. M. Morris, M.C.S.P., M.E.

Speech Therapists:—

Mrs. S. E. Latimer, L.C.S.T. (Part-time). Resigned 31.5.61.
Miss E. B. Moon, L.C S.T.
Miss M. E. Rawle, L.C.S.T.
Mrs. A. Taylor, L.C.S.T. (Part-time). Resigned 12.5.61.
Miss C. M. Allan, L.C.S.T. Commenced 4.9.61.

NURSING STAFF

Superintendent Nursing Officer:—

Miss I. Mansbridge, S.R.N., S.C.M., Q.N., H.V.Cert.

Deputy Superintendent Nursing Officer:—

Miss M. Blockey, S.R.N., S.C.M., Q.N., H.V.Cert.

Assistant Superintendent Nursing Officers:—

Miss G. L. Benfield, S.R.N., S.C.M., H.V.Cert., P.H.Admin. Resigned 10.9.61.

Miss P. G. O'Sullivan, S.R.N., S.C.M., Q.N., H.V.Cert.*

Mrs. A. Steele, S.R.N., S.C.M., Q.N., H.V.Cert.

*Completed Public Health Administration course 1.8.61.

Four Full-time School Nurses.

54 nurses and health visitors doing part-time school nursing, of whom 30 hold the Health Visitor's Certificate.

Eleven full-time Dental Attendants.

GENERAL STATISTICS

The area covered by the Local Education Authority comprises 967,054 acres and the estimated population of the Administrative County in June, 1961, was 221,460.

The number of pupils on the school registers in January, 1962 was 38,143, compared with 37,595 in the previous year, an increase of 548.

In January, 1962 there were in the county:—

		No. of Pupils
Nursery school	1	40
Primary schools	248	22,760
Non-selective secondary schools ...	24	9,891
Grammar schools	9	5,054
Secondary technical school	1	303
Residential special schools	2	
(One for educationally subnormal boys, age range 9-16 years)		57
(One for educationally subnormal girls, age range 9-16 years)		38

MEDICAL INSPECTION

The modification of routine medical inspection reported last year as commenced in Millom, continued during the year there, and otherwise the usual three routine examinations at school entry and in the tenth and fourteenth years were applied to other schools. At the time of writing this report, preliminary discussions are taking place on the introduction of a modification of medical inspections in certain of the county schools towards a more selective form of screening in the intermediate age ranges. Once again this year there was a heavy demand on medical officer's time for vaccination and immunisation purposes. As detailed later in this report, protection against tetanus is now being offered to school children, and the beginning of this scheme, together with the additional work in the summer term on fourth injections of poliomyelitis vaccine prevented all of the schools being visited in the year for routine examinations.

Findings at Periodic Medical Inspection

The following table sets out the numbers and proportions of children in each year group found to have some defect requiring treatment and those found "unsatisfactory" in overall physical condition.

Year	Total Periodic Examinations	Total Pupils found to have Defects	%	Total found with unsatisfactory physical condition	%
1961	8,754	715	8.2	9	0.10
1960	9,633	915	9.5	50	0.51
1959	9,985	1,072	10.7 (15.76)	71	0.71 (1.14)
1958	10,887	1,286	11.8	97	0.89
1957	10,864	1,302	11.9 (14.98)	132	1.22 (1.72)
1956	9,783	1,352	13.8	247	2.52

Comparative figures are given for the last six years and the figures shown in brackets for 1959 and 1957 are the available comparative figures for England and Wales.

The total number of pupils found to have defects shows a further drop in keeping with the trend of recent years, while the total receiving the label "unsatisfactory" has come down very steeply, and this year shows a percentage figure of 0.1 compared with 0.5 last year. Even allowing for the fact that a smaller number of periodic examinations were carried out, this figure is both interesting and gratifying—though one is always prepared when there is a steep drop in a figure in any one year to find a certain "rebound" the following year.

The beginning of an important advance in the school health service should be mentioned here, viz. the secondment to work closely with general practitioners of certain school nurse/health visitors. There are now six health visitors who are also school nurses, working in this way, and their attachment to general practitioners involve 23 doctors, 16 of these in Workington and Whitehaven, and 7 in the Penrith area. I am sure that this is forging a link between the general practitioners' work and the school health service which is of very great importance.

I quote from the comments of one of the school nurses involved in this scheme who has had over twelve months' experience of this arrangement now.

"In the Penrith area the general practitioners are consulted readily by most parents when the children are ill; also, children are taken to the doctor on the advice of the health visitor.

Consequently many defects and illnesses are discovered prior to the school medical inspection and are under observation or being treated at the time of the inspection. Information about treatment, or lack of it, can usually be elicited from the parent or child at the time of the inspection, but in doubtful cases a visit by the health visitor to the surgery provides

a quick answer to the problem. For example, enlarged tonsils are often not removed before the child attends school, but the child is under observation by the general practitioner.

Defective eyesight is often discovered by the medical officer and referred directly to the specialist without troubling the general practitioner.

Speech defects are referred to the speech therapist by the general practitioner or the medical officer. The health visitor, who visits school, surgery and home, can obtain useful information about the child's home background, behaviour in school and medical history. For example, she may find a history of prematurity, anoxia or otitis media. Such information may be found in school medical records or be known to the general practitioner. The speech therapist can follow up any information which seems relevant to the case.

Teachers bring to the notice of the health visitor children who are ill in school or frequently absent without good reason. The health visitor can check with the general practitioner whether or not the child is receiving treatment and obtain his permission to ask the mother to call at the surgery with the child. I have recently had a case in point; the home visit showed the mother was dissatisfied with the state of the child's health, but did not realise it was interfering with the education of the child who was listless and inattentive in school. The doctor was willing to see mother and child at the surgery. The teacher expressed satisfaction with the arrangement.

The health visitor concerned with the family should be present when the child is examined at school medical inspections, but this is not always possible owing to her other commitments. There are a number of children, mainly senior pupils, who attend Penrith schools, travelling in from rural areas. The help of the rural nurse or health visitor may be required after a Penrith school inspection. The long standing co-operation between rural nurse and general practitioner proves valuable on such occasions."

While therefore the medical treatment of the school child is in the hands of the general practitioner, his routine screening and the relating of his health to his educational environment is the particular responsibility of the school medical officer. The health visitor/school nurse attached to a general practice and to the school health service, provides an invaluable link. The correct person is at the receiving end for the benefits of a co-ordinated service, namely the child.

This is I believe, a significant advance in technique in the school health service. The broad advance over the years on the other hand is portrayed in very interesting fashion by Dr. Hunter, Senior Assistant School Medical Officer in West Cumberland, who writes as follows of his 25 years in that area:—

"A quarter of a century ago West Cumberland was still suffering from a long period of mass unemployment. In 1936, for instance, the total number of unemployed in Workington was 2,600 in a population of 27,000. In 1961 a state of full employment obtained, or near enough, and few families lacked food in plenty or reasonable comfort although many young families lived in discomfort with relatives. This period of 25 years coincides with my length of service in Public Health in the area. I find it of interest to compare conditions then and now in the environment and life of the school-child, not from an exact statistical standpoint but by personal impressions.

The hazards to the health of the school-child, in fact to a child of any age in 1936 were great, and perhaps greater in West Cumberland in those hard times. By then the cumulative effects of applied sanitary science had almost reached the zenith of their influence on health in relation to environment, although all the lessons had not been thoroughly learnt or fully implemented. Slum clearance programmes and new schools were greatly needed.

The application of sulphanilamide to a wide range of diseases was yet to come and the efficiency of an antigen to provoke protection against diphtheria was being proved mainly in fever hospital staffs.

Diphtheria was still of common occurrence. In Workington, 51 cases were admitted to Ellerbeck Fever Hospital in 1936 with one death. Measles, scarlet fever and whooping cough were leaving a trail of otitis media, infected tonsils, bronchitis and conjunctivitis. Pneumonia, tuberculous meningitis and enteritis were all claiming deaths among children. Infestation of heads was common and scabies was rife and often resistant to treatment—in Workington so much so that special arrangements were made in 1936 for cases to be admitted to the fever hospital.

In the background was a large element of under-nutrition consequent on long unemployment. The incidence of pulmonary tuberculosis in parts of West Cumberland was very high. At that time Whitehaven Education Authority instituted a canteen of some 50 places for the very needy cases of undernourishment in school-children. Milk for school-children was introduced in the distressed areas. Clog funds provided a minimum of footwear and steel-framed spectacles were issued free of cost.

It is easy to remember the conditions prevailing before the second world war but difficult to assess how much damage may have been passed on to the succeeding generation. War and the introduction of new industries changed the whole picture. On the medical side new drugs and an increasing armamentarium of preventive measures have had a significant effect on the health of the child. New schools and improving means of physical education have added to his wellbeing.

A school-child of today may well pass his ten years or more at school with little interruption by illness and little hazard to his health, minor or major. He may never need to attend a school clinic and the only medical incidents in his educational progress may well be periodic examinations, booster injections and screening tests of vision and hearing. He is more likely than not to retain his tonsils and not likely to have running ears. He will on the average be bigger and better nourished than his father was—indeed he may have to

guard against becoming overweight. He qualifies for milk during lessons and perhaps also a balanced hot meal at mid-day. In his schooldays death is likely to pass him by except through the misfortune of an accident, or, in the rare instance, by the genetic inheritance of some factor which makes him prone to the rarer diseases that kill. He has a rather less than fifty-fifty chance of being protected against smallpox, and an eight in ten chance against diphtheria and poliomyelitis. His name may now be recorded in the casualty department of the hospital as having had a course of anti-tetanus toxoid against the day he arrives there with an open injury. He is likely to carry the scar of B.C.G. vaccination into his place of employment or training, with the assurance of preparedness against tuberculosis. He has wider horizons in school—physically through great panes of glass, and scholastically in an extended range of technical and other subjects; at home —perhaps on the television screen. Whereas his father carried odd coppers he has silver in his pocket and is more inclined to indulge in sweets and tobacco, thereby raising extra risks for the future.

Although he may not appreciate it, he is being studied and weighed up — to see if in fact all the medical care that has in the past been expended upon him is, in his present good circumstances, the best expenditure for his total good; to see if some energies should be directed away from this phase of his life to the elucidation of factors that may produce for him a stillborn or handicapped brother; to the provision of further screening tests at the age of forty; and to the search for better ways of sustaining him in the needs of old age".

Dr. Spencer writes of her impressions at school medical inspections:—

"The average Cumbrian school attender is now a strong robust well-fed child with only the occasional short illness to mar his history. At five years old he is well adjusted, bright eyed and eager to start school, and at 10 years old he

is quite satisfactory. Very few show hearing defects and those with defects of vision wear spectacles willingly on the whole.

The boys and girls of 14 are often about to change the way of life they have known for the last 10 years for another largely unknown. When interest is promoted to pave their way socially in, for example, walking, climbing groups, camping, Y.H.A., golf, sailing, etc., the transition is easier. I do not mean just telling them but encouraging boys and girls in their last 2 or 3 years at school to become members of the rambling clubs, tennis and golf clubs, the Y.H.A. and scout movements."

Cleanliness

In 1961 authorised school nurses made 79,007 examinations for cleanliness and 1,269 children were found with either live parasites or nits in their hair. The number of examinations carried out in the previous year was 72,226 and 1,531 children were found to be affected. This had been a rather alarming rise on the previous year's figures and it is pleasing that there is a downward trend this year. The number is however still high enough to require this situation to be kept under very close review.

Because of the well recognised difficulty of eliminating infestation completely from certain homes, the control of the problem in the case of the children often occupies a disproportionate amount of a school nurse's time. The maximum protection must however be afforded to the perfectly clean child who would never suffer from head infestation apart from contact with his less fortunate fellows in school. The helpful co-operation of teaching staff in sorting out the children from time to time in order to keep exclusion from school to a minimum, is much appreciated but the total figures are still much too high for complacency.

Employment of Children Bye-Laws

There were 430 examinations carried out during the year and this involved 351 children. The routine of six monthly re-examinations was observed throughout the year. The following table gives details:—

Examined for 1st time	Re-examined once	Re-examined twice
321	63	8

Of the 321 children examined for the first time, 2 were found to be unfit. There were several missed appointments during the year and a second appointment had to be made in these cases. If this second appointment was also not kept, the Education Department were informed that the child's registration for employment should be cancelled.

ASCERTAINMENT AND TREATMENT OF DEFECTS

School Clinics

The school clinics available are set out in Appendix "D" to the report. A total of 1739 individual children attended the school clinics during the year, attendances at individual clinics and the types of case are set out below.

Clinic	New Cases	Total Attendances see notes
Alston	—	27
Aspatria	19	324
Brampton	150	29
Carlisle	9	68
Cleator Moor	30	241
Cockermouth	124	152
Egremont	78	142
Frizington	38	17
Keswick	12	262
Maryport	100	215
Millom	88	37
Penrith	25	106
Whitehaven (Mirehouse)	38	715
Whitehaven (Flatt Walks)	216	505
Whitehaven (Woodhouse)	143	221
Wigton	91	853
Workington	232	36
Parton	7	
	1,400	3,950

SCHOOL CLINICS

Defect Code No.	Conditions for which child attended	New Cases					Total Attendances				
		1961	1960	1959	1958	1957	1961	1960	1959	1958	1957
1	Cleanliness	1	5	1	5	2	7	16	6	11	4
2.	Infestation	6	51	38	73	32	13	126	146	219	116
4.	Skin diseases	524	827	628	508	933	1867	2906	2448	2092	3386
5.	Eye diseases	298	270	352	380	511	698	855	1109	1237	1716
6.	Ear conditions	63	72	99	105	92	233	247	356	316	379
7.	Nose and throat conditions	37	55	78	124	99	77	128	143	205	205
8	Speech defects	22	25	20	31	26	26	34	25	44	27
9.	Lymphatic glands	3	3	6	3	11	7	5	10	18	31
10	Heart	2	5	4	1	9	4	17	10	3	22
11.	Lungs	23	21	44	53	59	51	97	232	216	248
12	Developmental	2	1	3	—	8	8	9	7	1	19
13.	Orthopaedic	35	84	110	101	67	54	132	196	194	120
14	Nervous system	7	19	24	10	34	12	256	156	62	89
15.	Psychological	16	15	16	27	21	29	34	35	51	38
16.	Abdomen	5	17	6	23	19	8	40	16	44	36
17.	Other conditions	356	732	735	909	1093	856	1826	1828	2867	3022
		1400	**2202**	**2165**	2353	3016	3950	6728	6723	7580	9458

Following something of a peak in attendances for minor skin conditions in 1960, the attendances at clinics during the year on this account reverted to a figure more in keeping with the trend over the past few years.

Commenting on the way in which the pattern of school clinics has altered in one particular area, Dr. Patterson writes as follows:—

"If I may take Cockermouth as an example as to how a change has evolved: Monday mornings were 'school clinics' and Monday afternoons child welfare clinics. Because school clinic attendances were falling, and mothers could not always attend in the afternoon, particularly rural mothers, Mondays became a 'general clinic' operating all day, with a health visitor present in the morning and a health visitor and medical officer present in the afternoon.

Here we have let it be known that all services available via the Health and Welfare Departments can be obtained, and advice given at any time between 9 a.m. and 5 p.m. The public seem to be well satisfied with this arrangement.

The same applies to Keswick on a Thursday, but only in the afternoon at present with a health visitor and medical officer. The time is coming when a full day 'general clinic' will be required there as well".

Planning had started at the end of the year on a new satellite clinic to serve the Harrington and Salterbeck areas of Workington. School clinic work would be one facet of the activities of such a clinic and in particular it is gratifying that the Ministries of Health and Education have agreed to the provision of a dental suite in this clinic. The concept of such satellite clinics embracing school health work seems ideally suited to Workington with developing residential communities on the periphery of the town.

The school clinic cases at Alston are absorbed into the normal surgeries of the only general practitioner in this area.

who is also the school medical officer and medical officer of health.

Diseases of Ear, Nose and Throat

The statistical information relating to diseases of the ear, nose and throat, is set out in Table "A" and Table "B" Part II of Appendix A.

Tonsillectomy.

The table following brings the figures for school children at different stages who have undergone tonsillectomy, up to date for 1961. The overall percentage of children examined who have required tonsillectomy has decreased slightly on the previous year, but is still a high figure in Cumberland compared with most other parts of the country.

CHILDREN WHO HAVE HAD TONSILLECTOMY

Age Groups	Total Examined	1961 Boys	1961 Girls	1961 Total	1961 %	1960 Total	1960 %	1959 Total	1959 %	1958 Total	1958 %	1957 Total	1957 %
Entrants	3066	51	63	104	3.4	137	4.8	181	6.0	237	6.6	251	7
Intermediate ...	2380	217	217	434	18.2	653	20.4	680	20.4	931	26.3	1,025	27
Leavers	2085	303	322	625	30.0	791	29.5	554	22.5	818	29.2	934	31
Additional Periodic	1223	109	123	232	18.9	147	16.3	227	19.4	217	22.4	132	21
	8754	680	715	1395	15.9	1728	17.9	1642	16.4	2203	20.2	2,342	21.6

Provision of Hearing Aids

The total number of pupils in the schools who are known to have been provided with hearing aids is 42, of whom 15 have been equipped during this year.

Ascertainment and Treatment of Defective Hearing

A further step in the ascertainment and treatment of impaired hearing among children was taken in November when Professor and Lady Ewing and Dr. Taylor of the Department of Audiology, Manchester University, visited the county for three and a half days to train the nursing staff with health visiting duties in the techniques of testing the hearing of young children. Most of the full time health visitors had already had this training.

When cases are brought to light, preferably before the child would normally commence speaking, and a definite hearing impairment is confirmed by further testing and observation, the child's "education" begins, with or without the help of a hearing aid, by the peripatetic teacher of the deaf. This is highly important for the child's future educational career whether in ordinary or special school.

Audiology has emerged as a specialised field of work in its own right and encompasses the whole field of diagnosis, treatment, parent guidance, and the education of the hearing impaired child. Many workers are involved from the health visitor, who will we hope, point the finger first of all at the affected young child, the clinic medical officer specialising in this field, the general practitioner and the ear nose and throat surgeon, the teacher of the deaf; in older children the audiometrician, the hearing aid technician, and the speech therapist. The lesser and subtler degrees of hearing impairment may only be suspected later when the child goes to school, and the danger of his being mistakenly considered backward is now familiar to the teacher, school nurse, and educational psychologist. Some experts feel that only a specially trained audiologist, not necessarily a doctor, can preside over an audiology

clinic, and co-ordinate the contributions of all these workers effectively. Areas must inevitably differ in the structure of their service, and I am at present reviewing with my colleagues in hospital, the services for the ascertainment and management of hearing impaired children in the county. A very important circular by the Ministry of Health (23/61) received in September, urged a review of this subject. One of the things which I hope to establish in the coming year is similar follow-up and guidance service for the East of the county as has developed in West Cumberland and has been described in some detail in the last few annual school reports.

Once again Dr. Hunter has supplied an account of the year's work in this field in West Cumberland, as follows:—

"The scheme for the ascertainment and treatment of deafness in West Cumberland continues with only slight modification from the original set up in 1959. It is the firm intention to discover at as early an age as possible, all children suffering from the handicap of impaired hearing. To this end, health visitors carry out as a routine simple tests of hearing in infants in the home and in the clinic, and all children entering school are tested by audiometer. In addition, all children with any other handicapping condition, apart from deafness, e.g. speech defect, are also tested as a routine.

The slight modification in method mentioned above, and now adopted, concerns the *presumption* of deafness. It was earlier found that very large numbers of cases of hearing loss were adventitious and of little moment; that the presumption of deafness in all such and the adoption of full investigation meant in the end a hold-up in the ascertainment of significant cases. Therefore in addition to all cases of moderate or severe loss and special referrals by teacher or doctor, only those cases of mild loss which are confirmed by retesting in three months are *presumed* to have a definite loss demanding clinic examination, and, where indicated, specialist advice.

The simple working criteria for deciding on mild, moderate and severe loss are as follows:—

Mild loss—an average loss of up to 30 decibels in the three frequencies 500, 1000 and 2000.

Moderate loss—an average loss of 30—50 decibels in the frequencies 500, 1000, 2000.

Severe loss—an average loss of over 50 decibels in the frequencies 500, 1000, 2000.

The difficulties of presenting in tabular form the happenings in respect of a number of children were appreciated in previous years. I intend this year to tabulate firstly the numbers actually tested in the year 1961 with the immediate results of this test (Table 1); then separately to show also in table form the definitive conclusions reached on cases in 1961 irrespective of the year in which they first presented for testing (Table II). Finally Table III shows the numbers tested and the numbers on whom final conclusions were reached in the four years since 1958. Some comments are added on the material in each table. I think this simpier form of recording will facilitate the analysis of trends over the years.

Table 1 — Children first tested in 1961

Number tested in routine group (born 1956 and 1955)	2836	
Number with hearing loss	84	(3%)
Number specially referred	102	
Number with loss	43	(42.4%)

The bulk of cases specially referred for testing of hearing came from school medical officers, but 13 came because of suspicion of deafness by parents or teacher, 22 because of other handicaps, and one was referred by a general practitioner.

Table II — Final conclusions reached in 1961

	Total	RGP	RS	HA	FP
No. finally found to have normal hearing	56(1)	—	—	—	—
No. with loss due to					
Recurring catarrh ...	19(8)	2	4(2)	1(1)	—
Otorrhoea ...	17(11)	1	4(4)	—	—
Recurring wax ...	4(4)	1	1(1)	—	—
Unilateral nerve deafness	4(1)	1(1)	—	—	4(1)
Loss—associated with other handicaps ...	1(1)	—	—	—	1(1)
Loss—Aetiology undiscovered ...	3	—	—	1	1
Total cases ...	104(26)	5(1)	9(7)	2(1)	6(2)

Notes: The figures in parenthesis relate to special cases.
RGP—referral to general practitioners: RS—referral to otologist: HA—hearing aid supplied: FP—favourable position in class secured.

Thus, of these 104 cases, 56 were shown to have normal hearing and 48 to have a residual loss. The degree of deafness in these 48 was as follows:—

	Severe	Moderate	Mild
Unilateral	4	8	10
Bilateral	2	8	16
	6	16	26

The two cases of severe bilateral deafness were both seen by the otologist, one being issued with a hearing aid. The eight cases of moderate bilateral loss were distributed as follows:— One suffers from recurring accumulations of wax;one is associated with a congenital defect of the face; three have catarrhal otorrhoea, and three have a high frequency loss requiring hearing aids.

The sixteen with bilateral mild loss all suffer from catarrh or middle ear disease. One was recommended a hearing aid although the maximum loss in any one frequency was only 35 decibels.

Table III — Numbers tested and conclusions reached 1958-61

		Degree of Deafness:— Severe	Moderate	Mild
1958:				
No. examined—	Unilateral	7	4	8
Routine 3645		—	—	—
Special 228	Bilateral	1	8	8
1959:				
No. examined—	Unilateral	7	13	17
Routine 4891		—	—	—
Special 301	Bilateral	1	25	6
1960:				
No. examined—	Unilateral	3	9	11
Routine 2995		—	—	—
Special 69	Bilateral	—	6	13
1961:				
No. examined—	Unilateral	4	8	10
Routine 2836		—	—	—
Special 102	Bilateral	2	8	16

It will be seen that over a period of four years out of a school population of some 24,000 children, four cases of severe bilateral and 47 moderate bilateral deafness emerged.

At the end of the year a total of over 400 children were under observation and review for some degree of deafness".

Details of findings in pre-school children and an account of his work in the schools, are given in the report of Mr. Abbott, the peripatetic teacher of the deaf, as follows:—

"A great deal of time this last year seems to have been spent on pre-school children. I feel that in many ways this is the most important part of the work of a peripatetic teacher of the deaf. When a child, as has happened in the past, reaches 4 or 5 years of age and a way of life where oralism has little or no part, it is extremely difficult to make much progress with the child.

Pre-school children.

Four new cases in this group came under care during 1961. One of these, a girl, has since started at a normai school. Unfortunately this child was only weeks under 5 years of age when discovered, issued with a hearing aid and started on training. In a little over eight months she has progressed quite a lot but is still well behind normal children of her age in speech and language. Her progress will have to be supervised constantly to see if she can take worthwhile advantage of the education offered in a normal school.

All these four children have been given and are using satisfactorily, transistor hearing aids. Such an aid has also been provided during 1961 for one of the pre-school children who first came under observation in 1960, and another of the same group has now been shown to have normal response to various high and low frequency stimuli and at a recent date was talking quite well for his age.

At the time of writing there are 8 pre-school children suffering from various degrees of deafness:—

Partially deaf	4
Severely deaf	2
Profoundly deaf	2
	8

Parent guidance and pre-school training has been carried out at the following clinics:— Aspatria Cockermouth, Egremont, Whitehaven, Wigton, Workington, and in certain cases,

in the home. Attendances on the whole have been very good; in one particular case which meant a round trip of 42 miles for the parent, not a single absence has been recorded in the whole twelve months.

The main emphasis in this training has been on development of the child's capacity to comprehend speech and begin to talk spontaneously. Although all the children are individuals with individual difficulties, comparisons are hard to avoid. Some parents obviously work very well with their children, whilst others do little between the bi-weekly sessions Other factors, such as large families, living with in-laws, having other handicapped children, businesses to run, do of course make matters difficult.

A comparison of another kind is also inevitable. A partially deaf child responds much better than a profoundly or sub-totally deaf child, and the parents of the latter feel their child's progress is poorer than that of the partially deaf child attending the same clinic. I personally feel that any understanding of speech and words that is achieved by profoundly deaf children, particularly the younger ones is a great achievement.

Pupils in Special Schools

Fourteen children from West Cumberland are now in residential schools for the deaf and partially deaf outside the county. Two of these children have been admitted in the last twelve months, a profoundly deaf girl (Grade III) to the Northern Counties School for the Deaf at Newcastle, in November, and a partially deaf boy (Grade IIB) to the Liverpool School for the Partially Deaf at Southport, in April. An eight year old girl who was attending the Northern Counties School, died at the end of November.

Pupils in Normal Schools.

Forty-two children with a hearing loss are under supervision in normal schools in the county. Twenty-two of these children have Medresco transistor hearing aids. One

girl has greatly benefitted by the provision of a commercial transistor hearing aid, no Medresco transistor model for bone conduction being yet available. Eight children have left school this year and one is attending a private school.

The 42 children mentioned above are selected from those shown in Table III in Dr. Hunter's report as able to attend ordinary school and yet requiring some help through the teacher of the deaf.

Number of Children of School Age

Degree of Deafness		Action Taken
Mild	17	Favourable classroom position
Mild to moderate	14	Supervision & follow-up at school
Moderate ...	11	As above, plus extra tuition
	42	

Many of these children who manage quite successfully with a hearing aid and a favourable position in a normal school would have been catered for very inadequately in the years immediately following the last war. The alternatives open then were either attendance at a normal school, and the danger of being very much the odd one out educationally; or attending a deaf school with Grade III children (severely, profoundly or sub-totally deaf) and consequently being slowed down to their pace. It is heartening to see so many of these children taking advantage of normal educational facilities. For those that cannot, there are now the Grade II or partially deaf schcools.

These children in normal schools are under the supervision of the teacher of the deaf and are visited periodically. Some, particularly the younger ones, require speech correction. Others receive auditory training, lip reading instruction as appropriate, and in several cases, remedial teaching. As far as is possible this instruction is given in schools to obviate the loss of school time that the travelling to and from clinics would entail".

Visual Defects and Diseases of the Eye

During the year the practice of giving a routine eye test to each child who has a periodic medical examination was continued and in each school visited, each child who reached the age of eight years (i.e. born in 1953) had a visual acuity test.

2,535 of these children aged eight were examined, and 125 were referred for treatment, while a further 216 were recommended for observation and follow-up.

Of 3,066 school entrants examined, 73 were referred for treatment and 111 for observation.

In July 1961, attention was drawn by the Society of Medical Officers of Health to a disturbingly large number of children with defective vision over the country who were not being adequately dealt with because of insufficient ophthalmologists, and because fewer school medical officers today take part in refraction work. It was suggested that suitable school medical officers might be trained to undertake appropriate work in school ophthalmology clinics, and the Faculty of Opthalmologists had agreed to this. The Ministry of Education also supported the idea, and while the difficulty mentioned above has not been an acute one in Cumberland, I nevertheless invited Dr. Ross Wear, Consultant Ophthalmologist, to discuss the matter with the school medical officers. As a result of this, three school medical officers have expressed themselves as interested in receiving some instruction in ophthalmic work, and one has already commenced this with Dr. Ross Wear, with a view to undertaking refraction work with school children.

Ascertainment and Treatment of Squint

Miss Modlin, Orthoptist, has provided the following report:—

"Owing to the fact that no orthoptic clinics were functioning in Cumberland during the last six months of 1960,

there was a long waiting list to be caught up with when the clinics started again in January, 1961.

However, in spite of this, 1961 has been a successful year, attendances have on the whole been good at all clinics and both parents and children have, in general, been co-operative. particularly with regard to homework exercises which have been practised conscientiously.

The long lapse in treatment at the end of 1960 did not have any serious effect on most cases, but it was regrettable in that the progress of nearly all of the children was, to some extent, retarded.

A great variety of cases has been seen in the orthoptic clinic in 1961.

Full parental co-operation was not uniformly forthcoming in cases of amblyopia requiring occlusion of one eye. It is essential that the patch placed over the occluded eye should be constantly maintained in position and this prerequisite of successful treatment will have to be constantly impressed upon parents. Teachers on the other hand have been extremely helpful in their supervision of occlusion, and this has been a great support to the work of the department. A child uses his eyes most at school, and therefore it is here that occlusion is most beneficial.

We also have the teachers to thank for the fact that we are getting fewer and fewer children who refuse to wear spectacles or occlusion because other children tease them at school and I think we should be grateful that at least one body of people understands the value of early eye therapy and is willing to co-operate with this work."

The following tables give details of the patients seen, treated and discharged during 1961.

	Carlisle	Penrith	Workington	Whitehaven	Total
Total No. of attendances in 1961	345	213	381	381	1320
No. of new cases seen ...	61	23	42	43	169
No. of new cases registered for treatment	39	18	32	23	112
No. of cases receiving treatment on 31st Dec., 1961	102	65	61	84	312
Treatment during year of new cases:—					
Partially accommodative squint	8	8	9	5	30
Partially accommodative squint with amblyopia ...	8	—	7	4	19
Fully accommodative squint	6	—	4	2	12
Convergence excess ...	5	1	2	1	9
Tonic convergent squint ...	—	3	2	2	7
Tonic convergent squint with amblyopia	1	—	—	1	2
Convergent squint secondary to congenital myopia ...	—	—	1	—	1
Esophoria	2	1	—	—	3
Fixation disparity	2	—	—	—	2
Amblyopia	—	1	1	—	2
Constant divergent squint ...	2	1	4	1	8
Divergence excess	1	—	—	—	1
Convergence weakness ...	1	—	—	1	2
Consecutive divergence ...	—	1	—	—	1
Exophoria	1	—	—	—	1
Convergence insufficiency ...	1	1	2	5	9
Vertical muscle palsy ...	1	1	—	1	3
	39	18	32	23	112
Discharges during year:—					
Cured	2	2	3	4	11
Cosmetic	4	2	7	6	19
Improved	4	1	5	1	11
Failed to attend	4	—	4	3	11
Left district	2	1	3	2	8
	16	6	22	16	60

Orthopaedic and Postural defects:—

Orthopaedic treatment undertaken during the year:—

Number on aftercare register at 1/1/61 ...	1,067
New cases during 1961	129
Cases referred for orthopaedic physiotherapist only	45
Cases renotified after previous discharge ...	4
Cases attaining school age after having been referred originally from child welfare clinic	52
Number removed from register	248
Number on register at 31/12/61 ...	1,049
Attendances at surgeons' clinics	708
Attendances at intermediate clinics ...	2,229
Homes visited by orthopaedic physiotherapists	573
Plasters applied	67
Surgical boots and appliances supplied and renewed (including insoles)	433
X-ray examinations during 1961	72

About one-third of the number removed from the register is accounted for by persistent non-attenders. The remainder no longer required treatment.

NUMBER ON AFTERCARE REGISTER AT 31/12/61

Flat feet	315
Bow legs and knock knees	264
Poliomyelitis	49
Scoliosis, lordosis and kyphosis	16
Congenital defects (including talipes and pes cavus)	101
Congenital dislocation of the hip ...	28
Torticollis	6
Injuries (including fractures)	8
Cerebral palsy	68
Postural defects	54
Hallux valgus and deformed toes	27

Birth injuries	7
Osteomyelitis	1
Perthes disease and coxa vara	14
Arthritis	1
Spina bifida	7
Synovitis and rheumatism	4
Schlatter's disease	1
Muscular dystrophy	4
T.B. joints	6
Paraplegia	2
Other conditions	66
	1,049

Speech Therapy

For the first time since 1959 there are now three full time speech therapists—Miss Allan having joined the staff in September, 1961. Unfortunately the two part-time therapists had resigned during the summer. Miss Allan is responsible for the southern area of the county and has restarted clinics in Millom, Egremont, Cleator Moor and hopes to re-establish a clinic in Seascale.

Experience is showing that a very limited number of speech defects recover spontaneously. It is advisable for all children with defective speech, however minimal, to be referred to a speech therapist for assessment. Early help and advice given to the parents of these young children will prevent the condition being aggravated.

Miss Moon who has now been with the county as speech therapist since 1959, has provided the following informative commentary on this important aspect of the work of the school health service.

"When a small child tells his mother that there is a black cat sitting on the garden wall, he is performing a most com-

plex feat of co-ordinated nervous and muscular activity. Yet this human power to communicate by means of the spoken word is so fundamental to our daily lives, and develops so naturally that we take it completely for granted. When however the child fails to develop normal speech and language or begins to stammer, its importance becomes obvious and considerable anxiety is felt by all concerned.

If a young child develops a stammer it is most important for the mother to attend a speech clinic at the earliest moment. It is almost inevitable that parents will try to correct these children and/or give some form of advice as for example:— "Take a deep breath before you speak." Corrections and suggestions of this kind can do enormous harm. The idea that the child will 'grow out of it' is a dangerous half truth. While it is true that stammering in a young child can be a temporary phase if treated in the right way at home, misguided attitudes can turn it into a prolonged or permanent handicap. Experience shows that mothers should be seen at frequent intervals to ensure that the advice given is fully understood and really being carried out. Older children usually require regular treatment over a long period. Approximately 50% of the children referred for speech therapy stammer. The remaining 50%, although representing a very small proportion of the school population, comprise a variety of defects.

A very small number of children have a defect of voice due either to a disorder of the larynx or to persistent abuse of the vocal chords (the repeated staccato gun noises made by small boys when playing cowboys have been known to produce nodules on the vocal chords!). The number of children attending on account of cleft palate speech can be expected to be less than it was some years ago. This is due to changes in surgery and the fact that operations for palate repairs are now performed, if possible, before the child develops speech. When it is impossible for the surgeon to create a fully effective palate or mobile upper lip, the speech therapist must train the patient to compensate for the physical

inadequacy. The majority of children attending speech clinics, excluding the group who stammer, are there because their speech is unintelligible, or they fail to reproduce correctly the sounds of normal speech in the absence of any defect of hearing. These children have a defect of articulation—the co-ordinated muscular movements of the speech organs. In these cases an important distinction to be made is whether the articulation sound represents a stage in a development which is still progressing, or the development has ceased at a certain point or deviated from the normal. In both instances worried parents may unwittingly have aggravated the trouble by ill-advised attempts at correction. If the speech therapist sees a case early enough she can prevent this by showing the mother the best way to help a child. In the first type of case the result may be that he never needs regular treatment, or that the period of treatment necessary is shortened. In the second type a period of regular treatment is necessary and seldom lasts less than a year—often longer.

Parents sometimes have unjustified fears that the child's defective speech may be a sign of mental backwardness. It is of course true that mentally retarded children frequently have defective articulation, but this is part of the total picture. The majority of articulation defects however are in children of normal intelligence and their speech is the only abnormal feature of otherwise normally healthy children. For some reason these children fail to acquire normal articulation without specialised help. They have to be taught to do something which other children, who may be less intelligent, learn spontaneously, and in many there is a family history of slow speech development. They can usually be discharged around the age of 8 years.

Defects of language originating in the nervous system are happily rare. There are children with no fundamental defect in producing speech (dysphasia) who develop language very late for various reasons—severe mental retardation, psychological factors, or unusually slow maturation for speech. Where there is no dysphasia present, language develops ac-

cording to the intelligence of the child and the amount of stimulation he receives.

There is a minority however in whom the articulation defect is of a different nature as well as being of greater degree and persistence. These children may be of good intelligence but they are a cause of concern to their teachers who realise that their lack of attainment in all subjects involving language is not due to a lack of intelligence. This discrepancy between their achievement in language and non-language subjects stands to prejudice their whole education. On speech analysis their difficulty appears to be an inability in the higher brain centres either to receive or retain an accurate impression of sound, or failure to initiate the correct muscular movements to reproduce it. This is thought probably to be a specific developmental defect in those parts of the brain associated with speech and language. Reading and spelling may be much more seriously affected than speech. One such case in Cumberland has a reading age of $6\frac{1}{2}$ years compared with $10\frac{1}{2}$ years for arithmetic, the chronological age being almost 13 years. That these children do not necessarily have any general inadequacy of muscle movement is demonstrated by the fact that this particular boy plays in his school rugby team. Another case, a girl in whom speech is a primary defect, plays in the school netball team. On the other hand a third case did not walk until he was nearly 2 years, and is not very agile yet.

These are interesting and challenging cases — pioneer work has been done studying similar cases in other parts of the country, but there remains a wide and worth while field for further research."

The following tables show details of cases treated and attendances during the year:—

	On Register 1.1.61	Admitted	Discharged	On Register 31.12.61	Waiting List (included in previous column)
West Cumberland ...	153	64	59	158	17
S.E. Cumberland ...	114	26	17	123	30
East Cumberland ...	174	21	80	115	20
	441	111	156	396	67

Particulars of Cases Discharged:—

	West Cumberland	East Cumberland	S.E. Cumberland
Normal	45	25	14
Improved, unlikely to benefit further	8	20	—
Lack of co-operation	2	34	—
Left school and/or district	4	1	3
	59	80	17

Cases Treated:—

	West Cumberland	East Cumberland	S.E. Cumberland
Dyslalia	45	46	38
Stammer	20	40	40
Stammer and dyslalia	—	—	2
Sigmatism	3	4	—
Cleft palate	3	10	3
Hard of hearing	—	—	1
Dysarthria	2	—	1
Dysphonia	2	—	1
Dysphasia	5	1	—
Retarded speech development ...	61	30	28
Hypo-rhinophonia	2	—	—
Hyper-rhinophonia	1	—	2
Retarded speech development and stammer	—	7	—
Dyslalia and dysphonia	1	—	—

Stammer and hard of hearing ...	1	1	—
Stammer and Lateral sigmatism ...	—	2	—
Lateral sigmatism	—	—	5
Dyslexia	—	—	1
Dyspraxia	—	8	—
Submucous cleft	—	-	—
	146	151	122

Attendances:—

	Attendances	Waiting List
Cleator Moor	96	—
Egremont	100	—
Ingwell	—	10
Millom area	171	—
Seascale	—	5
Whitehaven	622	2
Cockermouth	246	6
Keswick	118	1
Penrith	327	6
Workington	592	17
Aspatria	110	5
Carlisle	697	6
Maryport	489	5
Wigton	277	4
	3,845	67

Child Guidance

The following table shows the statistics affecting the work of the three child guidance clinics in West Cumberland and the one in Carlisle.

Soon after Dr. Stuart increased the frequency of his Carlisle clinic from 2 per month to 3 per month in April, 1960, he was in fact able to commence holding the clinic weekly.

Towards the end of the year Miss M. Lamb, psychiatric social worker, Garlands Hospital, withdrew from her part-time work in the East Cumberland child guidance clinic, and following a short period in which Miss Vincent, social worker Garlands Hospital, kindly filled in her duties, Mr. Mayoh, psychiatric social worker and senior mental welfare officer assumed the duties which Miss Lamb had so ably carried out since the commencement of the clinic. Unfortunately Mr. Milne, psychiatric social worker in West Cumberland resigned during the year and his post has not been filled. Dr. Ferguson has agreed to a trial of an arrangement whereby a selected school nurse will carry out as much of the duties of a psychiatric social worker as she can.

CHILD GUIDANCE CENTRES—STATISTICAL RETURN FOR THE YEAR ENDED 31.12.61.

STAFF:	Carlisle	Maryport	Whitehaven	Millom	Total
Psychiatrist	Dr. Stuart	Dr. Ferguson	Dr. Ferguson	Dr. Ferguson	
Educational Psychologist	Dr. H. Blair Hood	Dr. H. Blair Hood	Miss Grey	Miss Grey	
Psychiatric Social Worker	Miss M. Lamb	Mr. R. Milne	Mr. R. Milne	Mr. R. Milne	
Cases remaining on register at January 1st, 1961	47	8	127	8	190
New cases referred during year by:—					
Consultants or General Practitioners ...	15	5	18	2	40
School Medical Officers	13	4	19	9	45
Children's Officer	—	—	—	—	—
Parents	—	—	1	1	2
Schools	5	2	4	1	12
Probation Officers or Courts	—	1	6	—	7
Others	—	—	1	—	1
Cases re-opened during year	4	—	4	2	10
Total cases on registers during year ...	84	20	180	23	307
Cases dealt with and closed	38	4	30	5	77
Cases remaining under treatment at 31.12.61	41	16	148	18	223
Cases awaiting treatment at 31.12.61 ...	5	—	2	—	7
	84	20	180	23	307
Interviews by Psychiatrists	323	98	276		697
Interviews by Social Workers	75	—	187		262
Interviews by Educational Psychologist ...	143	115	75		333

Handicapped Pupils

While a considerable proportion of the school medical officer's time has continued in the past year to be devoted to the regular supervision and care of the handicapped school child, special attention administratively has been focused on the end of his school life. This is particularly so in the case of the educationally subnormal school leaver, and an outline is given below under this special heading of the arrangements which have been established for supervision. In the case of physically handicapped children reaching school leaving age, it has now been possible to effect a closer link with the welfare services for the adult handicapped since these services now function as part of the health department. Every physically handicapped leaver will be reviewed in his last year at school or leaving special school to determine whether he is to be regarded as permanently and substantially handicapped, and as such registered as a handicapped person who requires special follow-up and help through the welfare section of the department.

In summarising two cases of handicapped children in whom she has taken a special interest, Dr. Halliday writes as follows and illustrates both of the above mentioned aspects of the school medical officers' work in this field.

"There was a time when a child, or his parents rather, had to make the best of things if an unkind fate had sent it into the world with one or many defects, but now in this year 1962 the story is unbelievably more encouraging. From pre-school years to the day for leaving school, many eyes are watching and many minds are working on the various problems.

In this county we have had several interesting examples of the amount and extent of care taken to rectify difficulties, and to judge the extent to which a child can or cannot benefit from normal education. There is the case of a little girl whose mother had rubella in the second month of pregnancy and who was born in 1956 with bilateral cataract. These

have been needled on three occasions. She did not sit until one year, and did not walk until she was two. At the age of 2½ years she could only say very few words. It was thought that this might be caused by some degree of deafness. All these various defects have been considered by specialists. As already stated the cataracts were dealt with on three different occasions. The speech therapist who tackled the delayed language development referred her to the teacher of the deaf who thought she could manage in a normal school. She was fitted with a hearing aid to try and help in that direction, but she would not wear it.

The next step was to refer her to the educational psychologist who saw her on several occasions. He was up against the problem of possible deafness and found her I.Q. probably under 50. However, he thought that the ability to get through might be helped by mixing with other children. The Ear, Nose and Throat specialist thought her hearing was not too much below normal.

She has in the last few years been under the supervision of the eye specialist, E.N.T. specialist, the educational psychologist and eventually the school medical officer recommends that she should not go to school at 5, but that by a later date she could attend an ordinary school, preferably, if possible a small country one where her retardation and shyness would not be increased by weight of numbers. Her case is under regular review by the school medical officer.

Another example of the amount of care and thought given to a handicapped child is that of a little boy born in December, 1945. He was a "Rhesus" baby and 24 hours after birth he developed jaundice. In January, 1947, aged 13 months, his mother took him to a child welfare clinic because he was unable to sit up. From here he was referred with the family doctor's agreement to an orthopaedic surgeon. His arms had become rigid but were less so after six months; he was late in getting his teeth; his hips could not be fully extended and his arm movements were full though not free.

The orthopaedic surgeon felt that there was no doubt that he was backward.

He was examined each following year and was seen to be very spastic. It was thought that he might be a suitable case for a spastic school. By the age of 6 he had had no education but was quite intelligent about the house, was bright and interested, although his speech and hand movements were uncontrolled, and he could not feed himself. In 1953, aged 7 years 6 months, he was seen by the head of a special spastic school who regarded him as being a severe spastic quadriplegic. At the school—to which he was admitted in January, 1954, aged 8 years 1 month, he was ultimately regarded as being too mentally backward to make any progress. In addition to the mental backwardness his physical disabilities became more acute. He was most unhappy and the general deterioration seems to have been a protest. Eventually, later in the year he was brought home and arrangements were made for home tuition which began in January, 1954. Accompanied by his mother he was later admitted to the clinic attached to the Percy Hedley School, Newcastle, where they found it difficult to assess his intelligence because of his very severe physical disabilities. However, Dr. Ellis the medical director thought that if his motor development could be improved by intelligent psysiotherapy, his speech would also improve. He said he was certainly educable and recommended that Mysoline (to control the spasm) be given three times daily.

With all the possible aids, such as glasses, a wheel chair, and, above all, the sympathetic co-operation of his mother, he made a fair amount of headway with home tuition. By 1961 the medical director of the Percy Hedley School thought the question of stereotactic surgery could be considered.

In this year, too, the home tuition ceased and the medical officer of health reported that there was a possibility of his being able to tackle some kind of assembly job. (He has a large model of an A.70 car which he not only drives, but can

take to pieces and put together again). So in 1962, at the age of 16 this boy may, in spite of his very severe handicap, be able to find in a handicapped persons centre, work which he can do well and which he finds interesting."

Dr. Thomson also writes an interesting account of two cases with which he has been closely concerned during the year.

"The first concerns a boy who is now aged 15 years and who suffered from a complete paralysis of the body below the level of the seventh thoracic vertebra, the result of an accident in 1956. He was in a special hospital for such cases until May, 1958 when he returned home. At this time he was only able to get about in a wheelchar, but was being encouraged to use crutches while at home. He attended the junior school in his home area, being taken backwards and forwards by car and moved about in the school in his wheelchair. He eventually passed the 11+ examination in 1959 and then attended the grammar school in the district. It was considered that he should really attend a residential school for physically handicapped children, but as the parents were un willing for this, preferring that he should remain at home, he was permitted to remain at the local school and at the time of writing this report is still attending the grammar school with considerable success.

The other case refers to a little girl who suffered from acute poliomyelitis at the age of 2½ months resulting in severe paralysis of both lower limbs and lower spine. Prior to coming to this district at the age of 8½ years in 1960 she attended a special school for the physically handicapped in another area where the family then resided. At this time she was in a wheelchair, but also getting about in the home with the use of elbow crutches and calipers on both lower limbs and a spinal brace. It was decided that she could attend the junior school which was situated near her home and arrangements were made for her daily transport to and from school by taxi. At first she moved about in the school in her wheelchair, but over the past year, after arrival at school in the

morning, she moved about in the school on her crutches and calipers and educationally has progressed wonderfully well.

I bring these two cases forward as an indication of what can be done with perseverence on the part of the disabled child and the good will and help of teachers and pupils. In the case of the boy the layout of the school is extremely awkward and he has to be pushed about in his wheelchair considerable distances involving uphill gradients, but at no time has there been any difficulty in having willing help from his fellow scholars. I think it is extremely important that physically handicapped children should be allowed, if possible, to continue in ordinary schools and be treated as normal school children."

Writing with special concern for the child with a serious double handicap, Dr. Campbell makes the following observation:—

"The case of children who are so handicapped as to be unfit for education in school is a more difficult one. Even here many of those who are handicapped by physical as well as mental handicaps could derive benefit from being allowed to watch their normal school fellows for short sessions, and so be given an opportunity to absorb a certain amount of social balance which would enable them to mix more easily with strangers when they no longer have homes of their own and relatives to look after them."

Blind and Partially Sighted Pupils

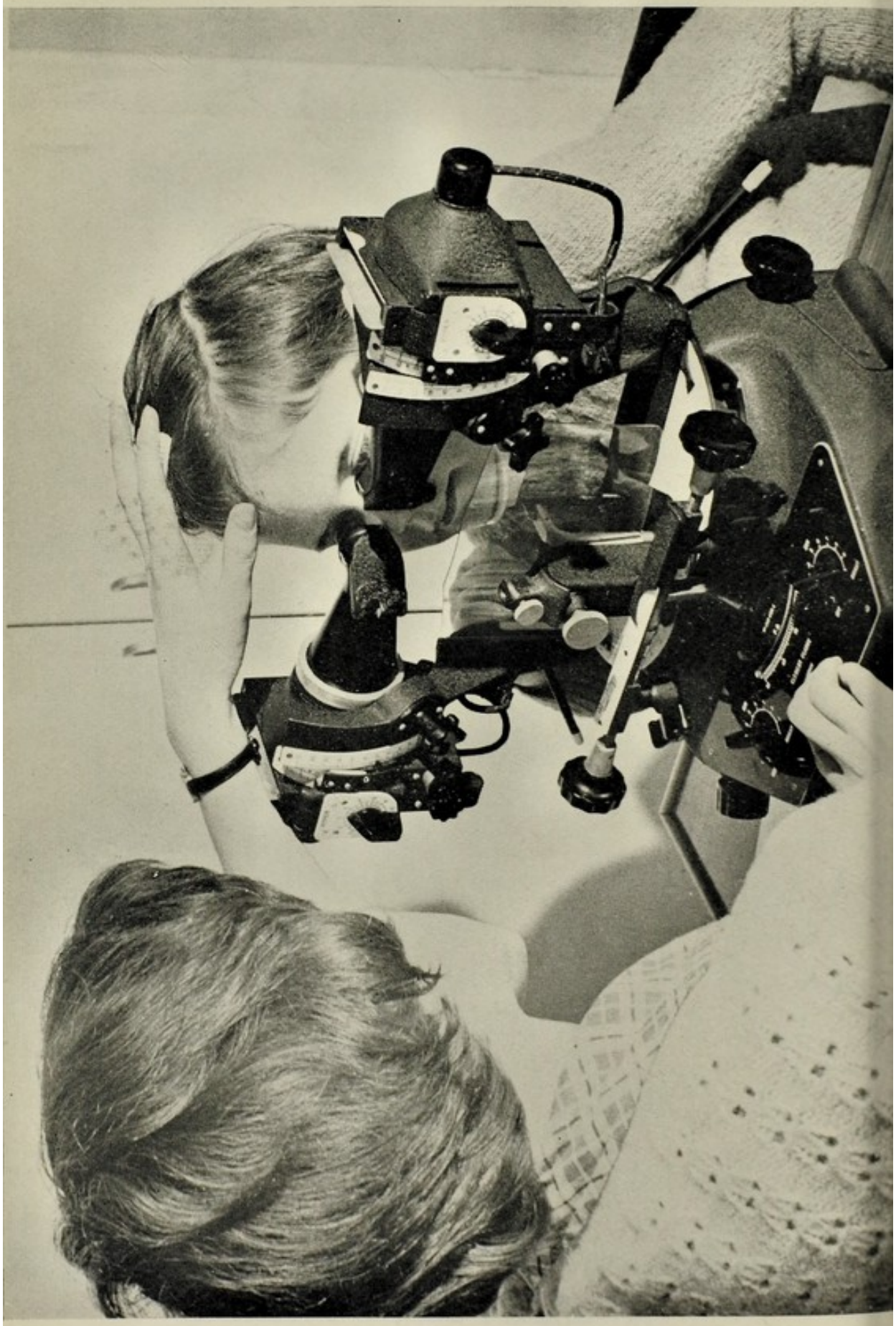
There are seven blind children and eight partially sighted children in special residential schools outside the county.

A recent review of the blind and partially sighted school and older pre-school children in the county shows that eight have a history or diagnosis which strongly suggests a hereditary factor; three are associated with a history suggestive of possible injury or anoxia at birth; two followed maternal rubella in early pregnancy; three resulted from retrolental

SPEECH TRAINING UNIT IN USE BY TEACHER OF THE DEAF


AT THE ZOO

ORTHOPTIC EXAMINATION
PHYSIOTHERAPY CLINIC



ORTHOPTIC EXAMINATION

fibroplasia. The latest of these latter three occurred in 1957. One case is associated with the development of a brain tumour. Of the remaining twenty-one cases, no such clearly definable causative factors were present, the defective vision being associated with other serious disabilities such as epilepsy, mental defect and hypothyroidism.

Deaf and Partially Deaf Pupils

There are at present 30 school children known to be handicapped by deafness or partial deafness. Many others have lesser degrees of hearing impairment which constitute only a minor handicap and can readily be coped with in ordinary school as long as the child has, for example, a favourable place in the classroom. An account has already been given on page 24 of the audiology work being undertaken in the county, together with the reports of Dr. Hunter and Mr. Abbott the teacher of the deaf.

Children suffering from Epilepsy

There are 33 school children ascertained as suffering from epilepsy, of whom 4 are at special residential schools. School leaving age is a particularly critical time in the life of an epileptic child and the school medical officers have often quite a task in advising the Youth Employment Officer on the occupational possibilities for these children. After considerable negotiation and liaison with family doctor and specialists concerned on one particular lad about to leave the residential special school for educationally subnormal pupils, it was determined quite clearly that his epilepsy was of such a degree, and his home circumstances so unfavourable relative to his handicap, that only placement in an epileptic colony would meet his case. The case was taken over at this stage by the welfare department, who made the necessary arrangements and were fortunate in securing him an early place in a suitable colony.

Pupils with Speech Defects

Invaluable advice has been obtained during the year from Dr. M. E. Morley, Consultant Speech Therapist, from the University of Durham, who now visits the county regularly to advise the speech therapists on their more difficult cases. This has, in one or two cases obviated the question of seeking places in special schools—places which are very scarce and difficult to secure.

Educationally Subnormal Pupils

The statistics of 2 H.P. examinations completed in 1961 and the waiting list for Ingwell and Higham Schools are shown below. The disquiet I expressed last year about the inadequate provision of special education for educationally subnormal children remains, especially since it has not been possible for the Director of Education to establish securely many of the "progress" classes in ordinary schools which I know he has in mind.

I outlined last year the effects which the Mental Health Act had on the work of examining and advising on the education or training of a child with a disability of mind. One final aspect of this work which was susequently considered, was the supervision of the educationally subnormal school leaver. Prior to the advent of the Mental Health Act and the changes it introduced to the sections of the Education Act which dealt with these children, a review had to be made of educationally subnormal children under Section 57(5) of the Education Act before leaving school to determine really whether they should thereafter be regarded as defectives for the purpose of supervision by the health department. Practically all supervision for subnormal people being now completely informal under the Mental Health Act, the statutory examination under Section 57(5) is no longer required and it was open to authorities to establish what arrangements for supervision they thought fit. It was felt that a broader base should be used in future bringing in the services of the health visitor by

unobtrusive and quite informal follow-up for the welfare of many educationally subnormal leavers, while the mental welfare officer's services would still be required as in the past for some of the more severely handicapped. The brief memorandum on this arrangement which was agreed between the Director of Education and myself is printed as Appendix "C" to this report.

2 H.P. EXAMINATIONS COMPLETED IN 1961 UNDER SECTION 34 or 57

Recommended Special School—E.S.N.	...	62
Recommended Special Class—E.S.N.	...	22
Reported unsuitable for education at school	...	19
No special educational treatment required	...	6
Decision deferred		19
Total	...	128 (132)

Number of Boys on Waiting List for Ingwell School		70
Number of Girls on Waiting List for Higham School		57
Total	...	127 (133)

NEW CASES REFERRED IN 1961

Referred by:	Referred for investigation of intellectual capacity
School Medical Officers	28
Psychologists and Teachers ...	111
Consultants and Hospitals ...	12
Family Doctors	6
Health Visitors	12
Parents	2
Others	10
	181 (141)

The figures in brackets shown against each total indicate the corresponding numbers in the previous year. Thus, a similar total number of children were examined under Section 34 or 57 of the Education Act as in the previous year, indicating that there is still a substantial number of children requiring this form of examination.

Unless it is thought likely that a pre-school child is going to prove unsuitable for education at school, in which case he is tested before reaching five years of age, it is usually of value that he should have a period at school before his assessment by the examining medical officer. By this time he will have been the subject of reports by the head teacher and by the educational psychologist and these are available to the school medical officer in his completion of form 2 H.P. which recommends the form of education most suitable for the child.

The total number of new cases referred in 1961 for investigation of intellectual capacity shows an increase on last year, and this is partly accounted for by the fact that there are now included in the figures, cases of infants and young children who have been the subject of special reports by the health visitor or a doctor, and who will in due course require the full scale investigation. This reflects the closer link up now operating between the child welfare service and the school health service to which I referred in my report last year.

Physically Handicapped Pupils

The cerebral palsied child continues to figure largely amongst the physically handicapped group, and details of these children are once again set out below. Dr. E. Ellis, Medical Director of the Percy Hedley School for Spastic Children, Newcastle-on-Tyne, continues to visit the county periodically to advise on the management of these children. The help and assessment which he can often offer by admitting a child with his mother for a period to the Percy Hedley Centre is of the greatest value.

Children Suffering from Cerebral Palsy.

The numbers in this category at 31st December, 1961, are as follows:—

Number of spastic children of school age—

West Cumberland	46
East Cumberland	17
Total ...	63

These may be divided into those:—

(a) Attending ordinary school	25
(b) At Percy Hedley School for Spastics (Newcastle)	8
(c) At residential schools for the physically handicapped	2
(d) At residential schools for the educationally subnormal	1
(e) Attending Training Centre	4
(f) At Dovenby Hospital	4
(g) Having Home Tuition	3
(h) Not attending school, not having home tuition	16

In addition:—

Number of children under school age but within the scope of the Education Act 1944 (i.e. 2-5 years) who are known spastics—

West Cumberland	11
East Cumberland	5
Total ...	16

Table Showing Handicapped Children in Special Schools

BLIND

Name of School	Boys	Girls
Royal Victoria School for the Blind, Newcastle	3	2
Royal Normal College for the Blind, Shrewsbury	2	—
Total	5	2

PARTIALLY SIGHTED

Preston School for Partially Sighted and Institute for Blind Welfare, Fulwood	4	—
Royal Normal College for the Blind, Shrewsbury	1	—
Barclay School for Partially Sighted Girls ...	—	1
Exhall Grange School, Warwickshire ...	1	1
Total	6	2

DEAF

Boston Spa Institution for the Deaf	1	2
Royal Cross School for the Deaf, Preston ...	1	2
Royal Residential School for the Deaf, Manchester	—	2
Burwood Park School, Walton-on-Thames, Surrey	1	—
Thomasson Memorial School, Bolton ...	—	1
Northern Counties School for the Deaf, Newcastle	—	1
Total	3	8

PARTIALLY DEAF

Northern Counties School for Deaf and Dumb, Newcastle	2	—
Boston Spa Institution for the Deaf	—	1
Liverpool School for the Partially Deaf, Southport	3	3
Royal Cross School for the Deaf, Preston ...	—	1
Total	5	5

EDUCATIONALLY SUBNORMAL

York Day School, Carlisle	2	2
Ingwell School	50	—
Higham School	—	34
Eden Grove School, Bolton, Appleby ...	1	—
Total	53	36

EPILEPTIC

Colthurst House School for Epileptics, Warford, Cheshire	2	—
Sedgwick House School, Kendal	2	—
Total	4	—

MALADJUSTED

Chaigeley School for Maladjusted Boys, Thelwall	1	—
Naemoor School, Rumbling Bridge, Kinross ...	1	—
Total	2	—

PHYSICALLY HANDICAPPED

Coltness House School, Wishaw, Lanarkshire ...	1	—
Hesley Hall School for Physically Handicapped, Tickhill, Notts.	1	—
Percy Hedley School for Spastic Children, Newcastle	5	3
Irton Hall School, Holmrook, Cumberland ...	2	—
Exhall Grange School, Warwickshire	1	—
Bleasdale House Residential School, Silverdale, Lancashire	1	—
Lord Mayor Treloar School, Froyle, Alton, Hants	1	—
Total	12	3

DELICATE

Name of School	Boys	Girls
Delicate Children's Convalescent Home and School, West Kirby	—	1
St. George's Hostel, Kersal, Manchester ...	1	—
Total	1	1

HOSPITAL SPECIAL SCHOOLS

Stannington Children's Hospital School, Nr. Morpeth	5	1
W. J. Sanderson Hospital School, Gosforth ...	2	—
Total	7	1

Dental Service

Mr. Neal, the Principal School Dental Officer, makes the following comments on the dental service:—

"It is with much regret that I announce the retirement of Mr. A. C. S. Martin, Principal School Dental Officer to Cumberland County Council for the past 24 years. The work which Mr. Martin did during the war years and in the post war perod to maintain an adequate dental service is something which will not easily be forgotten, nor will the help and friendship which he so freely gave to all members of the dental staff in particular and to everyone in general.

The year has been a most satisfactory one as regards work, despite the fact that considerably fewer sessions were worked than in the previous year due to illness which smote so many of the staff. Unfortunately, we have been one dental officer short of our establishment since Mr. Martin retired and so it has not been possible to maintain the same volume of work in East Cumberland. I hope that we shall be able to appoint another dental officer in the near future so that we can maintain our high standard of service.

It is most gratifying to see that the proportion of fillings to extractions is continuing to increase and has now reached the most satisfactory level of being virtually equal. The ratio of fillings to extractions is the best way of assessing the progress made in eradicating caries. Taking the permanent dentition alone, much has been achieved because, even including the numerous extractions of permanent teeth for orthodontic reasons, the proportion is one extraction to every 2.5 teeth filled, which does show that in Cumberland the children accepting treatment are really deriving great benefit from the service. During the past year many dental officers have undertaken work of an advanced nature, e.g. crowns, inlays and orthodontic appliances, not possible before because of the volume of work, which tends to show that urgent cases are fewer in number and so time can be devoted to routine work and the more time-consuming operations. More Women's Institutes, clubs and schools, have requested talks on dental subjects and I feel that these educational talks do a great deal to help in producing more dentally fit patients.

I am perturbed by the havoc caused by the ever growing habit of children (and adults) of eating ice lollies. In many cases it has been found that the acid content of these lollies is sufficiently high to dissolve the enamel of the teeth and this, combined with the sugar content, can cause rampant caries. Since one or two of the large ice cream firms of repute (who have scientific laboratories to control the products both chemically and bacteriologically) started to produce ice lollies, many small firms and even private individuals have decided to "cash in" on the craze for what should be frozen fruit juice, but which is in many cases nothing more than a syrup containing synthetic fruit flavouring, citric or tartaric acid, colouring, and then frozen. I, personally, feel that ice lollies are a very real menace to the dental health of children and that some rigorous form of control should be exercised over the manufacture of these products. It seems quite irrational that the manufacture and sale of ice cream should be controlled even to the extent of dividing it into the categories of "ice cream" and "dairy ice cream" when there is no designated standard for ice lollies. No means are available to overcome the damage caused by ice lollies and no amount of tooth brushing and dental care will help at all. The only thing we can do is to harden our hearts and refuse to buy our children their favourite summer delicacies.

There is one way in which much can be done to make dental treatment easier and more satisfactory than at present and which I would like to see universally adopted. It is by having facilities for undertaking dental treatment in the larger schools. If children are able to obtain treatment in their own schools they are much happier and easier patients because they are in familiar surroundings. Treatment then becomes part of normal school routine, apart from which they are usually away from class for only quarter of an hour instead of half a day, as in most cases when they attend an area clinic. Even if a proper dental suite is not possible, it is surprising how much can be achieved in only one room. In Cumberland there is one secondary modern school with a full

clinic suite and it is most gratifying to see children from other schools who were previously bad attenders rapidly become first class patients. By having a dental clinic in a school the children soon get to know the dental officer and his assistant, so that they are perfectly familiar with both the staff and surroundings, thus making the treatment easier for the dental officer to give and the child to receive, because the fear of the unknown seems to be one of the biggest difficulties that a child has to face up to. Another three schools, one a comprehensive and the other two secondary moderns, have made rooms available for dental treatment and the quantity of work done per session in these schools is approximately double that in the normal clinics. One other school is most anxious to avail itself of our services in this way and I hope to establish a clinic there by Easter. In course of time I hope that every school with more than 300 pupils will have at least a dental surgery included in the original plans for the school and that this part of the service may rapidly be extended.

I wish to express my sincere appreciation to everyone, not only in the dental and health departments, but in every section of the County Council, for all their help and co-operation since I took up this appointment. I would also like to thank the members of the various committees for the sympathetic understanding which has been meted out to me and I trust that I shall fully justify their confidence in me."

PREVENTION OF ILLNESS AND PROMOTION OF HEALTH

Protection of School Children against Tuberculosis

The two main approaches to the protection of school children against tuberculosis continue to be skin testing, and where advisable, B.C.G. vaccination for 13 year olds and the offer of mass miniature X-ray to pupils who have reached 15.

The following table shows the numbers of children affected by the B.C.G. scheme last year, compared with the 1960 figures:—

Year	No. offered Mantoux test	No. of consents	% of consents	No. Mantoux tested	% tested of those offered	No. found positive	% found positive	No. given B.C.G.
1961	3,854	2,909	75	2,671	69	405	15.2	2,185
1960	3,423	2,560	75	2,406	70	419	17.4	1,925

I made reference in my report last year to the Ministry of Health circular 6/61 in which authority was given for the extension of the B.C.G. vaccination scheme to children between 10 and 13 years where any authority thought this was advisable. I do not think there is evidence at present to suggest that this step should be taken for Cumberland now. It will be recalled that it has not yet been established that the effects of B.C.G. vaccination are prolonged for more than about 7 years, though many people feel that time will show that the protection lasts for at least 10 years. Since it is important to be sure that protection extends into young adult life, a vulnerable period for tuberculosis, it may be that the age of vaccination will be reduced gradually from 13 years so protecting children earlier, so long as the assurance emerges that the protection is indeed lasting well into the after school life.

Arising out of discussions on this subject with the chest physicians it was decided during the year to undertake a pilot Mantoux survey of groups of 100 school entrant children in four different areas, viz. Whitehaven, Workington, Maryport, Keswick. This is almost complete at the time of writing, and while the results at first appear much as one might have

predicted in keeping with the general reduction of tuberculous infection in the community, it will be instructive to compare the results with those obtained in 1954 on similar groups of children, immediately before the B.C.G. vaccination scheme commenced.

The following table gives the results of the Mantoux testing of 13-year old school children. The percentage of positive reactors in East and West Cumberland continues to fall steadily each year.

DISTRICT	Children Tested in 1961 born 1947			Children Tested in 1960 born 1946			Children Tested in 1959 born 1945			Children Tested in 1958 born 1944			Children Tested in 1957 born 1943			Children Tested in 1956 born 1942		
	No. Tested	No. Pos.	% Pos.	No. Tested	No. Pos.	% Pos.	No. Tested	No. Pos.	% Pos.	No. Tested	No. Pos.	% Pos.	No. Tested	No. Pos.	% Pos.	No. Tested	No. Pos.	% Pos.
Alston	22	2	9.1	36	5	14.0	27	10	37.0	39	6	15.4	32	19	59.4	31	11	35.5
Border	369	33	8.9	265	35	13.2	237	31	13.1	267	38	12.8	230	49	21.8	236	68	28.8
Keswick	118	29	24.6	83	19	22.9	78	17	21.8	92	19	20.7	99	28	28.3	78	30	38.5
Penrith R.D.	*—	*—	*—	43	7	16.3	69	8	11.6	66	16	24.2	62	10	16.1	58	13	22.4
Penrith U.D.	233	32	13.7	176	25	14.2	143	23	16.1	135	20	14.8	134	30	22.4	137	45	32.8
Wigton	274	28	10.2	231	20	8.7	278	39	14.0	288	52	18.1	283	69	25.3	231	55	23.8
Totai East Cumb.	1,016	124	12.2	834	111	13.3	832	128	15.4	887	151	17.0	840	205	24.4	771	222	29.0
Cockermouth R.D.	23	3	13.0	25	1	4.0	25	7	28.0	14	3	21.4	60	18	30.0	75	28	37.3
Cockermouth U.D.	194	50	25.8	188	46	24.5	140	33	23.6	157	34	21.7	104	30	28.8	101	23	22.7
Ennerdale	323	69	21.3	251	66	26.3	234	80	34.2	286	101	35.3	311	114	36.7	242	101	41.7
Maryport	97	11	11.3	126	23	18.3	137	29	21.2	160	50	31.3	108	41	38.0	108	37	34.3
Millom	135	17	12.6	170	28	16.5	176	56	31.8	184	64	34.8	170	60	35.3	146	65	44.5
Whitehaven	437	89	20.4	428	91	21.3	297	88	29.6	384	129	33.3	325	111	34.1	315	149	37.3
Workington	446	42	9.4	384	53	13.8	374	69	18.4	400	82	20.5	358	118	30.2	384	130	33.9
Total West Cumb:	1,655	281	17.0	1,572	308	19.6	1,383	362	26.2	1,585	463	29.2	1,436	492	34.3	1,371	533	39.0
GRAND TOTAL	2,671	405	15.2	2,406	419	17.4	2,215	490	22.1	2,472	614	24.8	2,276	697	30.6	2,142	755	35.3

* Children living in the Penrith R.D. who would have been due to be Mantoux tested this year. moved into Schools in the Penrith U.D.

The following table shows the findings at mass radiography of school children, including those attending private schools, over the age of 15 years:—

Children X-rayed on miniature films	1,372
Children recalled for large film examination ...	15
Children recalled for clinical examination ...	3
Children found with active tuberculosis ...	—
Children found with inactive tuberculosis ...	—
Children found with bronchietasis	1
Children found with abnormal cardiac conditions	1

Medical Examination of Teachers

	Total	Category A1	A2	B1	B2	C
Entrants to Training Colleges Form 4 R.T.C.	125	73	50	2	—	—
Entrants to employment as teachers by Cumberland Education Committee (Form 28 R.Q.) ...	89	62	27	—	—	—
There were examined in addition:—						
Teachers from other authorities entering employment in Cumberland ...	70	69	1	—	—	—
	284	204	78	2	—	—

A1.—Those who are in good health and free from any physical defect.

A2.—Those who are in good health but possess defects which are not likely to interfere with efficiency in teaching.

B1.—Those who are in good health but suffer from physical defects (including disfigurement or deformity) which are likely to interfere, to some extent, with efficiency in teaching though they are not serious enough to make the candidate unfit for the teaching profession.

B2.—Those who are temporarily in subnormal health, but may, under treatment, make a good recovery.

C.—Those whose condition is such as to make them unfit for the teaching profession.

Prevention of Diphtheria and Tetanus

During the year 394 children received a primary course of injections against diphtheria and 987 received reinforcement injections. The corresponding figures for 1960 were 845 primaries and 4,382 reinforcements. One of the main reasons for this considerable fall in the number of injections given is that the time of the medical officers was concentrated for a period of 2-3 months in early summer on the giving of a fourth injection against poliomyelitis. As a consequence, the diphtheria immunisation programme was curtailed, and the immunity index of school children protected (i.e. the number of children fully protected during the past five years) fell from 48.4% in 1960, to 44.6% in 1961. It is evident therefore that every effort must be made during 1962 to increase this immunity index. It is gratifying to note that 1961 was the thirteenth year since a case of diphtheria was reported in Cumberland, but it must be emphasised that the maintenance of a high immunity index is essential if we are to avoid cases of diphtheria in the future.

As mentioned in last year's report, the scheme for vaccination of school children against tetanus came into effect on 1st January, 1961 and this vaccination can now be given in schools and county council clinics, either as a primary course of injections, or as a reinforcing injection. Since the inception of the scheme early in 1961, 573 school children received primary vaccination against tetanus, and 289 received a reinforcement injection including a tetanus component. These figures would have been higher but for the interruption of the work occasioned by the fourth poliomyelitis injections as mentioned above. Following discussions with the casualty surgeons from the main East and West Cumberland hospitals,

an arrangement was established whereby a simple record card would be passed to the main hospitals when a child's vaccination against tetanus had been recorded in this department. The children who had already been protected by general practioners using the combined antigen, and all current vaccinations against tetanus are notified to the hospitals in this way as will be the five-yearly reinforcement injections which will in due course be arranged for school children.

Poliomyelitis Vaccination

The most notable feature of the poliomyelitis vaccination programme during the year was the introduction in April of a fourth injection for school children between the age of 5-12 years. When this was introduced it was emphasised that the object was to ensure that as many children in this age group as possible received a fourth injection before the summer months when the risk of contracting poliomyelitis was greatest. The majority of these injections were given by the medical officers in schools and at the end of the year, 15,399 school children had received this extra protection. Unfortunately it was necessary to stop the fourth injection in October owing to a shortage of vaccine. It is estimated that on 31st December, 1961, 85.7 percent of school children aged 5-15 years were protected against poliomyelitis by having received either 3 or 4 injections. A further 9.3 percent have the partial protection provided by their first two injections.

At the time of writing this report, trivalent oral vaccine has just been released for general use and will almost certainly replace to a very large extent Salk vaccine given by injection. In April, 1961, a small amount of oral vaccine became available for use only in serious outbreaks of poliomyelitis and only on the sanction of the Ministry of Health. There was never any question of this being brought into use in Cumberland, although four cases of poliomyelitis did occur in October. The general introduction now of an oral vaccine raises the hope of the ultimate elimination of poliomyelitis from the community.

Infectious Diseases

There are several features in the table of infectious diseases in school children, page 67 , worthy of brief comment. The increase in the number of cases of dysentery emphasises the constant danger of gastro-intestinal infection spreading amongst school children. Food poisoning is an ever present danger in schools which are handling meals, and in one grammar school in the county during 1961, over 100 pupils suffered a moderately severe attack of food poisoning. While investigation completely exonerated the catering staff from any blame, and the standards of hygiene were confirmed as being commendably high, several important points arose such as the investigation of the actual temperature achieved in roasting and serving meat under varying circumstances. This has been gone into further by the medical officer of health and school medical officer directly concerned, and, arising out of the same incident, further wash basins have been installed at the kitchen to streamline still further the personal hygiene efforts of the staff.

With regard to poliomyelitis, it will be noticed that there were two paralytic cases, neither of which proved fatal, notified in school children during 1961. These cases were part of a small outbreak occurring in the Maryport area, which was the first occurrence of poliomyelitis in the county since 1958. While it may not be possible to assess accurately the part played by the high level of immunity among school children in limiting this small outbreak, it is nevertheless very reassurring to know that a high proportion of the school children who might have been in contact with these two were fully protected by Salk vaccine.

Cases of Infectious Diseases in children of School Age

	Scarlet Fever	Whooping Cough.	Ac. Polio Paralyt.	Ac. Polio Non-Para.	Measles (Sxcluding Rubella)	Diphtheria.	Dysentery.	Meningococcal Infection.	Ac. Pneumonia.	Smallpox.	Food Poisoning.	T.B. Respiratory.	T.B. Meninges & C.N.S.	T.B. Other.	TOTAL
URBAN															
Cockermouth ...	—	—	—	—	13	—	3	—	—	—	1	—	—	—	17
Keswick ...	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Maryport ...	2	4	—	—	135	—	1	—	1	—	1	—	—	—	144
Penrith ...	7	—	—	—	8	—	31	—	—	—	—	1	—	—	47
Whitehaven ...	—	2	—	—	18	—	—	—	—	—	—	—	—	—	20
Workington ...	7	1	2	—	87	—	2	—	2	—	—	—	—	—	101
RURAL															
Alston ...	—	—	—	—	102	—	—	—	—	—	—	—	—	—	102
Border ...	6	—	—	—	339	—	6	—	—	—	—	—	—	—	351
Cockermouth ...	3	—	—	—	55	—	12	—	3	—	—	—	—	—	73
Ennerdale ...	2	13	—	—	64	—	—	—	—	—	—	—	—	1	80
Millom ...	2	11	—	—	131	—	2	—	—	—	2	—	—	—	148
Penrith ...	9	—	—	—	42	—	4	—	—	—	—	1	—	—	56
Wigton ...	22	—	—	—	58	—	3	—	1	—	1	1	—	—	86
	60	31	2	—	1052	—	64	—	7	—	5	3	—	1	1225

Tuberculosis.

There were 4 school children notified as suffering from tuberculosis. Details are given in the table below.

Age period	5-10 years		11-15 years		15 years & over		Total	
Sex	M	F	M	F	M	F	M	F
Pulmonary	1	1	—	—	—	1	1	2
Non-pulmonary	—	—	1	—	—	—	1	—
TOTAL	1	1	1	—	—	1	2	2

School Premises

Two new schools were completed during the year, viz., Lillyhall County Secondary School, Distington, and Ullswater County Secondary School, Penrith. For two existing schools, Rosley C. of E. School and Solway School, new premises were brought into use, and extensions to the following schools were also completed:—

Whitehaven College of Further Education
Gosforth C. of E. School
Gilsland School
High Hesket C. of E. School
Thornhill School (further extensions)
Whitehaven St. James' C. of E. Infants' School

In addition, over £1,100 was spent on minor improvements to heating systems and over £600 on small additions to lavatory accommodation.

School Meals

Mr. Gordon S. Bessey, Director of Education, has supplied the following report on the school meals service, together with the note on milk in schools which follows:—

"With the opening of a dining centre in Beckermet C. of E. School, on 16th October, 1961, children in attendance at all of the 283 nursery, primary and secondary schools maintained by the authority enjoyed the benefit of a hot midday meal. Following the trend established during the previous

year, the overall percentage of children taking dinners at all maintained schools during a day in September 1961 again showed an increase and reached the record figure of 70.5. The figures for that day, as compared with those for a day in September, 1960, are set out below:—

Year	Primary and Nursery Schools			Secondary Schools			All schools combined		
	Number of children present	Number taking meals	Percentage taking meals	Number of children present	Number taking meals	Percentage taking meals	Number of children present	Number taking meals	Percentage taking meals
1961	20,720	13,518	65.2	15,172	11,800	77.8	35,892	25,318	70.5
1960	21,455	13,583	63.3	13,762	10,496	76.3	35,217	24,079	68.4

The slackening tempo of new school building was reflected in the fact that, during the year under review, only two new schools with ancillary meals accommodation were completed and taken into use. These were Ullswater School, Penrith, whose 400 meals kitchen began to produce dinners on 7th September, and Rosley C. of E. School at which a 40 meals kitchen opened on 31st October, 1961. Hitherto, meals for children in attendance at the old Rosley School had been sent out from Wigton Central Kitchen and served in the Recreation Room, which the authority rented for this purpose.

During the year under review, adaptations and extensions were undertaken at Gosforth C. of E. and Ousby C. of E. schools. A 75 meals kitchen at the former school was taken into use on 18th July, meals being served in school, and a new scullery at Ousby School will be used for the first time on 8th January, 1962. The facilities at Gosforth are a great improvement on the former dining arrangements whereby dinners were sent from Egremont Central Kitchen and eaten in the local Methodist school-room.

Work began in the autumn on the formation of sculleries at one end of the assembly hall in St. John's Junior School, Workington, and in a cloakroom at Moresby School, so that dinners might be served in the schools, instead of in rented premises, as at present. It is hoped that, in each case, the

new arrangements will be in operation early in the Spring term, 1962.

Since 15th May, dinners have been served in Cummersdale School, as a result of which the use of the former dining centre in the Village Hall, has been discontinued.

While it had been hoped to carry out a fair number of minor improvements during the year, the County Architect was, in fact, only able to improve standards at four meals establishments. Wash basins were installed at Whitehaven Grammar School Kitchen, and at Frizington County and Lamplugh School Dining Centres and the walls behind the sink unit in Crosthwaite Memorial C. of E. Dining Centre at Whitehaven were tiled. The total estimated cost of these improvements amounted to £67".

Milk in Schools

The figures given below show the position regarding the consumption of milk by day pupils present at the 283 nursery, primary and secondary schools maintained by the authority on a day in September, 1961 as compared with a day in the same month in 1960:—

Year	Primary and Nursery Schools			Secondary Schools			All schools combined		
	Number of children present	Number taking milk	Percentage taking milk	Number of children present	Number taking milk	Percentage taking milk	Number of children present	Number taking milk	Percentage taking milk
1961	20,720	18,781	90.6	15,172	7,828	51.6	35,892	26,609	74.1
1960	21,455	19,228	89.6	13,762	7,482	54.4	35,217	26,710	75.8

Consumption at primary and nursery schools has remained virtually unchanged at its present very satisfactory level for some years but the consumption figures for secondary school pupils have shown a slight decline over the past three years. It is difficult to account for this slightly downward trend as far as secondary school pupils are concerned. One wonders whether there is a certain tendency for the older

school child to regard milk drinking as a characteristic of receding childhood.

The following table shows the percentages of different types of milk being supplied to children attending maintained day schools in September, 1961, the corresponding figures for 1960 being shown in brackets:—

Pasteurised	...	...	...	73.0% (80.5%)
Tuberculin tested	...	...		27.0% (19.5%)

Physical Education

I am indebted to the Chief Organisers of Physical Education, Miss Kathleen Sutton and Mr. Lionel Heyworth, for the following report:—

"County organisations, local clubs and schools with the support of the Education Committee continue to encourage, foster and give opportunity for physical training and recreation at school and in youth and adult fields.

Physical education has contributions to make in three fields of human development — physical, recreational and social.

The physical education programmes at primary, secondary, youth and adult levels have been designed to enable the individual gradually to adapt himself physically to his changing environment. In the larger new primary schools, halls present opportunity for indoor work during bad weather, good surfaced playgrounds enable many types of activity to be undertaken, changing and footwashing facilities afford opportunity for bare footwork, and playing fields at new schools are proving their worth in all round development.

With the steady increase in secondary school building providing gymnasia equipped with large apparatus, the natural development of secondary school children is being ensured, a development which should begin at the infant stage with the opportunity to hang, twist, curl and stretch. In some

primary schools this has been made possible by the provision of large portable climbing apparatus and we look to the time when all primary schools, whether urban or rural, can be provided with this equipment.

The vital link between outdoor activity and the regular indoor lesson in the secondary school is well illustrated at the new Ullswater School where the rock climbing training corner opened in September. A new feature in physical education, this has aroused considerable interest nationally and has been received with enthusiasm by the boys.

At secondary level good carriage, personal fitness and body development are stressed as important criteria at which young people should aim and it has been found that circuit training for boys provides a means for endeavour which can be graduated to individual needs. A girl at the secondary school stage, is given opportunity in the gymnasium, to develop her body through set movement tasks which call for initiative, control, courage and the ability to create her own movement patterns, and which train her to move with poise, confidence and economy of effort.

Swimming plays an increasingly active role in the physical education of the Cumberland child. The county's natural facilities offer opportunity for instruction in rivers, lakes and pools. During the current year over 2,500 children have learnt to swim and have gained certificates at progressive stages. Teachers have recognised the need for early instruction in swimming, and enterprising voluntary schemes have been completed at Millom Secondary School and Penrith National Boys' School, which has provided its own plastic swimming pool at a cost of £310, the ideal solution for the primary school. During a poor swimming season, 20 boys have learnt to swim in three weeks. In addition, voluntary efforts are being made to serve four other areas in the county. The new Solway Girls' School is the first school in Cumberland to include an indoor bath and learners' pool in its physical education facilities. Since the bath came into use

ten weeks ago, 180 girls gained county awards ranging from the beginners to the second class stage. The bath at present also serves the boys' secondary school and the local primary schools.

In the recreational and social fields, physical education has a major contribution to make to the welfare of the community. It is one of the primary aims in schools so to train the minds of young people that they appreciate they have a duty not only to themselves but also to those around them to occupy themselves profitably in their leisure hours.

Having in mind these principles, Cumberland teachers aim to train the child from an early age in fundamental skills and later specialised skills leading to a wide variety of activity, giving him the personal experience of breadth in recreation including all national field games, court games, aquatics, athletics, dancing, contest sports and the many outdoor activities so that he may choose for himself the alternative recreational pursuits which he will follow immediately upon leaving school and in later life.

Health Education

In undertaking health education work in schools one very necessary factor is a constant sensitivity to changes taking place in the background against which we work. Dr. Mair makes a thought provoking assessment of the mental attitude of the older school-child in the following comments:—

"Mental health at all ages is of great interest today. Over the past four years the mental health of the fourteen year old boy in the secondary modern school has improved. In 1958 the routine examination of this group was a depressing task. Few had any idea of what they wanted to do when they left school. Many were simply putting in time until they were fifteen. They were bored to death just with living.

Today this picture has changed completely. The education system seems to be guiding and releasing the future poten-

tial. There is an undercurrent of excitement, about what they intend to do. The boy who does not know is a rarity. The idea that the basic training to be had at school is of tremendous value has been accepted. He is quite prepared to stay an extra term to get the job he wants and he is proud to have won a place in an "end on" course. An apprenticeship has become a necessity.

From the almost universal disgruntlement with school of four years ago there is now a vast excitement, a thrusting potential and a surging forward to grapple with the problems of this Space Age.

Somehow, amidst all this excitement, the girls feel left out. There is still the shrug of the shoulders and "I suppose I'll . . . . . " answer to the question "What will you do when you leave school?"

Dr. Mair also comments on a more particular aspect of the health of the school-child, viz. foot conditions.

"During 1961 I have taken particular interest in feet. In the mass there is surprisingly little wrong with the feet of children. In each of the three routine groups there is the expected filthy pair of feet associated with general lack of cleanliness.

In the entrant group the orthopaedic defects are mostly the flat foot associated usually with the "developmental" knock knee and the toes that over-lap. Skin conditions are rare. I was astonished to find one child with a plantar wart but found none with any interdigital infection.

Between this examination and the next at 14, care of the feet seems to deteriorate. The secondary school child has developed the early signs of hallux valgus, frequently giving a history of such a condition being in the family. Plantar warts are to be expected and also one or two children with an interdigital infection.

Life has been described as "a slow process of death". Is this apparent deterioration in the health of the feet one of the early manifestations of this process in one particular group of people?"

How to influence the attitude of the school child in the right direction on all of these important aspects of personal and community health is the formidable task set in health education. Cumberland is a rural county and one of the characteristics of such an area from the point of view of public health nursing, upon which devolves much of the responsibility for health education in schools, is the combined midwife/district nurse/health visitor/school nurse. Miss Cormack who holds such a combined appointment in a rural area writes as follows on the broad front of health education which starts even before a child's birth.

"The combined midwife/district nurse/health visitor/school nurse, gives ante-natal care, helping the mother to establish the right attitude towards childbirth and the care of a family. She gains the mother's confidence and in the case of a home confinement she delivers the baby at birth. Through subsequent regular home visits the nurse comes to know the child very well, having observed his physical, mental and emotional development. She is in contact with the family doctor, the school doctor, the school teacher and the parents and so has a good all-round picture of the child's progress. The child also knows and trusts the nurse before school age is reached.

At school, every term, the child is seen by the nurse at the "Hygiene Inspection", when the general appearance, the hair, the teeth, the clothing and shoes of the youngster are noted. Each child is seen separately, and knowing the child well, the nurse is able to chat informally, teaching the necessity of personal hygiene. At the school medical inspection when the child is examined by the school doctor, the nurse acts as liaison between doctor and family, and is able to contribute much valuable information. When emotional problems occur,

such as enuresis or even nail biting, knowing the mother — child relationship is helpful.

Where individual teaching is beneficial to the young child, group health teaching is essential for the 11+ age group. The adolescent, who is probably passing through the most difficult part of his or her life, needs understanding and unobtrusive guidance. Emotional problems are uppermost at this time and although most adolescents are idealists at heart, they need steering into the right "channels" so that exuberance and energy can be released in healthy pursuits.

Health teaching can play a tremendous part, physically, mentally, emotionally, and spiritually, in the lives of these young people before they leave school, thus helping them to make sound judgment in the choice of companions and pursuits after leaving school. This group health teaching is carried out by the health visitor/school nurse but even more concentrated courses of talks are necessary to make the vital impression demanded. In view of the raised school leaving age and the ever increasing earlier age of marriage, the last years at school would seem an ideal time to teach parent craft, hygiene, first aid, etc., in order to prepare the adolescent to become the mature adult ready to accept the responsibilities of family life and citizenship."

From Wigton Miss Mercer writes of the progress in her area in health teaching to secondary schoolgirls.

"My visits to Wigton Secondary School have continued during the past year at approximately fortnightly intervals. All the girls in the 14-15 age group attend the classes in turn —changes being made at the beginning of each term.

This was started a few years ago at the request of the headmaster and the request was for talks and practical work on "Mothercraft". Five or six visits are paid to the school each term—on alternate Tuesday mornings and lasting an hour. Subjects covered during the term include clothing, bathing, feeding, general development, prevention of accidents and prevention of infection.

Some of the equipment used is provided by the school, i.e. model "baby", bath and film projector and some clothing which was made in the needlework classes. Other materials such as film strips, more clothing, bottles and samples of food I take from Wigton Clinic or obtain from the county health department along with posters and leaflets.

I think that this has now grown to be an accepted part of the girls' normal school life and I have been told that some of them do assist quite usefully in caring for the younger members of their families."

APPENDIX A

MEDICAL INSPECTION AND TREATMENT

Part 1—Medical Inspection of Pupils attending maintained Primary and Secondary School (Including Nursery and Special Schools)

Table A—Periodic Medical Inspections

Age Groups Inspected (By year of birth) (1)	No. of Pupils Inspected (2)	Physical Condition of Pupils Inspected			
		Satisfactory		Unsatisfactory	
		No. (3)	% of Col.2 (4)	No. (5)	% of Col.2 (6)
1957 and later	53	53	)	—	
1956	1,586	1,585	) 99.87	1	) 0.13
1955	1,427	1,424	)	3	)
1954	217	215		2	
1953	87	87		—	
1952	45	45		—	
1951	2,380	2,379	99.96	1	0.04
1950	244	243		1	
1949	95	94		1	
1948	44	44		—	
1947	2,085	2,085	100	—	
1946 and earlier	491	491		—	
TOTAL	8,754	8,745		9	

Table B—Pupils found to require treatment at Periodic Medical Inspections

(excluding Dental Diseases and Infestation with Vermin)

Age Groups Inspected (By year of birth) (1)	For defective vision (excluding squint) (2)	For any of the other conditions recorded in Part II (3)	Total individual pupils (4)
1957 and later	—	6	6
1956	37	102	132
1955	37	104	130
1954	2	14	16
1953	10	7	15
1952	4	3	6
1951	72	108	176
1950	9	12	20
1949	2	6	8
1948	6	3	9
1947	110	69	176
1946 and earlier	36	26	61
TOTAL	325	460	755

Table C—Other Inspections

Number of Special Inspections	2,958
Number of Re-inspections	6,265
Total	9,223

Table D—Infestation with Vermin

(a)	Total number of individual examinations of pupils in schools by school nurses or other authorised persons	79,007
(b)	Total number of individual pupils found to infested	1,269
(c)	Number of individual pupils in respect of whom cleansing notices were issued (Section 54(2), Education Act, 1944)	—
(d)	Number of individual pupils in respect of whom cleansing orders were issued (Section 54(3), Education Act, 1944)	—

Part II—Defects found by Medical Inspection during the year.

Table A—Periodic Inspections

Defect Code No. (1)	Defect or Disease (2)	PERIODIC INSPECTIONS Entrants (T) (3)	Entrants (O) (4)	Leavers (T) (5)	Leavers (O) (6)	Others (T) (7)	Others (O) (8)	Total (T) (9)	Total (O) (10)
4	Skin	14	49	10	55	14	55	38	159
5	Eyes—a. Vision ...	73	287	111	293	141	486	325	1066
	b. Squint ...	17	66	7	14	10	65	34	145
	c. Other ...	6	19	5	8	6	15	17	42
6	Ears—a. Hearing ...	10	75	6	14	14	58	30	147
	b. Otitis Media	4	45	3	15	1	27	8	87
	c. Other ...	5	10	2	4	8	15	15	29
7	Nose and Throat ...	40	338	4	74	16	147	60	559
8	Speech	21	67	—	9	9	29	30	105
9	Lymphatic Glands	2	85	—	5	1	26	3	116
10	Heart	5	36	1	19	2	26	8	81
11	Lungs	13	148	1	44	12	126	26	318
12	Developmental—								
	a. Hernia ...	1	12	—	3	4	7	5	22
	b. Other ...	1	38	8	11	6	101	15	150
13	Orthopaedic—								
	a. Posture ..	1	8	5	4	3	8	9	20
	b. Feet ...	27	50	3	17	14	36	44	103
	c. Other ...	15	100	4	47	13	66	32	213
14	Nervous System—								
	a. Epilepsy ...	—	6	—	8	—	9	—	23
	b. Other ...	1	12	—	4	3	8	4	24
15	Psychological—								
	a. Development	2	24	1	23	2	67	5	114
	b. Stability ...	6	41	2	6	1	22	9	69
16	Abdomen	1	25	—	12	3	17	4	54
17	Other	19	37	10	29	42	80	71	146

Table B.—Special Inspections

Defect Code No.	Defect or Disease	SPECIAL INSPECTIONS Pupils requiring Treatment	Pupils requiring Observation
(1)	(2)	(3)	(4)
4	Skin	504	31
5	Eyes—a. Vision ...	257	307
	b. Squint ...	9	12
	c. Other ...	103	10
6	Ears—a. Hearing ...	20	31
	b. Otitis Media	16	14
	c. Other ...	27	8
7	Nose and Throat ...	36	52
8	Speech	34	20
9	Lymphatic Glands ...	2	7
10	Heart	2	5
11	Lungs	14	25
12	Developmental—		
	a. Hernia ...	—	3
	b. Other ...	1	3
13	Orthopaedic—		
	a. Posture ...	—	4
	b. Feet ...	28	12
	c. Other ...	3	20
14	Nervous System—		
	a. Epilepsy ...	3	4
	b. Other ...	5	4
15	Psychological—		
	a. Development	10	24
	b. Stability ...	10	13
16	Abdomen	4	9
17	Other	339	50

Part III—Treatment of Pupils attending maintained Primary and Secondary Schools

(Including Nursery and Special Schools)

Table A—Eye Diseases, Defective Vision and Squint

	Number of cases known to have been dealt with
External and other, excluding errors of refraction and squint	139
Errors of refraction (including squint)	3,250
Total	3,389
Number of pupils for whom spectacles were prescribed	1,605

Table B—Diseases and Defects of Ear, Nose and Throat

	Number of cases known to have been dealt with
Received operative treatment—	
(a) for diseases of the ear ...	1
(b) for adenoids and chronic tonsillitis	64
(c) for other nose and throat conditions	25
Received other forms of treatment ...	71
Total	161
Total number of pupils in schools who are known to have been provided with hearing aids—	
(a) in 1961	15
(b) in previous years	27

Table C.—Orthopaedic and Postural Defects.

	Number of cases known to have been treated
(a) Pupils treated at clinics or out-patients departments	1,049
(b) Pupils treated at school for postural defects	—
Total	1,049

Table D.—Diseases of the Skin.

	Number of cases known to have been treated
Ringworm—(a) Scalp	—
(b) Body	16
Scabies	24
Impetigo	66
Other skin diseases	440
Total	546

Table E.—Child Guidance Treatment.

	Number of cases known to have been treated
Pupils treated at Child Guidance clinics	300

Table F.—Speech Therapy.

	Number of cases known to have been treated
Pupils treated by speech therapists ...	413

Table G.—Other Treatment Given.

	Number of cases known to have been dealt with
(a) Pupils with minor ailments ...	403
(b) Pupils who received convalescent treatment under School Health Service arrangements	124
(c) Pupils who received B.C.G. vaccination	2,185
Total (a)—(c) ...	2,712

Part IV—Dental Inspection and Treatment carried out by the Authority.

(1)	Number of pupils inspected by the Authority's Dental Officers:—			
	(a) At Periodic Inspections	31,921		
	(b) As Specials	392		
			Total (1)	32,313
(2)	Number found to require treatment			20,371
(3)	Number offered treatment ...			13,144
(4)	Number actually treated			12,492
(5)	Number of attendances made by pupils for treatment, including those recorded at 11(h)			28,085
(6)	Half days devoted to:			
	(a) Periodic (School) Inspection	283		
	(b) Treatment	3,349		
			Total (6)	3,632
(7)	Fillings:			
	(a) Permanent Teeth ...	14,938		
	(b) Temporary Teeth ...	1,870		
			Total (7)	16,928

(8)	Number of Teeth filled:			
	(a) Permanent Teeth ...	13,968		
	(b) Temporary Teeth ...	1,870		
			Total (8)	15,766
(9)	Extractions:			
	(a) Permanent Teeth ...	5,574		
	(b) Temporary Teeth ...	10,996		
			Total (9)	16,570
(10)	Administration of general anaesthetics for extraction			3,416
(11)	Orthodontics:			
	(a) Cases commenced during the year			121
	(b) Cases brought forward from previous year			59
	(c) Cases completed during the year			35
	(d) Cases discontinued during the year			26
	(e) Pupils treated by means of appliances			57
	(f) Removable appliances fitted ...			63
	(g) Fixed appliances fitted ...			—
	(h) Total attendances			510
(12)	Number of pupils supplied with artificial teeth			385
(13)	Other operations:			
	(a) Permanent Teeth ...	5,727		
	(b) Temporary Teeth ...	980		
			Total (13)	6,707

APPENDIX B

Handicapped Pupils requiring Education at Special Schools approved under Section 9(5) of the Education Act, 1944, or Boarding in Boarding Homes.

During the calendar year ended 31st December, 1961	(1) Blind (2) Partially sighted		(3) Deaf (4) Partially deaf		(5) Physically Handicapped (6) Delicate		(7) Maladjusted (8) E.S.N.		(9) Epileptic (10) Speech Defects		Total Cols. (1)-(10)
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
A. How many handicapped pupils were newly assessed as needing special educational treatment at special schools or in boarding homes?	2	2	3	1	6	—	—	51	—	1	66
B. (i) of the children included at **A**, how many were newly placed in special schools (other than hospital special schools) or boarding homes?	—	—	—	—	3	—	—	3	—	—	6
(ii) of the children assessed prior to 1st January, 1961, how many were newly placed in special schools (other than hospital special schools) or boarding homes?	—	1	2	2	3	—	—	25	1	—	34
Total (B(i) and B(ii)) ...	—	1	2	2	6	—	—	28	1	—	40
On or about 20th January, 1962, how many handicapped pupils from the											

	Authority's area—											
C	(i) were required places in special schools—Total (a) Day ...	—	—	—	—	—	—	—	28	—	—	28
	(b) Boarding	3	3	1	1	6	—	—	172	1	1	188
	(ii) included at (i) had not reached the age of 5 and were awaiting											
	(a) day places	—	—	—	—	—	—	—	—	—	—	—
	(b) boarding places ...	2	—	1	—	—	—	—	—	—	—	3
	(iii) included at (i) who had reached the age of 5, but whose parents had refused consent to their admission to a special school, were awaiting—											
	(a) day places	—	—	—	—	—	—	—	3	—	—	3
	(b) boarding places ...	1	2	—	1	1	—	—	62	1	—	68
D.	(i) were on the registers of (1) maintained special schools as—											
	(a) day pupils	—	—	—	—	—	—	—	4	—	—	4
	(b) boarding pupils ...	—	2	1	—	2	—	—	84	2	—	91
	(2) non-maintained special schools as—											
	(a) day pupils	—	—	—	1	—	—	—	—	—	—	1
	(b) boarding pupils ...	7	6	10	9	11	2	1	—	2	—	48
	Total	7	8	11	10	13	2	1	88	4	—	144

(ii) were on the registers of independent schools under arrangements made by the Authority	—	—	—	—	2	—	1	1	—	—	4
Total (D(i) and D(ii)) ...	7	8	11	10	15	2	2	89	4	—	148
(iii) were boarded in homes and not already included under (i) and (ii) above	—	—	—	—	—	—	—	—	—	—	—
Total (D(i), (ii) and (iii)) ...	7	8	11	10	15	2	2	89	4	—	148
E. On or about 20th January, 1962, how many handicapped pupils (irrespective of the areas to which they belong) were being educated under arrangements made by the Authority in accordance with Section 56 of the Education Act 1944											
(i) in hospitals	—	—	—	—	*13	—	—	—	—	—	13
* Comprising 4 P.H. long stay cases and 9 short stay cases undergoing treatment for infections and appendicitis.											
(ii) in other groups (e.g. units for spastics convalescent homes)	—	—	—	—	—	—	—	—	—	—	—
(iii) at home	1	1	—	—	12	—	—	4	1	—	19

APPENDIX C

ARRANGEMENTS FOR THE SUPERVISION OF E.S.N. SCHOOL LEAVERS

1. All educationally subnormal leavers in their final year to be reviewed by the school medical officer at his annual visit to the school.

2. This Department to arrange for an up-to-date report by the educational psychologist to be available to the medical officer at the review.

3. The medical officer to make a recommendation on the question of supervision after leaving school after discussion with the head teacher and consideration of the psychologist's report.

4. The criteria of the need for supervision to be no longer strictly confined to those children who would previously have been ascertained under Section 57(5) of the Education Act as requiring to be reported to the local health authority and therefore coming under statutory supervision thereafter as mentally defective. Any E.S.N. child leaving school whose future seems to present serious hazards should be recommended for supervision, usually by a health visitor. Outstanding among these hazards would be unpromising employment potential; the possibility of moral danger; and the possibility of drifting in an unsatisfactory home environment into delinquency. It is visualised that the health visitor would exercise her supervision in a completely informal and discreet fashion, and bring to the attention of the Department cases in which difficult situations were developing, and also make and maintain contact with other field workers such as probation officer, youth employment officer, where the need appeared. The aim is to maintain a continuing, if often infrequent, cotact with the youth or girl and his or her family. This would be of indefinite duration and it is thought, in the majority of cases, would not require

to occupy a lot of the health visitor's time. The medical officer should indicate the fact if he feels in any case that the follow-up would be best undertaken by a mental welfare officer.

5. The recommendations to be passed to the Director of Education for his letter to parents. It is suggested that wherever possible the school medical officer should see the parents of the child, probably at the clinic in most cases, to outline to them the purpose of the supervision, and further, that it would be suitable for the medical officer while doing this to introduce the health visitor, or mental welfare officer, who will be undertaking the supervision, where he or she is not already known to the parents. It is further suggested that the doctor might well deliver the official letter from the Director at this interview.

6. The 'back-log" of cases who have left school since the coming into operation of the Mental Health Act in November 1960 to be decided upon in this Department on the basis of the information on the files and the last educational psychologist's report specially obtained for this purpose.

APPENDIX D

SCHOOL HEALTH SERVICE CLINICS AS AT 31.12.61.

ALSTON:

Dental—2nd and 4th Tuesday—all day.
School—Each Wednesday a.m.

ASPATRIA:

Dental—1st, 3rd and 5th Mondays—all day.
School—Each Wednesday a.m.—Medical Officer attending on 1st and 3rd Wednesdays only.
Orthopaedic Aftercare—2nd Friday p.m., 4th Friday a.m.
Speech Therapy—Each Thursday p.m.

BRAMPTON:

Dental—Each Wednesday—all day.
School—Each Friday a.m. with Medical Officer attending on 1st and 3rd Fridays only.
Orthopaedic Aftercare—1st Tuesday a.m.

CARLISLE:

Dental—Daily—all day.
—At Eden School—as required.
School—2nd and 4th Wednesdays a.m. with Medical Officer in attendance.
Eye Specialist—Each Monday and Thursday a.m.
Orthoptic—Each Monday a.m. and 2nd Thursday all day.
E.N.T. Specialist—Monday p.m. as required.
Child Guidance—Each Thursday p.m.
Speech Therapy—Each Monday p.m. and all day Tuesday.
Orthopaedic Aftercare—Each Tuesday p.m.
Orthopaedic Surgeon—1st Monday every odd month p.m., 1st Monday every even month a.m. and occasionally as required.

CLEATOR MOOR:

Dental—Each Monday and Wednesday—all day.
School—Each Monday and Thursday a.m. with Medical Officer attending 1st and 3rd Thursdays only.
Orthopaedic Aftercare—2nd and 4th Tuesdays p.m.
Speech Therapy—Each Tuesday a.m.

COCKERMOUTH:

Dental—Each Tuesday, Friday and occasional Thursday —all day.

School—Each Monday and Thursday a.m. with Medical Officer attending 2nd and 4th Mondays.

Eye Specialist—Each Tuesday a.m. except 4th Tuesday.

Orthopaedic Aftercare—1st and 3rd Wednesdays—all day.

Speech Therapy—Each Thursday—all day.

EGREMONT:

Dental—Each Monday and Friday—all day.

School—Each Thursday a.m. with Medical Officer seeing cases 1st and 3rd Thursday p.m. before child welfare.

Speech Therapy—Each Wednesday a.m.

Orthopaedic Aftercare—2nd and 4th Tuesday a.m.

FRIZINGTON:

Dental—Each Tuesday—all day.

School—Each Monday and Wednesday a.m.—Medical Officer atending 2nd and 4th Mondays.

KESWICK:

Dental—Each Monday and Thursday—all day.

School—Each Thursday a.m.

Speech Therapy—Each Tuesday p.m.

Orthopaedic Aftercare—4th Monday all day.

Eye Specialist—Each 4th Tuesday a.m.

LONGTOWN:

Dental—Each Friday—all day.

MARYPORT:

Dental—Each Monday and Friday—all day.

School—Each Tuesday and Friday a.m. with Medical Officer atending on 2nd and 4th Tuesdays.

Speech Therapy—Each Wednesday—all day.

Orthopaedic Aftercare—1st and 3rd Tuesdays—all day.

Child Guidance—Each Monday p.m.

MILLOM:

Dental—Each Tuesday, Wednesday and Thursday—all day.
School—Each Tuesday a.m. and Friday p.m. with with Medical Officer attending 1st and 3rd Tuesdays only.
Speech Therapy—Each Thursday—all day.
Child Guidance—Thursday p.m. as required
Orthopaedic Aftercare—3rd Monday a.m.
Eye Specialist—each 1st and 3rd Friday a.m.

PENRITH:

Dental—Each Monday, 1st and 3rd Tuesday and Friday all day, and occasional Thursday—all day.
School—Each Tuesday a.m. with Medical Officer attending 2nd and 4th Tuesdays only.
Speech Therapy—Tuesday a.m. Wednesday all day.
Orthopaedic Aftercare—2nd and 4th Wednesday—all day.
Orthopaedic Surgeon — 1st Monday every even month p.m.
Orthoptic—Each Wednesday p.m.

SEASCALE:

Dental—As required.
Orthopaedic Aftercare—3rd Monday p.m.

SILLOTH:

Dental—Each Wednesday—all day.
Orthopaedic Aftercare—3rd Friday p.m.

WHITEHAVEN (Flatt Walks):

Dental—Daily all day. 2nd Clinic Wednesday—all day.
School—Daily a.m. with Medical Officer attending each Wednesday morning.
E.N.T. Specialist—Tuesday a.m. as required.
Eye Specialist—Each Monday, Wednesday and Thursday a.m.
Speech Therapy—Monday and Friday all day.

Orthopaedic Aftercare—Each Thursday all day.
Orthopaedic Surgeon—1st Friday every odd month a.m., 2nd Friday every even month a.m. and occasionally as required.
Orthoptic—Each Friday—all day.
Child Guidance—Each Wednesday p.m. Each Friday a.m.

WHITEHAVEN (Woodhouse):
School—Each Monday, Wednesday and Friday a.m. with Medical Officer attending each Wednesday.

WHITEHAVEN (Mirehouse):
Dental—Thursday—all day.
School—Tuesday and Thursday a.m. with Medical Officer seeing cases before child welfare every Tuesday p.m.

WIGTON:
Dental—Tuesday, Wednesday and Thursday—all day.
School—Each Monday a.m. with Medical Officer attending 1st and 3rd Mondays.
Speech Therapy—Each Thursday a.m.
Orthopaedic Aftercare—3rd Friday a.m.

WORKINGTON (Stoneleigh):
Dental—Daily all day.

WORKINGTON (Park Lane):
Dental—Daily—all day.
School—Daily a.m. with Medical Officer attending each Tuesday a.m.
Speech Therapy—Each Monday and Friday all day.
Orthoptic—Each Thursday—all day, except 2nd in month.
Orthopaedic Aftercare—Each Friday all day except 3rd
Orthopaedic Surgeon—1st Friday every even month a.m. 2nd Friday odd month a.m. and occasionally as required.
Eye Specialist—Every Thursday a.m.
Child Guidance—Each Wednesday a.m.