[Report 1968] / School Medical Officer of Health, Cumberland County Council.

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CUMBERLAND COUNTY COUNCIL
EDUCATION COMMITTEE

The School Health Service

1968

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1958

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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 1968.

The formation of the general practitioner led family health care teams in this county practising from central surgeries with full attachment of nurses, social workers and others, has now set a pattern for the comprehensive provision of medical advice, treatment and administrative action for families who are in need.

The year has seen the development of this comprehensive team in two particular areas where from the medical members of the team there, one doctor, having special interest in paediatric medicine, has carried out for the practice in the rural areas concerned, the school health and child welfare duties on behalf of the education and health authorities. This development is proving of great value to the parents, the children and the teachers concerned. This system now is operative for about 15 per cent. of pre and school children in the County.

The school nurse is now becoming more of a community nurse associated with the general practitioner paediatrician and it may not be too far into the future where both the general practitioner paedriatrician and the community nurse have part-time appointments in the paediatric unit of the district general hospital.

The general trend of events, and views, expressed in the Sheldon Report on child welfare centres are accepted in this county and the transition from child welfare clinics to child health centres with stronger links between hospital and group practice continues to take place. I would like to see the centralising of assessment centres in hospital as a step which will not be too long delayed and which will prove, I am sure, of value to the handicapped child and its family.

The speed of events continues to quicken and it is salutory to realise that last year when preparing this report I was thinking in terms of community and hospital medicine, whereas the passage of even one year has altered my views on

this. Hospital and community medicine now appear to me to be part of the same continuing process and must be jointly planned. The presence of limited resources of skilled personnel and money means that it is essential that the best use should be made of what is in fact available, and this can only be achieved by co-ordinated planning.

Most importantly, the prevention of disease cannot in the light of present-day knowledge be regarded as a separate process or as being different in quality. The prevention of most of today's illnesses does not depend upon public health staff, or indeed on teachers, but calls on the active and joint participation of family doctors, hospital doctors, teachers, parents and school health staff.

Thus, I now view the concept of a unity in medicine as being essential and this is reflected in the community's wish for a unified service. The future unity of the medical services, and possibly of the social services, is one which will not be too long delayed I hope, as there is a feeling of insecurity during a time of change. I for one would be glad to see the way ahead clearly marked out as soon as possible. The role of the school health nurse in the future is indeed one which needs far more definition than we at present have.

The following pages show the general work of the school health service during the year, which is one of which we can all be proud, as indeed, we can of the continuing health of the school child.

My thanks go to my deputy, Dr. J. D. Terrell, for the preparation of this report, and to all members of the Health Department for such hard work during the year.

I am, Mr. Chairman, Ladies and Gentlemen,

Your obedient servant,

John Leiper.

Principal School Medical Officer.

County Health Department,
11, Portland Square,
Carlisle.
May, 1969.

SCHOOL HEALTH SERVICE STAFF

AS AT 31st DECEMBER, 1968

SCHOOL MEDICAL AND DENTAL STAFF

Principal School Medical Officer—

*J. 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.

Assistant Medical Officers—

C. A. Bentley, B.A., M.R.C.S., L.R.C.P., D.P.H.
Northern Area Medical Officer.
Also Medical Officer of Health Border R.D.C.

*E. M. O. Campbell, M.B., Ch.B., D.P.H., D.T.M. & H.
Also Medical Officer of Health, Maryport U.D.C.

D. H. Chowdhury, M.B., B.S., D.P.H., D.I.H. (resigned 18-1-68).
Also Medical Officer of Health, Penrith U.D.C. and R.D.C.

J. E. M. Garland, M.B., Ch.B., D.P.H. (part-time Medical Officer of Health to Wigton R.D.C.).

*A Hargreaves, M.B., Ch.B., D.P.H.
Also Medical Officer of Health, Cockermouth R.D.C. and U.D.C. and Keswick U.D.C.

J. R. Hassan, M.B., Ch.B., D. Obst. R.C.O.G. (part-time General Practitioner).
Also Medical Officer of Health, Alston with Garrigill R.D.C.

*J. L. HUNTER, M.B., Ch.B., D.P.H. (Western Area Medical Officer).
Also Medical Officer of Health, Workington Borough Council.

*F. S. Rogers, M.B., Ch.B., D.P.H. (Northern Area Medical Officer) (resigned 15-5-68).
Also Medical Officer of Health to Border R.D.C.

*S. Smith, M.B., Ch.B., D.P.H. (Southern Area Medical Officer).
Also Medical Officer of Health, Whitehaven Borough and Ennerdale R.D.C.

The above are District Medical Officers of Health and Assistant School Medical Officers.

*J. E. Ainsworth, M.B., Ch.B.
*H. M. Marks, M.B., Ch.B.
*M. Timperley, M.B., Ch.B., D.C.H.
K. R. Walker, M.B., Ch.B.
*Approved for the ascertainment of educationally sub-normal pupils.

Principal School Dental Officer—

R. B. Neal, M.B.E., T.D., L.D.S., R.C.S .

Area School Dental Officer—

I. R. C. Crabb, L.D.S., R.F.P.S.

Senior Dental Officer—

A. M. Scott, L.D.S.

School Dental Officers—

J. Colvin, L.D.S. (commenced August, 1968).
A. B. Gibson, B.D.S.
F. H. Jacobs, L.D.S.
A. Osuhor, B.D.S. (resigned December, 1968).
I. H. Parsons, L.D.S.
A. R. Peck, L.D.S.

MEDICAL AUXILIARY STAFF

Screening Assistants—

Miss A. Jackson.
Miss D. Kidd (commenced 26-8-68).
Mrs. J. Laidlaw.

Orthopaedic Physiotherapists—

Mrs. P. P. Bratt, M.C.S.P. (part-time).
Miss M. Sivewright, M.C.S.P., O.N.C. (part-time).

Orthoptists—

Miss J. A. M. Davies, D.B.O. (commenced 2-1-68).
Mrs. G. M. Richardson, D.B.O. (part-time).
(resigned 19-7-68).
Mrs. J. Scott, D.B.O. (part-time).

Speech Therapists—

Mr. M. S. Beattie, L.C.S.T. (resigned 31-7-68).
Mrs. E. M. Blacklock, L.C.S.T.
Miss E. B. Moon, L.C.S.T. (part-time).
Mrs. S. Latimer, L.C.S.T. (part-time).
Mrs. J. Stone, L.C.S.T. (part-time).

NURSING STAFF

Superintendent Nursing Officer—

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

Deputy Superintendent Nursing Officer—

Miss K. J. Hayes, S.R.N., S.C.M., H.V. Cert. (commenced 8-7-68).

Area Nursing Officers—

Miss J. Reid, S.R.N., S.C.M., Q.N., H.V.Cert. (Southern Area).

Miss J. M. Crossfield, S.R.N., Q.N., H.V.Cert. (Western Area).

Mrs. J. M. Roberts, S.R.N., S.C.M., Q.N., H.V.Cert. (Northern Area).

Nurses Qualifications Code

1. State Registered Nurse (or Registered General Nurse).
2. State Certified Midwife.
3. District Nursing Certificate.
4. Health Visitor's Certificate.
5. Registered Fever Nurse.
6. Registered sick children's nurse.
7. Orthopaedic Nursing Certificate.

School Nurses—
Full time

Mrs. E. Fagan, 1, 3, 5	Workington
Mrs. E. Foster, 1, 6	Maryport
Mrs. M. E. Sansom, 1, 2, 5	Workington
Mrs. S. Miller, 1	Whitehaven
Mrs. B. F. Wilson, 1	Whitehaven

Health Visitors/School Nurses—
Full time—Northern Area

Miss I. Arnott, 1, 2, 3, 4	Penrith
Miss C. M. Bannon, 1, 2, 3, 4	Aspatria
Miss M. M. Butler, 1, 2, 3, 4	Longtown
Mrs. W. Davison, 1, 2, 4	Penrith
Mrs. M. D. Dixon, 1, 2, 4	Silloth
Miss J. Gibson, 1, 2, 3, 4	Penrith
Miss B. W. Knibbs, 1, 2, 3, 4	Brampton
Miss E. Lockart, 1, 2, 3, 4	Alston
Miss E. Mercer, 1, 2, 4, 5	Wigton
Miss A. M. Murray, 1, 2, 4	Penrith
Miss P. B. Simpson, 1, 2, 3, 4	Dalston/Thursby
Miss E. Tongue, 1, 2, 3, 4	Brampton

Part-time—

Mrs. M. Dobson, 1, 2, 3, 4	Houghton/ Wetheral/Scotby
Mrs. D. Edmondson, 1, 2, 4	Lazonby
Mrs. A. E. Henderson, 1, 2, 3, 4	Kirkbride
Mrs. F. M. Hurst, 1, 2, 3	Bewcastle
Mrs. M. McCredie, 1, 2, 4	Lazonby
Mrs. M. J. Matthews, 1, 2, 3, 4	Watermillock

Western Area—

Full time

Mrs. D. R. Bari, 1, 2, 4	Workington
Mrs. A. E. Campbell, 1, 2, 4	Keswick
Miss G. Davies, 1, 3, 4	Workington
Miss A. Dixon, 1, 2, 3, 4, 7	Cockermouth
Mrs. J. A. Graham, 1, 2, 3, 4	Workington
Mrs. M. Hedworth, 1, 2, 3	Maryport
Mrs. M. Hewitson, 1, 2, 4	Workington
Miss A. Jackson, 1, 2, 4	Workington
Mrs. M. Lythgoe, 1, 2, 4	Cockermouth
Miss J. E. Surtees, 1, 2, 4	Workington
Miss S. Twigg, 1, 2, 3, 4	Maryport

Part-time

Miss M. Casey, 1, 2, 3, 4	Keswick
Mrs. M. E. Dobson, 1, 2, 3	Cockermouth
Miss M. P. Reynolds, 1, 2, 4	Cockermouth

Southern Area—

Full time

Miss I. M. Alcock, 1, 2, 4	Whitehaven
Mrs. I. M. Bowe, 1, 2, 3, 4	Millom
Mrs. S. Crellin, 1, 2, 4	Whitehaven
Miss E. Crosby, 1, 2, 4	Ennerdale
Mrs. A. Donald, 1, 2, 3, 4, 6	Millom
Miss M. E. Gibson, 1, 2, 4	Ennerdale
Mrs. A. Petch, 1, 2, 3, 4	Whitehaven
Miss R. Sheppard, 1, 2, 3, 4	Ennerdale
Miss A. Singleton, 1, 2, 4	Whitehaven
Miss P. Walsh, 1, 2, 4	Ennerdale

Part-time

Mrs. E. Kirk, 1, 7	Seascale
Mrs. T. Rich, 1, 7	Millom

Dental Surgery Assistants—

Miss M. I. Stout, Senior Surgery Assistant.
Miss O. Bird.
Mrs. E. M. Byers.
Mrs. E. Hocking.
Miss S. Newall.
Mrs. L. Messenger, S.E.N. (pt commenced 1-8-68).
Mrs. E. Plumb.
Mrs. W. F. Reeves.

GENERAL STATISTICS

The number of pupils on the school registers in January, 1969 was 39,203 compared with 39,009 in the previous year, an increase of 194. In January, 1969 there were in the County:—

	No. of schools.	No. of pupils.
Nursery school	1	40
Primary schools	230	23,202
Secondary schools	6	2,276
Comprehensive schools ...	24	12,418
Grammar schools	3	1,173
Residential special schools .. ... (one for educationally sub-normal boys, age range 9-16 years)	2	94
(one for educationally sub-normal girls, age range 9-16 years)		
		39,203

THE SCHOOL HEALTH SERVICE IN CONTEMPORARY MEDICINE

I drew attention in my Annual Report last year to some of the developments of the School Health Service in relation to both education and medicine, stressing the essential integration which is necessary with both. The greatly extended horizons in the world of education in terms of pupil counselling in every aspect of life and development call for a very careful parallel assessment of medico/social services offered to young people as members of families in the community. It would be a sterile argument as to whether guidance offered to a young person through family health social services channels were of greater importance than that provided by the staff of schools. Clearly unless both operate on the same wavelength only confusion can be expected to result for the child. I am glad that there is every indication that in Cumberland this fact is well recognised and I say a little more on the role of the nurse in this context on page 77.

The intensely personal and individual service, however, which has traditionally in this county been associated with medical care, has produced development in the health services along somewhat different lines. The people and the doctors of this county are firmly wedded to the concept of the "family doctor" as the medical person of first referral for all age groups. Although some specialisation occurs within practice groups of doctors, and more of this may well occur in the future, the family remains the essential unit for medical care. At the same time, for good practical reasons, group practices have been tending to restrict the geographical area of the practices' activity. Particularly in urban areas however, various group practices from whom the public has a choice of doctor operate alongside each other and the difficulties of matching a particular practice to a school will be evident. It is an important contemporary question, however, in medical care, the extent to which the individual will receive personal health care in more than one setting. Thus for the school child the school health service, and for the working population, industrial health services, must increasingly co-operate and even integrate with family health care, and avoid any competitive element which leads to conflicting advice, bad personal relations and expensive inefficiency all round. The process of unification of care can only be gradual and so long as special medical care in the school setting is acknowledged as necessary the appropriate special skills will be needed by the professional personnel involved. The

current widening of interest in post graduate training for doctors in paediatrics is very gratifying in this context. Cumberland is a district geographically at a disadvantage in such schemes which are focussed on a regional centre, in this case Newcastle, and I have under active consideration with consultant paediatric colleagues ways and means of arranging short local courses for groups of doctors interested in further activity in the child health services. Our own particular and local contribution to this situation at present is the planning of a one-week residential refresher course for medical officers at Keswick in March 1969 under the general title of "Child Health in Community Medicine". This is the latest in a series of such staff training courses, now planned in conjunction with the Staff Training Group of the Medical Officers of Health of the Northern Region. Something of a breakthrough this time is the fact that a course whose contents until very recently would have interested only departmental medical officers of local health authorities, has attracted attenders approximately half of whom are general practitioners. The help and support of the University of Newcastle Organisation for Post-graduate Medical Education has been much appreciated in the sphere of advertising. Amongst other distinguished contributors, local, regional and national, the course will be honoured by the presence on the opening day of Sir Wilfrid Sheldon, Chairman of the 1968 Report on Child Welfare Centres. I hope to include a brief account of this important course which is so directly related to the School Health Service, in my annual report next year.

Dr. E. M. O. Campbell has been a school medical officer in Cumberland for 13 years and retires early in 1969. She writes below of the many advances which these years have seen and some of the subjects she touches on are dealt with more fully later in the report.

Dr. Campbell writes:

"The work of the school medical officer in Cumberland has changed considerably over the years. The scope is a very much wider one than it was when I joined the Cumberland County Council School Health Service as an Assistant School Medical Officer thirteen years ago.

"In those days the three main duties of the school doctor were School Medical Inspections, undertaken once yearly, aimed at diagnosing defects in school children with subsequent referral for specialist advice, or to the family doctor

or for treatment at minor ailment school clinics. The second duty was that of carrying out immunisation sessions, and the third minor ailment treatment clinics.

"The minor ailment treatment clinic has long been abolished and any child suffering from such an ailment is now referred to the family doctor.

"Diagnosis of defects where present is still a major aim of school medical examination, but other important factors are now involved. Modern social problems have emphasised to a greater extent than ever before the need for prevention of 'near-disease'. Social factors such as the very prevalent present-day one of both parents working full-time leave the child with a sense of insecurity in his home background which often causes mental or physical health problems. Higher living standards due to higher wages but often with unwise choice of diet, the well attended nightly bingo sessions and many more of these factors, which have arisen through the modern way of life, can all reflect on the health of the school child. The school doctor is involved more and more with trying to solve these problems by discussions and advice to parents and consultations and discussions with head teachers and class teachers.

"The Selective School Medical Examinations Scheme which was introduced into West Cumberland four or five years ago, by elimination of routine medical inspections of normal children and by visits to schools at least once a term (often more frequently) gives greater opportunity for discussion with parents, head teachers and school staffs.

"In former years it was the practice to recommend children with severe physical handicaps for admission to special schools when vacancies occurred. Nowadays the view is taken in Cumberland that the child is better accommodated in normal school, if this can be arranged, so that he can lead as near-normal a life as possible and gain confidence to mix with normal adults in his post-school future. A large part of the school doctor's work is involved in making arrangements for these handicapped children to be so accommodated so that they can lead as happy and productive a school life as their handicap permits. This again involves frequent discussions with and advice to parents and consultations with head teachers and school staffs.

"Here, at the present day, we have the great advantage of the results of research and advances in treatment of many handicaps—a notable example is the great strides which have taken place in heart surgery which transformed the child with a heart defect, after surgical treatment, into a normal school child taking his place in normal school activities, unlike the child of former years whose severe restriction in school activities was a constant worry to the school doctor and his teachers, with little hope for the future.

"The introduction of audiometry into the Cumberland Health Service ensure that children with hearing losses were discovered. Before the appointment of trained audiometricians to carry out sweep tests for hearing loss in school entrants and children suspected of having hearing loss, we in school health service had no reliable tests to determine whether or not the child could hear normally. For the children who fail to pass the audiometric test special clinics are held by the school doctor to investigate their hearing loss further and refer them to the Ear, Nose and Throat specialist when necessary.

"The future of physically handicapped school leavers is a matter of concern to the school doctor. A special form was used to indicate to the Youth Employment Officer the conditions in employment prohibited on account of the handicap. This form has recently been enlarged and amplified to describe in greater detail the capabilities of the handicapped school leaver. In addition, meetings are now held periodically between the school doctor and Youth Employment Officer to discuss how best these handicapped children can be fitted into employment.

"Similarly the future of school leavers in special schools for educationally subnormal pupils is now considered and recommendations are made by the school doctor as to whether they require supervision after leaving school.

"Immunisation sessions are wider in scope than they were formerly. Immunisations against diphtheria and tuberculosis were the only two immunisations undertaken. B.C.G. vaccination was in its infancy in the Cumberland County School Health Service thirteen years ago. Through the years immunisation against tetanus, poliomyelitis and, more recently, measles have been introduced. Sessions have been facilitated by the introduction of disposable syringes which greatly facilitate the movement from school to school

by abolishing the care which had to be taken over keeping a steriliser and glass syringes sterile in transit.

"Health Education has always been given individually to children at school medical examinations. For some years group education in health has been practised. The emphasis on health education in schools whether given by the school nurse, a health visitor trained in health education, or the school doctor is very much greater than it was thirteen years ago.

"Talks on the dangers of smoking were given in the Maryport Junior Schools. These were carried out with the aid of a cartoon film and discussions were held afterwards. Questions were asked freely by a number of children but these were mostly to clear up points which were obscure in the cartoon and which they had not understood. They did, however, show interest in the ill-effects of smoking in athletes. This was obviously the nearest they could apply the subject to themselves."

I am grateful to Mrs. Kirkpatrick, Headmistress, Valley Infants' School, for the following comments on the work of the school health service, linking this very significantly with the pastoral work of the school on the one hand and the high level of service at West Cumberland Hospital on the other.

Mrs. Kirkpatrick writes:—

"I cannot speak too highly of the tremendous co-operation which I have received from the School Health Service during 1968. Every effort has been made to ensure that any problems regarding the children's health and welfare have been resolved.

"The school nurses, health visitors and peripatetic specialists are welcomed by staff and children alike.

"In this large widely spread Infant School it was found advisable to hold medical inspections in the nearby clinic, the parents collecting the children from and returning them to the school. This proved to be an ideal arrangement as the children will now go along happily even for dental treatment, confident that they are among friends.

"Doctors and nurses visiting the school for inoculation purposes are particularly thoughtful regarding disruption of

the normal routine and even then they are always pleased to discuss any special cases I am anxious about.

"Children with severe speech defects visit the Speech Therapist regularly, and a marked improvement in reading confidence has been noted in one particular case with a cleft palate. However, I find that working parents are less likely to take advantage of this service as it means taking time off.

"I should also like to mention the close integration that exists in my school between the School Health Service, the School Psychological Service and the Peripatetic Teacher of the Deaf. Anxious parents now realise that they are welcome to come into school to discuss their children's health, confident that a phone call will put me in touch with someone who will help. Teachers appreciate this service too, especially those who have children in class with several medical defects.

"I should like to pay tribute to the unfailing attention given to the children by Miss I. J. Alcock, who has literally become 'one of us', to Dr. H. M. Marks, who is never too busy to listen, and to Mr. Peck, Dental Surgeon, and his assistants for their compassion for little children often in pain.

"Several times each month I take 'casualties' to the West Cumberland Hospital. I must record my appreciation of the kindness and courtesy shown to children and parents. The treatment is carried out with as little delay as possible and more often than not bravery is rewarded!

"This secure 'integration' at all levels and the parental confidence won through the developing pastoral work must ensure that the School Health Service will provide an added incentive to young parents to settle down in Cumberland."

Writing from the point of view of a girls' secondary school, Miss Windle views the contribution of the school health service to the overall task of education for living and the health of the community.

Miss Windle writes:

"All schools would agree that the most effective teaching develops from a knowledge and appreciation of children, their homes and neighbourhood and the School Health Service is of great assistance to us in building up a picture of

the social background and problems of the girls whom we teach. Although we receive some information when girls are transferred to us from the primary school, it is understandably not very extensive. Here the Health Visitor and the school nurse are of great assistance and often provide us with information about the community which helps us to establish good relations with the home.

"The health of modern society is improved by the preventive measures which are taken in the school. Periodic checks by the doctor and the dentist, injections against serious disease and infection, visits by the audiometrician, the psychologist, the speech therapist, are routine events of a school year. Parents are encouraged to attend on these occasions and discussions between home, specialist and school are of great benefit to the child. I would particularly like to mention the films, posters and pamphlets which we receive from the school dentist as dental health is becoming an increasingly urgent problem.

"In spite of the affluent living in this country there is still a need for nutritional help to prevent obesity amongst school girls. The doctor records weights and rate of growth and can often mitigate the factors preventing successful reduction by advice to parents and the provision of diet sheets. Recent surveys have revealed the large proportion of children going to school with little or no breakfast. This usually means apathetic and tired pupils in the first vital lessons of the day and excessive sweet eating which harms the teeth as well as increasing weight. Some Medical Officers advocate the employment of a community dietician who could promote a better understanding of food values among ante-natal patients in parentcraft classes and perhaps set up a clinic for overweight children.

In school we seek to prepare our girls to face up to the social problems with which they will inevitably meet in the future. The School Medical Service helps and sustains us in this task."

Again, from another secondary school comes a comprehensive comment on the service. Mrs. Steel writes:—

"Since I have been in charge of children I have found that more and more the School Medical Service makes me feel like the man on the T.V. Advert who says that he 'has the strength of his insurance around him'. Our school has

never called in vain for help and daily the link strengthens between the School Medical Service and the school. The day when the children feared the School Dentist, Doctor or Nurse has gone, and in its place is friendship and trust.

"The school dental clinic is always willing to accept any emergency calls, and the regular inspections and follow-up visits to the nearby clinic is obviously improving the state of the children's teeth.

"The efficiency and smoothness of the Medical Examinations cause very little unrest in the school, whilst the atmosphere and friendliness between Dr. Ainsworth and the children and parents makes it no longer a day to dread, but almost a social occasion!

"Of particular value to this medical examination is the follow-up when Dr. Ainsworth advises me about any unusual, or difficult cases, for example thyroid cases, diabetics, children deaf in one ear only, etc. This knowledge can do a great deal towards making the school life of a child much happier and healthier.

"Our visiting teacher of the deaf, Mr. Abbott, in his weekly visits, gives our partially deaf boy added confidence, which must help him in his future work as well as making his school days more beneficial.

"As we are more and more realising that children need counselling and guidance, particularly those with unknown problems, the close co-operation with the child guidance team is especially valuable—at the moment I am thinking of one girl in particular who was a complete misfit in her class, and who found life desperately miserable—she is now a happy, useful and friendly member of her form.

"In a Secondary School probably the greatest need has been fulfilled by Mrs. Hewitson, our Health Visitor, in the talks given on puberty, hygiene and sex—in other words—on growing up. This friendly contact is established in the first year and continues right through to the end of their school days.

"Not only does the Health Visitor help in this way, but she also renders a valuable service by intimate knowledge of the home background of the children. This helps the staff to understand and sympathise with many of the troubles of the pupils.

"To sum up, I know I have missed mentioning many valuable members of the School Medical Service, and to them I apologise. I think the greatest compliment we can pay you all is to say that you are *our* Doctor, our Dentist, our Nurse and so on, in other words you *belong* to us."

Medical Examinations

I commented last year on the development of progressive screening of the young child at regular intervals before school entry as recommended by the Sheldon Report and the following note by Dr. Timperley, School Medical Officer, in the Northern Area, who has extensive training in developmental paediatrics indicates an area of this work which she is beginning to explore.

Dr. Timperley writes:—

"With the increasing use of developmental screening of infants and young children, it has become apparent that, in addition to those children in whom development is uniformly retarded, it is also possible using e.g. a 'Griffiths profile', to identify uneven development, e.g. those who may have later specific learning difficulties, also the 'clumsy' children at the stage when the essential foundations of later scholastic ability are still being laid down. In many cases experienced teachers have long been recognising such children, and giving them the essential early remedial teaching they require.

"If it were possible to identify these children as 'at risk' at school entry by simple screening methods based on the associated development of e.g. co-ordination, recognition of shapes and ability to reproduce them, awareness of normal body image (including laterality) etc., this would place the teachers' impressions of ability on a firm basis and allow for remedial teaching of potential weaknesses to start within the optimum period for learning that skill. It is often not realised that by the age at which a child of otherwise average ability is diagnosed as dyslexic, i.e. often 9-10 years when he has already failed in school, he may be beyond the peak learning period for the skill.

"During the past 12 months I have, within the framework of the entrant school medical examination, been using a series of simple screening tests as outlined above. These are not unduly time consuming, and have usually enabled me to place the child in one of these categories, i.e.,

(1) Those with normal development in whom no learning difficulties are likely.

(2) Those with below average overall ability, i.e. who are evenly immature.

(3) The most important group with uneven development, e.g. the child who may learn to read easily at 5 but makes no attempt to write.

"This classification would appear to correlate remarkably well with the teachers' opinion, and if such screening could be undertaken prior to school entry it would, especially in larger schools, enable such children to receive the early help they require. Such a need has been recognised in the report of the National Child Development Study."

Medical examinations have been continued in 1968 on the selective basis and similar numbers of children examined as in 1967. Also the proportions selected for examination at 8 and 12 years arising mainly from the questionnaire to parents at these stages has not varied greatly. The figures are given in the Table on page 89.

At the 8 year level 19.2% of those selected for examination were found to have defects, compared with 13.3% in 1967 and 17.6% in 1966. At the 12 year level the proportion with defects for the three consecutive years, 1966, 1967 and 1968 were 10.7%, 7% and 13.4%.

Dr. S. Smith, Southern Area Medical Officer, has examined in a little detail the defects found in just over 1,000 8-year old children examined selectively during 1968. This comment given below clearly questions whether selective examination goes any significant way towards uncovering more defects in school children. It should not be forgotten however that one of the most important features of the selective scheme of medical examinations is the termly visiting of schools by the school medical officer rather than annual visiting. This allows of more frequent and wider consultation between school medical officer and school staff.

Dr. Smith writes: "During the past year 1,002 8-year old children in Southern Area were eligible for selective medical examination and from these 484 were selected. In all, 461 defects were found in these children which, of course, includes visual defects and hearing defects which would have

been detected by the routine visual and audiometry tests. A large number of the remainder of the defects were already known and these children would have been reviewed as re-examinations at school medical examination. Only 14 defects were not already known and of these most were of short duration and were already under treatment by the general practitioners. Only two were referred to specialists—both of these being orthopaedic conditions namely, one of flat feet and one of knock knees. Six of these cases, unknown, were enuretics and this, I feel, could have been recorded at the school entrance examination."

Dr. H. Marks makes the following contribution, writing generally on one of the problems which has confronted her at medical examinations.

"The most common items discovered on examination were eye defects and minor orthopaedic disabilities. One finds knock knees and flat feet are often associated with obesity: and one continually tries to educate obese children and their mothers at each school medical inspection. It is rare indeed to see a case of under-nourishment in West Cumberland. Sometimes it is difficult to convince pupils they are overweight—a look in the mirror is often a more reliable guide for estimating obesity than body weight. Over-eating is a habit—which can be formed in babyhood—though in some cases the habit may be due to an emotional disturbance or lack of security. Two such cases spring readily to mind:—

(1) One was a small statured girl, of 13 years weighing 13½ stone who worried over her plump figure. Despite co-operation from the School Meals Service, a diet sheet from the hospital, the fortnightly weighings showed very little weight loss. On discovering that this girl was living with her grandmother but really wished to be with her parents and siblings, we were able to refer her to the Child Guidance Clinic where she was helped with her problems.

(2) Another, a boy, five feet tall at the age of 12 years weighed 15 stones. He was embarrassed, his malleoli were separated by almost seven inches due to the thickness of his thighs, and this was due to habitual over-eating in an only child.

"After a period of hospitalisation on a very low calorie diet, he lost weight and has maintained his loss. Now at the age of 13 years he weighs 9st. 5lbs. and has grown to 5 ft. 3 ins."

Employment of Children Byelaws

The figures below show the numbers of children examined during the year in accordance with the above byelaws:—

Total examined during the year ...	365
Total number of children involved	351

Examined for the first time.	Re-examined once.	Re-examined twice.
327	24	Nil

School Clinic Work

It will be seen that quite a substantial number of attendances are still made at school clinics in certain of the larger centres. It should be appreciated, however, that this refers in the main to repeat examination or testing of children who have been seen in schools or previously at the clinic. When treatment is involved the matter is passed to the family doctors.

The figures are once again shown below of the numbers of children attending school clinics:—

Clinic	*New Cases.*	*Total Attendances.*
Aspatria	2	2
Brampton	—	38
Cleator Moor	9	10
Egremont	4	7
Flatt Walks	43	54
Longtown	5	20
Mirehouse	12	12
Millom	12	14
Park Lane	69	239
Wigton	15	16
	171	412

SCHOOL CLINICS

Defect Code No.	Conditions for which child attended.	New Cases						Total Attendances.					
		1968	1967	1966	1965	1964	1963	1968	1967	1966	1965	1964	1963
1.	Cleanliness	4	—	5	—	1	11	7	—	5	—	1	16
2.	Infestation	5	3	—	2	17	2	20	13	—	9	34	2
4.	Skin diseases	25	40	59	36	88	147	28	80	103	62	195	408
5.	Eye diseases	60	112	76	119	145	169	62	129	138	212	186	316
6.	Ear conditions	20	31	81	87	110	78	47	82	157	208	163	105
7.	Nose and throat conditions	8	9	7	14	25	44	11	13	7	20	53	68
8.	Speech defects	25	8	19	26	17	21	28	18	20	30	19	22
9.	Lymphatic glands	—	—	—	2	—	3	—	—	—	2	—	4
10.	Heart condition	—	1	1	1	1	3	—	1	2	4	1	3
11.	Lungs condition	2	2	3	4	6	18	3	4	4	6	6	26
12.	Developmental	3	1	3	1	2	2	4	1	5	4	3	5
13.	Orthopaedic	13	8	37	38	36	46	13	9	38	49	47	48
14.	Nervous system	—	2	6	6	20	2	—	3	17	8	70	3
15.	Psychological	17	17	18	18	13	12	23	27	21	26	21	17
16.	Obdominal condition ...	1	3	4	5	5	13	1	3	4	9	9	16
17.	Weight	5	—	—	—	—	—	11	—	—	—	—	—
18.	Other conditions	21	26	42	56	103	103	45	47	88	69	237	188
		209	263	361	415	589	674	303	430	609	718	1045	1247

SPECIAL SERVICES

All of the services generally included under this heading have continued to operate for school children in 1968 but with the usual problems requiring to be met in their maintenance, and some new ones. It will be realised that some of these special services organised for school children through the school health service, depend largely on the services of medical specialists seconded from the Regional Hospital Board, others mainly on the S.M.Os. and school nurses; and others again on some of the professions supplementary to medicine, including the services of orthoptists, speech therapists, audiometricians, teachers of the deaf and physiotherapists. Staffing problems have hitherto mainly interfered with the work of the latter group and 1968 was no exception, in that one full-time speech therapist resigned early in the year leaving a gap in South Cumberland and one of the longest serving part-time orthoptists moved away from the area. I hope that the possibility is realised in due course of Mrs. Richardson returning to Cumberland and to orthoptic work here. Her going however, was considerably "cushioned" by the presence of Miss Davies who returned from training as an orthoptist under the County Council scholarship scheme at the beginning of 1968. Similarly the speech therapy position should be much improved with the return in the summer of 1969 of the first trainee under the speech theraptist training scholarship. These scholarship projects are thus seen to be proving their worth to the full.

During 1968, however, staffing also presented an acute problem in the ear, nose and throat speciality and the Special Area Committee felt it necessary to withdraw all in-patient E.N.T. Surgery work to Carlisle. This was intimately associated with a failure to recruit the required specialist medical staff. Very understandable concern was aroused in West Cumberland and it is good to know that there is a possibility of the restoration of out-patient services in West Cumberland if and when adequate medical staff can be recruited. Meantime the audiology service of the School Health Service has continued its good, if unobtrustive, work in detecting and arranging appropriate management of deafness in children. In this we have been given every support by the hard pressed E.N.T. surgeons, Mr. Venters and Mr. Robson.

Audiology Service

Dr. J. L. Hunter, Western Area Officer, who has been intimately concerned in the audiology service in West Cumberland since pioneering days, takes up the 1968 chapter of the history of this service.

Dr. Hunter writes:—

"Despite shortages in staff and the need for training of new personnel, the work in audiology was completed in all schools during the year. It was also possible, by the recruitment of an extra audiometrician in August, to extend the screening of school children by non-medical staff through the introduction of the Keystone Vision Screening System. The screening procedure for deafness continued on the same lines as previous years.

"A total of 1,476 school entrants in the Western Area were tested by the pure tone audiometer. Of these 166 (11.2%) had an apparent loss of hearing. On retesting 55 (3.7% of the original number tested) were considered to require further investigation. In addition 97 special cases were referred from various sources—the school medical officer (30); the headteacher (25); the parent (17); the speech therapist (1); the health visitor (1); and 23 cases were tested because of the presence of other handicapping conditions. Fifty-six of the special cases had in fact no demonstrable loss of hearing. The balance of combined routine and special cases requiring further investigation numbered 96 and at the end of the year the position was that 19 were being kept under observation with minor or minimal defect, 56 had been referred to the medical officer, 4 to the family doctor, and 17 to the otologist. Although none was referred to the peripatetic teacher of the deaf he took part in the elucidation of some cases in consultation with the medical officer and the otologist.

"The criteria used in assessing the degree of impairment of hearing was the same as in former years, i.e. an average loss of 30 decibels in the 500, 1,000 and 2,000 frequencies was considered to be 'mild'; an average loss of 30-50 decibels a 'moderate' loss; and over 50 decibels a 'severe' loss.

"In the severe range three bilateral cases came to light. One has a severe perceptive loss with no known or discovered factor and has been fitted with a hearing-aid; the second case

also had no known factor, was tested in infancy by the health visitor and found to be normal in response but the question of hearing was again raised by the same health visitor at the time of school entry and the case has been referred to the otologist; the third case has left the area. Of two cases of severe unilateral deafness one has been assessed by the otologist as perceptive in type and probably due to mumps, and the second case is being investigated by the medical officer but will be passed to the otologist as there is no conductive cause apparent.

"In the 'moderate' range of impairment of hearing nine bilateral and ten unilateral cases were discovered, eight of these by routine audimetry and eleven from special referrals. All cases were referred to the medical officer, eight further to the otologist and two to the family doctor (because of acute bilateral infections). The otologist reported conductive causes requiring treatment in three cases, confirmation of deafness in two cases (one being perceptive in type) but no obvious cause or present treatment indicated, old scarring in one case and the hearing normal on re-testing in one case. The perceptive case may yet require a hearing-aid.

"In severe and moderate cases discovered before 1968 two severe cases were seen by the otologist and fitted with hearing-aids but one would already appear to be improving and it may be that the conductive cause will be alleviated so that the aid may not be required. Two cases of moderate deafness include a perceptive case (factor: difficult birth) still under observation by the otologist and a conductive case who has had an operation.

"Of new mild cases referred to the otologist three have had, or will have, tonsils and adenoids removed, two cases were found to be normal on retesting and in one case a report is awaited.

"At the end of the year 1968 the position of the state of deafness in the Western Area was as follows:—

Profoundly deaf—Four children were in special schools for the deaf or partially hearing. One profoundly deaf boy had transferred to another area during the year. His younger sister also is in the same category but she had not yet entered special school.

Severely deaf—Twenty-one children in ordinary schools wear hearing-aids. During the year two boys left school and found employment. One girl left, appeared to be well fitted into a job but threw it up for no good reason and a new job is being sought by the Youth Employment Officer and Teacher of the Deaf. The latter continues to supervise all children wearing hearing-aids for two years after leaving school. Twenty-seven children have severe unilateral deafness but are generally well adjusted to the defect and are given a favourable position in class. Three cases were fitted with hearing-aids during the year. Although all cases of children wearing hearing-aids in school are included above it should be noted that four would more properly be regarded as having moderate or even mild losses and all four are likely to be able to dispense with the aid in due course.

All cases with hearing-aids are seen regularly in school by the teacher of the deaf who in turn gives a report in person to the Area Medical Officer on progress or lack of progress twice yearly. In cases of handicapped children about to leave school a close liaison is also maintained with the Youth Employment Officer with whom cases are taken up individually or at the bi-annual Leavers Conference attended by the Youth Employment Officer, the Area Medical Officer, School Medical Officers, paediatrician, psychologist and Senior Welfare Officer.

Moderate Cases—Nineteen new cases came under the observation and treatment during the year. After discounting those who had left school in 1968 a total of 30 unilateral and 21 bilateral cases were still being looked after at school medical inspections and elsewhere.

Mild Cases—At the end of the year 70 unilateral cases and 96 bilateral cases were still under review or under treatment. The majority of these cases are conductive in nature.

Cases below School Age

"Seven children below 5 years of age are at present under special observation. In two cases prematurity is a

factor, meningitis at an early age in one, history of family deafness in one, two have no known 'at risk' factors and one has a severe mental handicap.

"Although the 'at risk' register has not been operative for very long and the present form of birth register for the area started only in 1963, it is becoming more easy to trace whether or not cases are likely to show a factor in deafness. The testing by Health Visitor at an early age becomes also easier to check now that children reaching school are all on the birth register which contains records of various events including screening tests.

"In fact although most routine new cases were known to have been checked in infancy and records of any 'at risk' position nearly always available, in only two cases did factors emerge. In one child with a mild loss prematurity and jaundice could have been factors. In the second case toxaemia in the mother was recorded. The time would not yet appear to have arrived when more selective testing would suffice to bring forth the majority of cases of perceptive deafness. It is likely too that many cases of conductive deafness would be discovered much later than at present. In this connection it is interesting to note that of seventeen cases of children deaf and wearing hearing-aids seven are of the conductive type of loss of which five were discovered at routine audiometry and two of the perceptive cases followed brain damage (one by direct injury and one by meningitis).

"It is pleasing to note in this Area that a proportionately larger number of cases have been referred by head-teachers and parents in the year under review. The observation of these two, parent and teacher, who are in fact in the ideal position to anticipate later findings of the technician and clinicians can by their interest help a great deal to lessen the effects of the handicap of deafness in the school child."

Mr. Abbott, who is peripatetic teacher of the deaf for both the Southern and Western Areas, gives the following report:—

Pre-School Children

"During the year two new cases have come under my care. One is a boy with a profound hearing loss and he is making some progress these last few weeks. The other child, also a boy, has a marginal loss of a fluctuating nature. He also has additional difficulties which complicate things.

"Two of the children who were shown in the table last year have moved to other parts of the country; one being a boy with a relatively minor loss, the other being a profoundly deaf girl who has now started at a deaf school as a day pupil. One other child's hearing has improved to the extent that he now attends school and manages well without an aid. The girl with the severe loss is making good progress and is talking fairly fluently if somewhat imperfectly, and the partially hearing child with a serious additional handicap is also progressing within her severe limitations.

"Once again the supply of auditory training units is adequate and I am pleased to say that they have all functioned well with only minor maintenance.

"Some 25 children have been referred to me for testing during the year, most of these have been of pre-school age and quite a few had additional handicaps which caused me some difficulty.

Children receiving pre-school hearing guidance in 1968

Profoundly deaf	1
Severely deaf	1
Partially hearing	1
No significant loss of late	1
	4

Pupils in Special Schools

"Pupils in special schools from West and South Cumberland now number 10. Families of two of the children have moved from Cumberland and the children are now attending other deaf schools as day pupils rather than as boarders. A partially hearing girl who left school at Easter had obtained suitable employment prior to actually leaving school.

"All the children have been seen during the year particularly those in their last year at school, who have been seen on more than one occasion.

"The Border branch of the National Deaf Children's Society, which consists mainly of parents of deaf children, has gathered strength during the year. Several meetings have been held including two in West Cumberland. Various problems have been discussed and this month the parents have purchased a mini-bus for the use of the children in the area. Two uses for the bus are envisaged, the main one being that children at residential schools may come home at three-weekly intervals (the schools used by the authority are in three groups, Yorkshire, Lancashire and Newcastle-on-Tyne), and secondly to enable the children to have some contact with each other during the longer holidays. I think the Society is serving a useful function in all its many activities.

Children with Impaired Hearing in Normal Schools.

"Currently there are 44 children with hearing impaired to a greater or lesser extent in local authority schools in South and West Cumberland. This includes two who attend training centres.

"Three of the children have post-aural aids and currently ten of the children manage without using their aids. During the year four children left school; two of them obtained jobs immediately while one boy had to wait two months for a suitable position; the remaining girl got a place at a College of Further Education.

Hearing Aids.

"The biggest disappointment of the year has been the non-appearance of the Medresco post-aural aid. At the time of writing an order has been placed by the Government with a Danish firm for several thousand but so far none have been issued in this country. When they are issued it will be interesting to compare the aid with the body worn model—not only performance-wise but also in respect of the attitude of the older children to what must be a vastly more acceptable instrument.

"There have been six new issues of hearing aids during the year and two children with aids have moved to the area from other authorities.

"I must stress again the importance of the teacher of the deaf being informed at the time of issue of all hearing aids to children.

"One of the other issues has been to a boy with a conductive loss of the nature of 15 decibels on the better ear and whose loss on the worst ear averages 30 decibels on the main speech frequencies. Naturally there has been some difficulty in this case.

"The following table shows the average hearing loss for speech in the better ear on the main frequencies. Although the accepted way of showing losses it does not take regard of losses above 2k.c.p.s. and approximately 30 per cent. of the children, having a loss of only 30 decibels or so in the table, have much bigger losses for the higher frequencies. Particularly with congenital deafness this remains a problem as these youngsters do not hear the sibilants and fricatives—and aids as opposed to speech trainers do not reproduce the higher frequency elements of speech in their entirety.

Up to 30 db.	14
30 db. to 40 db.	13
40 db. to 50 db.	9
50 db. to 60 db.	7
60 db. + ...	1
	44

"Supervision has been carried out with these children along the following general lines although of course rarely do two children have exactly the same problems.

1. Supervision which can include auditory training and use of the hearing aid, favourable position in class, regular checking of hearing loss and assessment of speech difficulties, etc.

2. Remedial or more specialised work such as speech improvement or lip reading etc."

Dr. K. R. Walker also writes:

"In the Southern Area in the course of the year 1,663 tests were carried out on the school entrants. These tests showed that 149 children had some degree of hearing loss. This figure shows a marked increase over the past two years.

1966 67 out of 1,448
1967 65 out of 1,760
1968 149 out of 1,663

"However, in most cases the losses were slight and in about half the children only one ear was affected. The children with mild defects are being kept under observation.

"Forty children were shown to have a moderate hearing loss and they were called up to the clinic for more thorough testing and examination. It was found necessary to refer 14 for a consultant's opinion. The outcome of these referals is as follows:—

4 children needed myringotomies.
3 required T's and A's removed.
4 kept under observation at West Cumberland Hospital and to have hearing assessed at the deafness clinic.
3 awaiting replies.

"In addition to the routine cases 157 special cases were investigated. The interesting point arising from these is the increased number of referrals made by the teachers. This shows that many more of the teaching staff realise that even slight hearing defects can produce an alteration in a child's attitude to school work. Twenty-four cases were referred by teachers this year whereas last year only 4 cases arose from this source.

"From 157 special cases 40 were sufficiently affected to be kept under observation and sixteen were called up for further investigation. Eleven children were referred to a consultant with the following results to date:—

1 needed adenoidectomy and myringotomy.
1 needed a myringotomy.
2 needed T's and A's removing.
1 needed further treatment to an old mastoid cavity.
3 are being kept under observation at West Cumberland Hospital, 1 child in this group may require a hearing aid as her hearing is only just socially adequate at present.

"All the special cases requiring treatment were in the 7-11 age group.

"Many cases were kept under observation from 1967. Of these, hearing had return to normal in 54 children and 51 still had hearing defects severe enough to require further assessment at the clinic.

15 were referred to Mr. Robson, E.N.T. Surgeon.
We have heard about eight of these so far.
2 had bilateral myringotomies and adenoidectomy.
2 had T.'s and A's removed.
1 had ears syringed and is to be seen again.
2 are being kept under observation.
1 hearing adequate—no treatment.

"A further survey of hearing in 8 year olds was done. This year Hensingham Junior School was chosen.

"Ninety-nine children were involved—90 born in 1960 and 9 in 1959. On the first test 26 children had an apparent loss and they were retested eight weeks later—2 were absent so 24 retests were done.

"Hearing had returned to normal in 7 cases but 17 children had actual hearing defects. Only five of these had been known about previously and were being kept under observation. Three children had moderate losses and were referred to Mr. Robson."

Miss Cronie, who is a peripatetic teacher of the deaf in the Northern Area, reports:—

PRE-SCHOOL CHILDREN

Fourteen babies were referred after failing screen tests of hearing. Of these, eight required two or more visits before a satisfactory test was obtained. Thirty-one pre-school children were also referred with a history of ear trouble or poor speech development. In the two groups, thirty-one were referred by General Practitioners and Health visitors, six by Assistant County Medical Officers, three by the Consultant Pediatrician, three by the Speech Therapist, one by a teacher and one by the Senior E.N.T. Consultant.

Forty of these pre-school children have now been screened, six after medical treatment; two have started school where they are still under observation and having medical treatment; two are under observation and one girl, aged four, has been found to have a severe loss of hearing. One boy, thought previously to have central auditory imperception, has

had further tests at the Department of Audiology at Manchester University and has now been assessed as severely deaf.

Hearing aids have been issued to both children and each has an Auditory Training Unit for use at home. They are now making good progress, largely because there is a satisfactory home background, with all members of each family taking part in the training programme.

One boy in this group last year, thought to be severely deaf, was seen at Manchester University in January and assessed as having no significant peripheral loss of acuity, although his response to sound and his understanding of speech were very abnormal. He has been seen regularly with his parents by Dr. Waldon at the University Department and has been under the care of Miss Moon, Speech Therapist, and myself. His handicap is too severe for him to make progress commensurate with his innate ability in ordinary school and application has been made for interview and possible placement in a school for children with serious speech disorders. In the meantime he is to have a trial period in a local school, with special help from Miss Moon and myself, including advice and guidance to his teachers and parents.

Summary of children in pre-school group:

Under observation with slight losses	2
Severely deaf	2
Receptive Development Disphasia ...	1
	5

Children at Special Schools

One boy, who, last year, was partially hearing and coping well in ordinary school, suddenly lost his residual hearing after an illness in January. At the end of one term it was decided that he could no longer benefit from normal schooling as much as he would in special school. He was accepted for the school for partially hearing children at Southport, to which he transferred in September and where he has settled very well.

One of the boys previously in the pre-school group also went to Southport on reaching school age in September. He has made a good start, largely due to excellent home training on the part of his parents.

There are now nine children from the Northern Area in Special Schools, including one girl from Keswick. They were seen during the summer holidays.

CHILDREN WITH IMPAIRED HEARING IN ORDINARY SCHOOLS.

In this group seventeen new cases have come under observation. In many instances the loss fluctuates and it is hoped that after treatment their hearing will return to normal. In the meantime, parents and teachers have been grateful for advice and information about the children's problems. In the few years I have been engaged in this work in Cumberland I have noticed an increasing awareness on the part of parents and teachers of the importance of children's hearing and of the adverse effects of a hearing loss at home and in school.

One boy has left school and found suitable employment. One girl has been transferred to my supervision from West Cumberland, now that she attends Higham Special School for girls, which I already visit.

One hearing aid has been issued to a school child this year and of the twenty-one children with Medresco aids, two no longer use theirs and three wear theirs in school for some lessons only.

Special help with reading, number work and mathematics, speech improvement, lipreading and auditory training has been given where necessary, particularly to children with significant losses who have no hearing aids.

Audiometric assessments have been carried out regularly, and below is the table of average loss for the better ear, the results of pure-tone tests over the main speech frequencies.

Up to 30 decibels	27
30-40 db.	11
40-50 db.	4
50-60 db.	4
over 60 db.	3
	49

A survey of hearing was carried out in the Junior Training Centre with the help of Miss Jackson, Schools Audiometrician. The table shows the results.

	1st Test	2nd Test	
Number of children	32	10	(of 18 defective in 1st test, six had left the Centre and two were absent).
Number hearing within normal limits	14	1	
Number with hearing defect	18	9	

Analysis of hearing defect:

	Boys.	*Girls.*	*Total*
Conductive	5	—	5
Perceptive	1	2	3
Mixed	1	—	1
	7	2	9

In eight cases the losses, averaged over the main speech frequencies, would come in the category "Up to 30 db." The ninth is a unilateral sub-total loss. From speech tests carried out with these nine children and observation in the classroom, it would seem that they are coping with their losses. Further tests will be made next term.

TABLE I
ENTRANT GROUPS

Area	Year of Birth 1963	1962	1961	Total	No. with apparent loss	No. of re-tests	No. requiring investigation
North ...	1133	180	68	1381	297 (21.5%)	268	128 (9.3%)
West ...	1034	382	60	1476	166 (11.2%)	151	55 (3.7%)
South ...	907	656	100	1663	313 (18.8%)	270	149 (8.9%)

TABLE II
SPECIAL CASES REFERRED

Referred for testing by:	North	West	South	Totals
School Medical Officer	132	30	65	227
Family Doctor	4	—	8	12
Head Teacher	64	25	24	113
Parent	19	17	5	41
Speech Therapist	8	1	1	10
Teacher of Deaf	1	—	—	1
Paediatrician	—	—	3	3
Referred re 2 H.P. examination	8	23	48	79
Other—Educ. Psychologist	—	1	3	4
	236	97	157	490

TABLE III

Disposal of cases Discovered:	Routine			Special			Totals		
	North	West	South	North	West	South	North	West	South
For observation	115	10	229	59	9	40	174	19	269
Referred to School Medical Officer	1	36	40	1	20	16	2	56	56
Referred to General Practitioner	1	3	—	—	1	—	1	4	—
Referred to Otologist	—	6	14	—	11	11	—	17	25
Referred to Teacher of Deaf	11	—	—	15	—	—	26	—	—
Other	—	—	—	—	56	—	—	56	—
	128	55	283	75	97	67	203	152	350

Ophthalmology

The work of the ophthalmology clinics in East and West Cumberland for school children continues as an essential feature of the school health service and in West Cumberland these clinics are now entirely conducted in hospital premises. It is gratifying to record that two of the school medical officers who have been trained in refraction work are now making a material and important contribution to the work of these eye clinics. Their presence at the clinics and that of the school nurse provides an essential liaison with the schools and results in a very satisfactory arrangement for all concerned. I am grateful to Dr. Griffith, Consultant Ophthalmologist, West Cumberland Hospital for the following comments on the service during 1968:—

"The Workington and Whitehaven area school eye clinics have now for some time been conducted entirely on hospital premises and this has, as far as I know, been very satisfactory. No parent has reported their children as being more alarmed at the prospect of coming to hospital rather than the local health authority clinic and there has been the advantage that in the cases which need the extra facilities of hospital investigation, any concern that the child may have felt, has in fact been much less as they were in the company of numerous other school children. It has been particularly helpful to have the orthoptic department working at the same time as the clinic; one knows that this could have been organised at outside clinics, but would have felt there would have been a considerable unnecessary expense of public funds in duplicating such equipment. From the doctor's point of view, there has been less time needed in travelling, which is again a further economy. It is of invaluable help that one still has the assistance of the school nurse at these school eye clinics in hospital; by their presence, one can get up to date and far more accurate information in many cases, which would be impossible to receive by other means. One also has the means of directly arranging follow-up of particular cases.

"One is also particularly grateful for the assistance of Dr. Ainsworth and Dr. Marks, helping to see some of the routine follow-up cases at some of the clinics. This enables one to spend more time on the difficult problems and to discuss some points of these cases with them; I am also sure that by discussion with them at the time of a clinic, one is able to arrive at a better management of cases particularly where

there are other general problems such as behaviour disorders."

One of the School Medical Officers now involved in this work is Dr. H. Marks, and she writes as follows on her work.

"I am particularly interested in the Ophthalmology Clinics and the eye defects constitute a high proportion of all the defects listed. Children complaining of eye symptoms or headaches are referred to the Opthalmologist. As I now have a hospital attachment to the eye clinic at West Cumberland Hospital, I have the opportunity of seeing many cases when first noticed right through to the end of school life. Each week I do a clinic in the hospital out-patients while Dr. Griffith does a clinic in the room next door. He sees all the new cases and I see them on subsequent visits and if I have any problems about the cases I see, I can discuss them with him. This service offered here to the school-child is near-perfect and it is an excellent introduction to the hospital world, for the small child, in a non-painful manner. This year we have been fortunate in having a fully staffed department. The hospital school eye clinic consists of Dr. Griffith, myself, the school nurse, an optician and an orthoptist. The appointment list contains 24—26 cases and few of these fail to keep their appointments. The school nurse makes a brief summary of each case which is recorded and filed in the Form 10M to be available for information at School Medical Inspections. I feel it is a good thing for the school-child to be introduced by the School Medical Officer and the school nurse when he attends at the hospital. Also this secondment puts me in a good position to be able to deal with the so called 'emergency eye defect' and I quote an instance where this happened.

"One Thursday afternoon, I saw an eleven year old boy who had recently been reunited with his parents having been brought up by various aunts in their respective homes. He had a gross eye defect consisting of nystagmus and an alternating squint, visual acuity was Rt. 6/24 Lt. 6/12 with glasses Rt. 6/24 Lt. 6/18. The mother had no knowledge of his previous attendances at the eye clinic, she was unaware of the treatment that he had had. I felt he needed immediate attention and was able to ask them to come to the school eye clinic held the following morning where he was seen by Dr. Griffith. His records showed that he had had an eye operation two and a half years ago and he had not been to the clinic since for his routine refractive tests."

Mrs. Scott whose continued part-time work in East Cumberland is a source of great strength to the orthoptic service, summarises the staff position and adds interesting comments as follows:—

"During 1968 Mrs. Richardson left the County service for what we hope will be a temporary period, so the clinics have had to be re-organised. Miss Davies kindly consented to coming to Carlisle one day a week to help with the Portland Square clinic, so that I could go to Penrith for one session a week to keep the clinic there open until Mrs. Richardson's return. Two clinics were worked previously but with some co-operation from the parents one clinic is just adequate. Orthoptic clinics are being maintained on the mornings that the ophthalmic surgeons have their clinics at Portland Square so close co-operation can continue between the work of the surgeon and the orthoptist.

"A great deal depends on the co-operation of the parents with home exercises. A child with a fully accommodative squint i.e. a squint which is only present when the glasses are removed can be taught to control the squint himself. This takes quite a lot of practice, but when it has been well learnt the child finds it very easy to squint or keep his eyes straight at will. The child is first taught how to do this at the clinic and at first it is quite usual that he can only maintain binocularity for a few seconds at a time. The mother is then instructed how she can practise this with him so that the length of time he can keep his eyes straight gets longer until perfect control is obtained. This need only take the mother and child five or ten minutes per day and a co-operative and intelligent child will also practise alone. Most parents are only too willing to help in this way.

"A lot of parents are now bringing their children to the clinic when a squint is very first suspected, and even if no squint is elicited at the clinic on the first visit we are only too willing to see the child on observation to make quite sure no squint is present or to rake appropriate action if a squint is seen. To start treatment at the onset of a squint avoids many complications such as lazy eyes and impaired binocularity."

Miss Davies is the first Orthoptist to return trained under the Council's scholarship scheme for training orthoptists. She has rapidly immersed herself in this important work

and she gives a very full and interesting account below of her first year in post.

Miss Davies writes: "1968 has been my first complete year as an orthoptist in Cumberland—both have been a pleasant experience. The work has been varied and interesting with several more unusual cases having been seen. As the clinics are held in Workington Infirmary, West Cumberland Hospital and Cumberland Infirmary, Carlisle, there is less opportunity for one to tire of the same four walls every day—at least they are not the *same* four walls each day.

"At first it seemed impossible that the chaos of names and addresses of new patients would ever fall into a semblance of organised clinics, but with the help and co-operation of the hospitals' staff this has been achieved. As Cumberland has been without a full time orthoptic service for some time there has been some difficulty in ensuring that each child had adequate supervision and treatment—I hope that this may now be rectified.

"I have found that there has evolved some mystery exactly as to what orthoptics entails. It may be defined as the diagnosis and treatment of squint and other binocular anomalies, though oddly enough we do not wear black cloaks or wave magic wands! Patients are referred directly from the consultant ophthalmologist and it is most helpful if the orthoptist can work in close proximity so that advice may be sought and that there is general benefit from the discussion of cases.

"In all cases, however, it is important that the squinting child should be referred immediately a squint is seen or suspected to be present. Irreparable damage to visual acuity and to the normal development of the binocular reflexes may otherwise ensue. Orthoptic treatment may most effectively be given up to about ten years of age, while the child is still within the developmental period, but intractible amblyopia may be established long before then if there is neglect.

"For the purposes of treatment, squint may be broadly classified into constant or intermittent types which can be convergent, divergent or containing a vertical element. Binocular single vision is the ability to obtain single vision under normal conditions of seeing. When a squint occurs this is lost, either constantly or intermittently. At the onset a double vision would occur but this diplopia is readily

suppressed by the child as it is inconvenient and uncomfortable. In a constant squint this would mean a constant suppression and the neglected use of this eye will most probably result in amblyopia where alternation (i.e. the squint may be present in either eye alternately) is present; however, this is unlikely to occur as each eye may be used in turn. In a young child, occlusion by patches will be given to achieve this even though visual acuity cannot be accurately tested. Occlusion will of course also be used in all cases within the development period. This occlusion will be total patch, covering the whole eye, where vision is less than 6/18 and partial or lens occlusion or part-time occlusion where it is more than this. It is essential that the child wears the occlusion as instructed and here co-operation of parents and teacher must be enlisted.

"Exercises form another major part of orthoptic treatment. These can only be employed, however, in cases where binocular single vision is present. In convergent squint of the fully accommodative type (where binocular single vision is present at all times when the hypermetropic refractive error is corrected) a child of reading age can be taught to keep his eyes straight without glasses. This is done by teaching him when to recognise that he squints, by the appreciation of diplopia, and how to correct it by relaxing the visual axis. In certain cases, where there is a low refractive error and no astigmatism present, glasses may even be dispensed with. These cases respond well but owing to the fact that many children do not now read fluently till nine or ten years of age it is not possible to treat them fully till then.

"Although about 80 per cent. of orthoptic work is involved with children there are in fact many adults attending, with convergence deficiency difficulties and those requiring tests and measurement where an ocular palsy has occurred and possibly surgery may be needed.

"Many children with squints may need an operation to improve the appearance or function of their eyes. Where there is a constant squint present, surgery before about three years of age before abnormal reflexes are established may result in normal binocular single vision developing. If it is too late for this to be probable and full binocular function has not developed due to the presence of a long standing deviation a psychologically damaging and unsightly squint may be improved by surgery. Intermittent squints in which there is a large deviation unsuitable for exercises may also

gain binocular single vision at all distances. These cases must all be properly measured before and after operation with orthoptic treatment in the form of occlusion and exercises available.

"Nowadays, the child requiring squint surgery is in hospital only for a few days and I have seen many excellent results since coming to Cumberland."

The numbers of children tested in 1968 and the numbers referred for treatment or observation are shown below, along with figures for the previous three years.

Year.	*Total No. tested.*	*Referred for treatment.*	*Referred for observation.*
1968	10,064	310	1,197
1967	11,084	444	1,865
1966	12,085	452	2,028
1965	13,096	473	2,400
1964	13,933	615	2,443

Details of cases treated during the year are given below:

Total number of attendances in 1968	2,640
Number of new cases seen	1,806
Number of new cases registered for treatment ...	485
Number of cases receiving treatment on 31st December, 1968	544
Treatment during year of new cases:—	
Partially accommodative squint	110
Partially accommodative squint with amblyopia ...	105
Fully accommodative squint	21
Fully accommodative squint with amblyopia ...	—
Accommodative Convergence excess	16
Non Accommodative convergent squint	44
Non Accommodative convergent squint with amblyopia	8
Convergent squint with hypertropia	1
Convergent squint secondary to congenital myopia ...	3
Atypical Accommodative	1
Esophoria	6
Fixation	2
Fixation Disparity	5
Amblyopia	22
Constant divergent squint	9
Divergence excess	13

Mixed type	13
Convergence weakness	11
Intermittent divergent squint	8
Consecutive divergence	2
Intermittent convergent squint	3
Exophoria	—
Convergence Deficiency	15
Muscle palsy	2
Ocular muscle palsy	28
Hyperphoria	1
Pseudostrabismus	23
Eccentric fixation	13
Total	485

Discharges during the year:

Cured	42
Cosmetic	24
Improved	7
Failed to attend	13
Left district	12
Not responding	1
Refused	1
Deceased	2
Transferred	5
Total	107

Orthopaedic Service

The provision of physiotherapy services for school children should I believe be intimately related to the medical care which any child is receiving for a condition under treatment; and so the care and supervision of minor postural defects should be through a physiotherapist working with the family doctor. More complex problems requiring the attentions of an orthopaedic surgeon often also require physiotherapy help, and this should be hospital based where the complex equipment of a hospital department is needed. Physiotherapy is provided ideally by the physiotherapist in the family doctor team, in all other cases. This is very much an ideal, however, and mainly because of the serious shortage of physiotherapists it has only been possible to provide a part-time physiotherapist to three separate group practices in the county. One of the therapists involved is Miss Sievewright, who writes briefly as follows of her work with school children:—

"As time is extremely limited it has not been possible to hold regular clinics. However, every child whose name is in the records has been seen at least once during the year, and footwear and exercises reviewed. The parents have been most co-operative in these respects. A number of new cases has been seen and treated in the clinics, and it has also been possible to deal with children in the group practice surgeries where they are under the case of the general practitioners.

"Most of these children suffer from mild foot deformities, knock knees, bad posture and breathing defects. These are all readily treated at home with parental co-operation and occasional supervision. Anything more serious is brought in to be seen by the specialist and if necessary dealt with in hospital."

Speech Therapy

The speech therapy service did not achieve quite the degree of stability hoped for in 1968 but has continued to provide a very reasonable cover for most of the county. The resignation of one of the full-time therapists left the Southern area with only a skeleton service again in the latter part of the year. This will, however, be corrected in the summer of 1969 with the return from training of the first student trained within the authority's scholarship scheme. Meantime the service is being run by one full-time therapist and 3 part-time workers, the total being equivalent to two full-time persons. In the course of her remarks below on her work during the year Mrs. Blacklock comments on the very important work which she carries on in conjunction with the plastic surgeon who visits the Cumberland Infirmary for the correction of cleft palates. The statistics of the service for 1968 are shown on page 49.

Mrs. Blacklock writes:

"During this year the number of patients needing attention has increased in the Workington area and it is now obvious that a full-time therapist is needed there. At the present time everyone is having treatment fortnightly at Workington and Maryport and in some rural schools in the northern area, where it is impossible for the children to attend clinics. The work at Alston is now covered by periodic visits and the children from Brampton area travel in to Carlisle for therapy. Urgent cases from the southern area can be seen at Workington and four are receiving regular treatment; of these three are children with cleft palates re-

ferred by the plastic surgeon at the review clinic held within the hospital. At the Cumberland Infirmary a speech therapist attends these clinics and she has the opportunity for very close co-operation with the plastic surgeon, and consultant orthodontist. The patients who need regular speech therapy are then treated by the therapist nearest to the child's home. One visiting consultant plastic surgeon remarked on the high standard of speech in the Cumbrian cleft palate patients, and I am sure that this standard has improved over the last six years since this degree of co-operation has been established.

"It is unfortunate that the scheme for closer work with the family doctor group practices in both Brampton and Seascale has had to be postponed because of reduction in speech therapy staff. In Workington there is no actual attachment of speech therapists to group practices but there is close co-operation between Health Visitors who are attached and school nurses. This is also true of the Penrith area and helps to provide a far better service.

"Last year a comment was made by a secondary school teacher that she had little faith in speech therapy because of the number of pupils in her school who had not benefitted by speech therapy. When the discharge numbers were analysed (see Annual Report 1967) it showed that 75 per cent. of all speech defective children were discharged before 12 years of age, the majority having normal speech by that time. Of those having treatment in the secondary school group 25 per cent. were discharged for lack of co-operation. It is obvious that the greatest benefit from speech therapy is derived in the infant and junior groups and to a certain extent the adverse comment is justified!

"In the description of cases treated it can be seen that there are fifteen sub groups of defective articulation some signifying only one defective sound, for example, the incorrect articulation of the S sound. Within these fifteen sub sections cleft palate, dysarthria, dysphasia, dyspraxia and submucous cleft have an obvious physical or neurological cause. The length of time that seems needed to achieve satisfactory speech with some children with those functional difficulties may seem out of all proportion to the presenting difficulty on first impression and it is worth noting Power's comment in the British Journal of Disorders of Articulation that articulatory problems 'are by no means so simply explained and treated as many people have assumed.'

"With the stammers most people recognise the complexity of the condition and yet sometimes one simple modification in the environment can bring about tremendous changes:—a boy in a grammar school with quite a mild stammer, felt sick every morning on the bus and had to spend quite a lot of time in the sick bay because of this. He had no further difficulty after all reading aloud in school was stopped. The certainty of knowing that he would never again be asked to read aloud relieved all the tension associated with apprehension which had caused the nausea.

"One looks back with interest over the year's work and finds it has emphasised that each patient has his special difficulty needing very individual treatment. The attendance at courses and opportunity for discussion with colleagues would seem to be one of the key notes to an efficient service."

Details of speech therapy cases treated and attendances during 1968.

	Northern Area.	*Western Area.*	*Southern Area.*	*Total.*
On register 1.1.68	138	143	132	413
Admitted	83	109	21	213
Discharged	75	90	36	201
On register 31-12-68	146	162	117	425
Particulars of cases discharged:—				
Normal	31	39	18	88
Improved, unlikely to benefit further	15	11	8	34
Lack of co-operation ...	10	29	8	47
Left school and/or district ...	17	10	—	27
Passed to teacher of deaf ...	2	1	1	4
Referred to child guidance ...	—	—	1	1
Total	75	90	36	201
Waiting list	3	—	37	40
Cases treated:—				
Stammer and dispraxia ...	—	—	54	54
Dyslalia	62	80	43	185
Stammer	50	85	—	135
Stammer and dyslalia ...	13	—	8	21
Sigmatism	5	3	9	17
Cleft palate	9	10	10	29
Hard of hearing	2	—	4	6
Dysarthria	2	—	4	6
Dysphonia	—	—	—	—
Dysphasia	1	—	1	2
Retarded speech development	54	50	26	130
Dyslalia and dysphonia ...	—	—	1	1
Dyslalia plus low intelligence	9	4	4	17
Lateral sigmatism	8	6	7	21
Dyspraxia	5	10	6	21
Submucous cleft	—	—	3	3

Alalia	—	1	—	1
Hyponasality	—	—	6	6
Hypernasality	1	—	—	1
Stammer and dysphonia ...	—	—	—	—
Stammer and dysarthria ...	—	3	—	3
Total	221	252	186	659

Attendances.

Northern Area.	
Alston	17
Allhallows	—
Aspatria	133
Brampton	55
Carlisle	399
Penrith	461
Rosley School	31
Wigton	208
Wigton Infants' School	99
Wigton Junior School	49
Western Area.	
Cockermouth	293
Keswick	129
Maryport	188
Workington	502
Southern Area.	
Whitehaven	531
Total	3095

Child Guidance

The statistics for this service for 1968 are shown on page 57. These show the steady pressure and demand upon this service. Thanks to the excellent service provided by the Regional Hospital Board by way of secondment of psychiatrists to this service; and the presence of senior Social work staff and Educational Psychologists, the waiting period for appointments in Cumberland is much shorter than in many parts of the country. It seldom exceeds 14 days and it will readily be appreciated that this represents a vital factor in a service where prompt help is often required to be effective at all. The need for some special educational unit or units for maladjusted children is very much a live issue still and will, I trust, receive due attention whenever finance will allow of such a development. Dr. Ainsworth comments on this from the School Medical Officer's point of view as well as giving interesting thoughts in the role of the Local

Authority Medical Officers of the future in this field. Her report and that of Dr. Blair Hood, Education Psychologist which follows complement each other very appropriately in my view. To both I am grateful for their contributions on this service.

Dr. Ainsworth writes:—

"In previous reports over the past few years I have remarked how emotional problems seemed to be on the increase. This last twelve months has impressed this fact upon me once more. One wonders if this increase is connected with the outlook and mode of living of our present society, or is it that being less occupied with physical defects, we are looking for, and are more aware of, the emotional problems that affect so many children in the schools?

"These problems interest me very much and I feel this is a useful part of the school health service in which we are not overlapping colleagues, as these problems are usually not brought up spontaneously to the family doctor. By trying to provide help in this field I feel we can be of real value to a child in need of help. On the questionnaire completed by a child's parents when he is 8 and 12 years of age a tick by 'nervousness' can uncover much on further questioning of the parent about disturbed behaviour—be it defiance, or crying easily, etc. A cause for this can be sought and often help offered, whereas otherwise this would pass and no-one apart from mother would be aware of it.

"The behaviour problems seem to fall into two main groups:—

(1) Minor ones, e.g. nail biting, some cases of enuresis, nervousness, e.g. crying easily, 'twining' and 'naughtiness', or attention seeking behaviour, defiant behaviour not of severe degree, and stammers.

(2) Major ones with more severe behavioural disorders:
(i) disturbed children from a disturbed emotional environment at home.

e.g. a child in one of the infant schools comes from a broken home with no mother—she does not speak, she is withdrawn and only communicates to an immature and backward child in the school. This child was referred for help by the Child Guidance Service.

(ii) behaviour disorders resulting from a child being in an educational setting with which the child cannot cope, e.g. an E.S.N. or ineducable child in a normal class.

(iii) disturbed behaviour from a child having an inadequate personality, e.g. a boy was afraid to go to school and developed nervous diarrhoea after older boys had told him that if he was naughty he 'would be put under a lamp.'

"The major problems are a greater challenge. One sees children less frequently with very disturbed behaviour and they are a real problem. A child with this degree of disorder can disturb a class and its teacher to such a degree that the teaching of the remainder of the class can suffer. On the other hand, the child himself is in real need of help and I feel very seriously that we could help these children by eventually having Assessment Centres and Units for Maladjusted to which these children could be referred and attend as day pupils and, when necessary, as residential pupils. It does take so long to admit a disturbed child to a Residential School for Maladjusted Children because of lack of places and valuable time is lost in helping this child.

"Two examples in this category come to mind:

1. One small boy who had to be humoured and rather carefully handled during his time in Infants' School, became very disturbed after entering the Junior School. This child disturbed his class to such an extent that the Head Teacher, who was very understanding and tolerant, almost had to consider exclusion. He disturbed the class to a degree which was disturbing the schooling of others. Without provocation and for no obvious reason he had outbursts in school every day. These consisted of

(i) standing in a corner banging and shouting and pushing all the books off the shelves;

(ii) coming to school with a whistle, using this, and if anyone attempted to take it away he had an aggressive outburst.

"This little boy was not backward. He was of normal intelligence, and with understanding, kindness and sympathetic handling in school he started to make a little educational progress and did start to read, but his very disturbing outbursts continued every day. His background had been

very unsettled. He was illegitimate along with two other illegitimate children. At 1 year 4 months he was taken into care because the Children's Department felt his mother was unable to look after him at that time. He was away 12 months and mother said he did not know her when he returned. When he returned mother was housed with her brother and sister. The whole domestic complex involved mother, her brother and sister, and a lodger, with no clear focal point of authority. The reasons for his disturbed behaviour were clear. He was referred to the Child Guidance Clinic who advised that referral to a Unit for Maladjusted Children would be the best treatment here, but this was not available. The only alternative has been a formal assessment and a recommendation for a residential school for maladjusted children of normal intelligence. With greatest difficulty the mother and her family (i.e. her sister and brother with whom she lives) were eventually persuaded to agree to this recommendation. They would more readily have agreed to a day unit.

2. Another boy, in Junior school, was showing evidence over 12 months of disturbed behaviour in school. He was aggressive. This child's mother had been ill for many years and for several years she had been in a psychiatric hospital as she was unable to manage any longer at home. This boy was one of a large family, the eldest being a 16 years old girl who had left school to help her father look after the home. This was a home where management was not satisfactory. Father objected to his 16 year old daughter going out, and worried about the influence on her of certain female relatives. This little boy had, for many months, been missing his mother and asking to see her but father did not agree to this for his own reasons. The child told the Head Teacher how he missed and wanted to see his mother and, knowing his difficulties, kindness and tolerance was shown to him at school in spite of his outbursts of aggression. At this stage father was approached for his agreement to refer the child to the Child Guidance clinic, but father refused this offer and said he could manage the boy alone. Following this his mother died. The child became more disturbed and was suffering from the effects of the bereavement. He continued to receive kindness and tolerance at school but finally he hit his teacher and marked her. Head Teacher then felt she must exclude the boy until the position was resolved. I asked the Children's Department to re-visit with a view to fostering and the child was simultaneously referred to the Child Guidance Clinic. This child is still attending and the outcome of this case is yet in the future. Behaviour disorders can also

result from a child being placed in an educational environment which is beyond his capabilities. One case I remember is a girl who, although in the progress class, was unhappy and unable to make or keep friends and unable to keep up with the others educationally in class. This was because she was in normal school but was educationally subnormal due to kernicterus at birth. She should have been in a school for E.S.N. children, but unfortunately her parents could not be persuaded to allow her to go.

"I do feel this is a most useful area of the school medical officer's work which for the most part would not otherwise be dealt with. I feel we are dealing here in some cases with the germ of criminal potential and if the cause of the disturbed behaviour is recognised and the right help is offered in these formative years I believe we can help to prevent many children growing up disturbed and aggressive against society. I do think that, when more of the routine work of the school medical officer is taken on by family doctors, this field of handicap is one which could be readily developed to use the experience of the present school medical officers. If eventually assessment centres could be developed the school medical officer could be linked to the paediatrician and Child Guidance Services and work in conjunction with the Educational Psychologist, Speech Therapist and Teacher of the Deaf in these centres, assessing and advising with such problems of disturbed behaviour.

"In addition I would also like to mention that I feel it would be helpful in the future, after the family doctors take over the school medical inspections, to use the special training that school medical officers have received in Developmental Paediatrics. They could be seconded to family doctors to undertake sessions of Developmental Paediatrics for pre-school children where the family doctor is agreeable to this."

And now from the East Cumberland Child Guidance Clinic, we have the report of Dr. Blair Hood, Educational Psychologist:

Dr. Blair Hood writes:

"The work of the East Cumberland Child Guidance team has continued during the past year without any dramatic changes. Of course a dramatic change is a rare occurence in child guidance nowadays, since the techniques for helping a child who has a behaviour problem have remained relatively

unchanged for many years. While techniques have tended to remain the same, the emphasis placed on a particular method of helping a child may change over the years. I can detect two points in which such a change of emphasis has occurred. One consists in an extension of the time spent by a child patient in the playroom. Everyone is now aware that we do not lay on these play sessions merely to amuse the child and keep him happy—although children being what they are this would be quite a legitimate object. Play is therapeutic, in that it tends to ease tensions and to weaken resistances which are holding up the process of adjustment. It may sometimes succeed more quickly in its aim if the child shares the playroom with brothers or sisters of around the same age, should there be any, and so on occasions we may encourage mother to bring all the younger members of her brood, and not to worry about the noise they make. A logical extension of this would be to have even more flexible play sessions, in which several child patients, carefully selected on the basis of their symptoms, personalities and background, were taken in groups in the playroom. This of course is done in larger units, and it is found that this inter-action of members of the therapeutic play group is both revealing to the observer and beneficial to the children.

"The second point of change is that during the past year there appears to have been significantly fewer children referred for the distressing complaint of enuresis (bed wetting). Up to a point this is welcome, but even if other child guidance units in the county confirm the same trend, it will not necessarily mean that the complaint is diminishing in frequency. It may well be because general practitioners are treating such children themselves, possibly employing in some instances the alarm bell technique, instead of referring cases straight to child guidance. It has been suggested, however, that since enuresis is so frequently a symptom of some degree of emotional disturbance, such children should always be examined initially at the child guidance centre as a precautionary measure, and after psychiatric 'vetting', returned to their own family doctor for appropriate treatment.

"I should like now to touch on one final point which is concerned with each psychologist's individual contribution to the school psychology service. All three of us I think are more and more concerned about what can be done to give psychological guidance to the mothers of young children in whom behaviour disorders are looming up. Full scale child guidance is not always possible, not always justified, and not

always even wanted by the parents. It is then that we see our efforts as being directed toward the prevention of more serious child trouble, not of course working in isolation, but integrating our approach to families with those of doctors, health visitors and other members of the social service team. Contact with a difficult child in school is leading with increasing frequency to early visits to the home, so that we can learn what the child is like at home, inform mother what he is like in school, and bring his difficulties thoroughly out into the open. This procedure has the additional advantage that it occasionally brings to light a pre-school child who is causing parents some anxiety, or who clearly is heading for behaviour difficulties without the parents being aware of it. The value of such cases being identified before the problem becomes too serious is obvious. Child guidance may follow, but not always so. Sometimes a link is formed between home and school, where none had existed before. Sometimes, on the other hand, one comes up against strong resistance and no great impact is made. In any case, success is often difficult to measure, and we do not expect wonder cures. Psychologists are looking for fresh ways of participating in this form of preventive work, and one looks for its expansion during the coming years."

It will be clear that Dr. Ainsworth and Dr. Blair Hood are both underlining the vital importance of early detection and treatment of behaviour disorders. Their reports and comments indicate that different members of the team may in appropriate cases play the leading role within the context of the specialist contribution of each member.

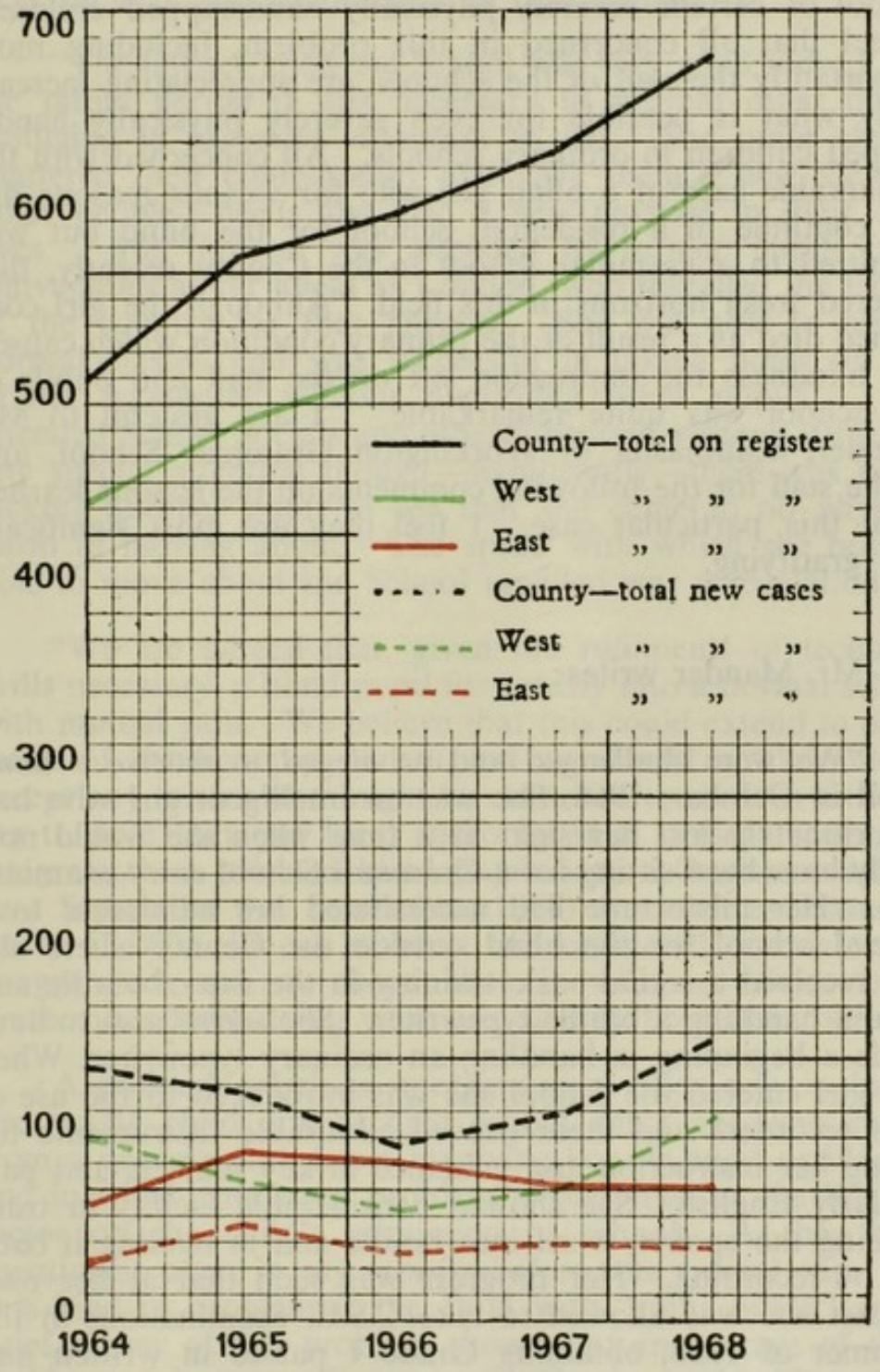
CHILD GUIDANCE CENTRES—STATISTICA L RETURN FOR THE YEAR ENDED 31-12-68

STAFF:	Carlisle:	Maryport:	Workington:	Whitehaven:	Millom:	
Psychiatrist	Dr. J. R. Burgess	Dr. T. Ferguson	Dr. T. Ferguson	Dr. T. Ferguson	Dr. T. Ferguson	
Educational Psychologist	Dr. H. Blair Hood	Mr. K. G. Hare	Mr. K. G. Hare	Mr. C. R. Haigh	Mr. C. R. Haigh	
Psychiatric Social Worker	Miss E. A. Welch	Miss E. F. Hall	Miss E. F. Hall	Mr. M. Ruddick		Total
Cases remaining on register at 1st January, 1968	31	11	452	39	3	536
New cases referred during year by:—						
Consultants or General Practitioners	24	1	5	2	1	33
School Medical Officers	1	5	35	35	10	86
Children's Officers	4	—	—	—	—	4
Parents	—	—	—	2	—	2
Schools	3	—	—	7	—	10
Probation Officers or Courts ...	1	1	—	—	—	2
Others	2	—	—	—	2	4
Cases re-opened during year ...	4	—	4	3	—	11
Total cases on register during year ...	70	18	496	88	16	688
Cases dealt with and closed	16	6	406	25	4	457
Cases remaining under treatment on 31-12-68	47	10	80	57	12	206
Cases awaiting treatment on 31.12.68.	7	2	10	6	—	25
	70	18	496	88	16	688
Interviews by Psychiatrists	343	32	124	94	23	616
Interviews by Social Workers ...	190	11	38	56	—	295
Interviews by Educational Psychologists	153	35	145	129	23	485

CHILD GUIDANCE REGISTER 1964-1968

		1964	1965	1966	1967	1968
Total on Register during year.	East	64	91	86	72	70
	West	449	493	519	563	618
		513	584	605	635	688
Total new cases during year.	East	38	51	37	41	39
	West	99	76	58	71	113
		137	127	95	112	152

CHILD GUIDANCE REGISTER, 1964-1968



HANDICAPPED PUPILS

In the year 1968 the problems of handicapped pupils have been most prominent at the individual case level, especially in the matter of the admission to, or retention in school of certain severely physically handicapped children I feel that all concerned in this problem, including mos importantly the staff of the schools, are appreciating increasingly what is possible for even severely physically handicapped children in ordinary schools. All concerned with the remarkable case of a blind girl who for various reasons did not continue in a residential school for the blind but was admitted to a grammar school in the County recently, discovered fresh horizons in this field. Although the girl concerned died as a result of the primary condition which caused her blindness the impression left on the staff and pupils of the school was quite remarkable. I am grateful to Mr. Mander, headmaster of Workington Grammar School, and to the staff for the following comments on the lessons learned from this particular case. I feel they are most significant and gratifying.

Mr. Mander writes:

"We were challenged and privileged to receive a blind pupil in October, 1966. She was an intelligent girl who had unfortunately lost her sight at a time when she would normally have been sitting for a Grammar School entry examination. Her misfortune had necessitated her admission to a special school for the blind outside the County where she had received a sound basic training in the use of braille and also in handling a braille typewriter. She seems also to have made a beginning in handling an ordinary typewriter. When this girl entered the school she was introduced to the use of tape recorders and these proved admirable instruments for giving her instruction and guidance in key subjects and particularly English. She showed considerable facility in transcribing the spoken word into braille and in reading it back and re-recording. Her progress was such that at her own request she was allowed to take C.S.E. examinations in the Summer of 1968, obtaining Grade I passes in written and spoken English and a Grade 2 in History. Again, at her own wish, she was being prepared for a G.C.E. 'O' level examination in Scripture when unfortunately a recurrence of the condition which had produced her blindness terminated her life on 26th November, 1968.

"This girl, as seems to be customary, found certain of her senses exceptionally developed as a partial compensation for her blindness. Her memory was good and her concentration varied from normal to good. Her manual dexterity was surprising and she performed exceptionally well in practical subjects and particularly in Needlework.

"The impact upon the School was very good indeed. In the initial period it was necessary to prevent other pupils indulging in excessive attention to her. She quite clearly shattered their complacency and gave them a new view of other people's needs and also a new purpose in their own lives. Her funeral was attended by former pupils from Universities as far afield as London, who travelled the length of the country for that purpose. She was able to attend normal classes and was successful in taking notes on her braille typewriter without disturbing other pupils. She attended School Socials and other functions without attracting any special attention though—significantly—there was never lacking another pupil to see that she came to no physical harm in moving about. The speed with which she became able to move about the School unaided was a revelation.

"We are agreed that, given the rudiments of technical skills necessary, a blind pupil fits readily into a normal school with mutual gain. We believe that this could extend to other forms of handicapped person and we should not hesitate to accept any others who might be entrusted to us. It is interesting to note that one local authority is at present hoping to integrate three selected blind pupils into a Grammar School next September (i.e. September, 1969) at a cost estimated at up to £3,000. In our opinion this estimated cost is vastly exaggerated and we hope that it will not deter other Authorities from doing what has already been done here."

A problem which is emerging more often now is that of the young child approaching school entry age who suffers from a neurological defect involving bowels and/ or bladder and in which this latter problem is presented as the limiting factor on the child's admission to school. As has been mentioned often in my reports before, the typical case with this kind of problem is the child with "spina bifida" and a brief survey of this problem shows that an average of three children each year will survive in Cumberland with varying degrees of handicap affecting control of bowel and bladder, movement in the lower limbs, and associated mental capacity. Undoubtedly the most severely affected will require residential special education but on the other hand the child per-

manently restricted to a wheel chair may well become a familiar feature of our schools and even now, in my opinion, demands some special consideration in the planning of new schools.

I show in the table on page 64 some particulars of the numbers of handicapped school leavers case conferences which were held during 1968. A key member of the team which confers on these occasions is the Youth Employment Officer of the Department of Employment and Productivity. I asked Mr. Hambleton, Principal Youth Employment Officer, for an account of the value of the handicapped leaver conferences fro his point of view and he has kindly provided the following notes:—

"The Youth Employment Service in the County areas of Cumberland is administered by the Department of Employment and Productivity and is responsible for providing vocational guidance and assistance in obtaining suitable employment for all young persons leaving school. Except for the lack of opportunities in some areas, able-bodied boys and girls present few problems but handicapped children often require special attention and assistance. For the purpose of this report, a handicapped child may be regarded as one who is suffering from some physical or mental disability of a degree sufficient to render certain types of employment unsuitable to him.

"At a meeting at the Courts, Carlisle, in May, 1967, attended by representatives from the Cumberland County Council Education, Health and Social Services Departments, from the Voluntary Organisations and from the Youth Employment Service, it was agreed that it was important that cases of handicapped young persons should be identified as soon as possible. This would allow the Youth Employment Officer ample time to discuss, with school headmasters and staff, suitable courses or subjects which would be of benefit to the school leaver and so enhance his/her career prospects.

"As a result of the above meeting, twice-yearly case conferences are now held in Carlisle, Workington and Whitehaven and cover all areas of the County. The Area Medical Officer, School Doctors, the Educational Psychologist and other interested representatives, discuss, with the Youth Employment Officer, the cases of children who are on the Handicapped Register and who will be eligible to leave school in the following eighteen months to two years. The

Youth Employment Officers are thus supplied with up to date medical guidance which is a valuable addition to other relevant details supplied by the school.

"Quite a number of the children discussed are educationally sub-normal and close liaison is maintained between the Youth Employment Service and the staff of the Special Schools. In the case of the physically handicapped, assistance is received from the Local Authority, Health and Welfare Departments, and from the Voluntary Organisations, e.g. National Institute for the Blind, National Institute for the Deaf, Spastics Society, etc. On some occasions, the specialised knowledge of the Group Disablement Resettlement Officer of the Department of Employment and Productivity is invaluable for the more difficult cases.

"The majority of handicapped school leavers are found suitable employment and only on very rare occasions is it admitted that little can be done to assist. Where it appears unlikely that the young person will be able to work under normal conditions, the early identification of such cases enables the question of application for entry to a training centre to be considered, and the necessary arrangements made. Thus entry to a course is possible immediately after leaving school. Some examples of the type of case dealt with are as follows:—

"A girl suffering from epilepsy was placed in residential domestic employment in a Youth Centre.

"Arrangements were made for a girl, suffering from poliomyelitis, to go for a short-term assessment course at a Training Centre. This girl is now attending a full-time course at the same Centre combining further educational studies and typing.

"Close contact is maintained with school leavers after they have started work to ensure that they are in suitable employment. In some instances, further advice is necessary and steps are taken to resolve any problems.

"The Youth Employment Officers in Cumberland find the twice-yearly case conferences extremely useful and look forward to the continuance of the assistance, advice and close co-operation extended by the representatives of the various departments of the County Council, and by the Voluntary Organisations".

HANDICAPPED LEAVERS' CONFERENCES

Cases considered were as follows:—

Deaf and partially hearing	8
Blind and partially sighted	3
Epileptic	15
Diabetic	7
Physically handicapped	37
Educationally Subnormal	110
	180

CHILDREN SUFFERING FROM CEREBAL PALSY

The numbers in this category at 31st December, 1968, are as follows:—

Number of spastic children of school age—

North Cumberland	24
South Cumberland	31
West Cumberland	17
	72

These may be divided into those:—

(a) Attending ordinary school	44
(b) Attending Percy Hedley School for Spastics, Newcastle	3
(c) At Residential Schools for the Physically Handicapped	—
(d) At Residential Schools for the Educationally Subnormal	1
(e) Attending Training Centre	6
(f) At Dovenby Hospital	3
(g) At Prudhoe Hospital	—
(h) Having Home Tuition	2
(i) Not attending school, not having home tuition	2
(j) Irton Hall	5
Special Care Unit	6
	72

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:—

North Cumberland	3
South Cumberland	8
West Cumberland	4
	15

Table Showing Handicapped Pupils in Special Schools

PHYSICALLY HANDICAPPED

	Boys.	*Girls.*
Percy Hedley School, Newcastle-on-Tyne	1	2
Irton Hall School, Holmrook, Cumberland	4	2
"The Cedars" Special School, Gateshead	—	1
H. K. Campbell School, Carlisle ...	1	—
Lord Mayor Treloar, Froyle, Alton, Hants	1	—
Spastics Society—Dene Park F.E. Centre, Tonbridge	1	—
Portland Training College, Mansfield, Notts.	—	1
	8	6

DEAF

Northern Counties School, Newcastle-on-Tyne	4	1
St. John's School, Boston Spa. ...	—	1
Royal Cross School, Preston	1	5
	5	7

PARTIALLY HEARING

Northern Counties School, Newcastle-on-Tyne	1	—
St. John's School, Boston Spa. ...	—	1
Royal Cross School, Preston ...	—	1
School for Partially Hearing, Birkdale, Southport	2	1
Bridge House School, Harewood, Yorkshire	1	—
	4	3

BLIND

Royal Normal College, Shrewsbury ...	2	1
Royal Victoria School, Newcastle-on-Tyne	1	—
Chorleywood College, Hertfordshire	—	1
Henshaws Institution for the Blind, Manchester	1	—
	4	2

PARTIALLY SIGHTED

Royal Normal College, Shrewsbury ...	—	1
Derby School for Partially Sighted, Fulwood, Preston	—	2
St. Vincent's School for Partially Sighted, Liverpool	—	1
	—	4

EPILEPTIC

Colthurst House, Alderley Edge, Cheshire	1	—
	1	—

DELICATE

Windlestone Hall School, Rushyford, Ferryhill, Co. Durham	1	—
	1	—

EDUCATIONALLY SUB-NORMAL

York School, Carlisle	1	—
Higham School, Bassenthwaite Lake, Cumberland	—	33
Ingwell School, Moor Row, Cumberland	49	—
	50	33

Educationally Sub-Normal Pupils

This is the largest single group of handicapped pupils with whom the school medical officer is directly concerned and the "2.H.P." examinations referred to in the table on page 68 are carried out by school medical officers specially trained in this work. The high number (88) carried out in 1968 maintains the high level of referrals and assessment reached in the previous year. The number of referrals (97) was even higher than in 1967 (87). It is important that these referrals are made early enough for follow-up of the child to proceed for some time before a decision has to be taken about education in a special school. Not only can the school medical officer and educational phychologist collaborate on more detailed testing which may isolate particular areas of learning difficulty in a child, but more time is allowed to condition parents as to what is the best course for the child.

Towards the end of the year the Department of Education and Science called for a review of all children in hospitals for the subnormal with a view to assessing what further provision in special schools or units may be needed to enable some of these children to receive education in a special provision for handicapped children. One group which tends to find its way into these hospitals are severely maladjusted children who also have educational subnormality and for whom special residential provision in a really appropriate school is not available when it is required—often with some degree of urgency. This review is at present proceeding.

Another development affecting this area of school health service work is the announcement of Government policy that the training of severely subnormal children, hitherto a responsibility of local health authorities, is in future to become that of the education authority. I believe this is basically a sound development although certain safeguards will require to be observed. It will finally allow of the abolition of the unpleasant and unwieldy machinery of formal exclusion of a child from school as "unsuitable for education at school". Clearly all of the heart-burnings of parents of severely handicapped children will not disappear overnight but everything must be done to ensure a smooth transition.

2 H.P. EXAMINATIONS COMPLETED IN 1968 UNDER SECTION 34 OR 57.

Recommended Special School—E.S.N.	37
Recommended Special Class—E.S.N.	16
Reported unsuitable for education at school	25
No special educational treatment required	4
Decision deferred	6
Total	**88**
Number of boys on waiting list for Ingwell School ...	27
Number of girls on waiting list for Higham School ...	10

NEW CASES REFERRED IN 1968

Placed under supervision for further investigation of intellectual capacity	80
Referred by:—	
School Medical Officers	22
Psychologists and Teachers	61
Consultants and Hospitals	9
Health Visitors	1
Others	4
Total	**97**

Supervision of Educationally Subnormal Leavers.

A recent review of some of the educationally sub-normal girls who have left school in recent years embraced a total of 45 girls. Of these, 16 are married and appear to have stablished homes with a reasonable degree of success; another expects to marry in the near future. In one case a marriage has broken down and divorce is pending.

In the case of four girls who have never married illegitimate children have been born and two girls (including one of these with two illegitimate children) have had to be admitted to a hospital for the sub-normal.

Of the remaining girls of this group surveyed six have been in steady employment since leaving school, three have been intermittently employed and six have never been employed but have continued to live satisfactory lives under supervision at home. Three have become regular attenders at adult training centre.

SUPERVISION OF EDUCATIONALLY SUB-NORMAL SCHOOL LEAVERS

	1966	1967	1968
Total number of leavers	65	73	63
Placed under supervision of Social Welfare Officers ...	17	13	11
How placed at end of one year:			
(a) employed	7 (8)	5 (6)	7
(b) unemployed	5 (5)	6 (4)	2
(c) unemployable	— (—)	2	1
(d) at training centre	5 (3)	—	1
Placed under supervision of Health Visitors	24	15	33
How placed at end of one year:			
(a) employed	15 (15)	11 (13)	13
(b) unemployed	7 (6)	4 (2)	18
(c) unemployable	1 (2)	—	2
(d) at training centre	1 (1)	—	—

Figures in brackets denote the situation at the end of 1968, of 1966 and 1967 leavers.

DENTAL SERVICE

The year 1968 has been one of continuing and steady progress in providing a comprehensive dental service for the school children of Cumberland. Despite the familiar difficulties in regard to staff and financial resources for development a good service has been maintained.

On the subject of clinic premises one should mention, with grateful thanks to the Education Committee, the very good and modern surgery provided at the new Whitehaven Grammar School. This surgery has very up-to-date equipment and means that the pupils lose very little school time to receive their dental treatment—a matter of serious import when studying for university entrance. The headmaster and all staff are most co-operative and fully appreciative of the service provided.

During the forthcoming year it is hoped to re-equip one surgery at Whitehaven and one at Maryport, where equipment is obsolete and working conditions very bad. Keswick will then be the only clinic remaining which is completely outdated, but some replacements will also be required for the earlier clinics which were converted. Several clinic premises are most unsuitable for this purpose and one can but only hope that soon these will be replaced by new health centres or clinics, because even new equipment in unsuitable surgeries does not always give ideal working conditions.

In September 1969 the County hope to augment and improve this dental service by providing a dental auxiliary to divide her duties between Whitehaven and Workington. She will undertake dental treatment on pre-school, infant and junior school children. These auxiliaries provide a real service by their superb technique in handling and treating young children, and also by dental health education talks and demonstrations. It should be emphasised that there is no question of cheaper or inferior work being carried out by the auxiliaries, but rather that they are doing a job for which they are much better suited than the average dental officer. A young lady is not so frightening to a child and she can more easily bring herself down to the age and mental capacity of her patient than the majority of dental officers.

With much regret we said goodbye to Mrs. Ann Osuhor, who has spent a year with the County at Workington on a part-time basis. Her work has been invaluable in an area where there is a marked shortage of general dental practioners and also local authority dental officers. A very large gap has been filled by the appointment of Mr. J. Colvin, who commenced duty in August and has taken over the Egremont, Millom and Seascale area of the County. The service still needs two more dental officers in order that a fully comprehensive service may be given, but it would appear that prospects of recruiting more staff are poor.

If only more dental officers could be recruited, Cumberland could have one of the finest services in the country, because the facilities are already there for all types of work to be undertaken, so one can only hope that two more dental officers will join the staff during 1969.

Fluoride adjustment of water supplies in parts of West Cumberland (to a dental optimum) is due to commence during the present financial year and a survey is being made of both non-fluoride and fluoride areas over a ten year period to prove the efficacy of this method of caries control. Appreciation must be expressed to Professor Jackson and Mr. Gravely of Leeds University for conducting the survey so meticulously, and also the head teachers of all the schools who took part for such wonderful help and co-operation.

The outstanding event during the year from the point of view of many children in West Cumberland was a visit from Pierre the Clown. Dental Health Education can be a very dull subject to young children, but not when carried out by Pierre, and one hopes that the effect of his visit will remain long after the apple has been eaten, the painting sheet painted and the Apple Club badge lost or worn out. It is hoped to have the services of Pierre for a further week towards the end of 1969 for the benefit of children in East Cumberland.

PREVENTION OF INFECTION

The outstanding event in the field of vaccination and immunisation during 1968 was the introduction of *measles* vaccination in stages for all children up to 15 years. The initial stage of the campaign occupied the months of May and June and was centred on the infant schools in order to take in as many as possible of the first priority group, those

children aged between 4 and 7 years. Although it was clear that as soon as possible measles vaccination should be in the hands of the family doctors, it was agreed with them that the initial "crash" exercise to cover as many as possible of the 4 to 7 year olds during the summer school term should be undertaken by the school health service. During May and June 1,681 children were protected although this period was a rather anxious one in terms of supplies of vaccine which were severely restricted. One of the important imponderables was the number of children whose parents would not require measles vaccination for their children because of measles previously suffered. As the summer holiday period progressed the supplies of measles vaccine rapidly became more plentiful and by August it was possible with reasonable confidence to offer vaccine to general practitioners for younger children over the age of one year. Then by September it was clear that the older school children not yet protected and who had not already had measles could readily be included. Parents were advised to seek all protection against measles henceforth from the family doctor. It will be appreciated that all children will in future be protected against measles long before school entry and the position is not yet clear as to the possible future requirement of reinforcing injections.

One side-effect of the concentration on measles vaccination during the summer school term was the restriction which this placed on the normal routine of reinforcement of protection for school children against diphtheria, tetanus and polio. I comment briefly on this below.

The B.C.G. vaccination programme for protection against *tuberculosis* proceeded as in previous years and similar numbers of 12-13 year old children were protected as in recent years. This comment includes the reasonably high level of parental consent (88.4%) to preliminary skin testing and subsequent B.C.G. vaccination where necessary.

A total of 300 i.e. 11.6%, of the children skin tested were found positive and the remainder, being those susceptible to tuberculosis infection, were given B.C.G. vaccination. Of the 300 positive skin reactions 225 accepted the offer of check chest X-ray. 186 children had already had B.C.G. vaccination for some reason and 29 were already under the care of the Chest Centre.

In the campaign of vaccination against *polio*, the total number of children receiving protection was 3,392 (4,141).

Of these 770 were primary vaccinations and 2,622 were re-inforcements. As with Diphtheria and Tetanus protection some ground will have to be made up in 1969.

In the prevention of *diphtheria and tetanus* the numbers of school children protected in 1968 were as follows:—

Diphtheria:

Primary courses	530 (1,130)
Reinforcing injection	4,047 (4,930)

Tetanus:

Primary courses	580 (1,221)
Reinforcing injection	4,166 (5,118)

(The figures in brackets refer to the previous year).

These figures, as representative of one "year group" due for different stages of protection, are not wholly satisfactory and I have indicated above that the measles vaccination programme has interfered here. It should be remembered, however, that, with few exceptions, children who have missed a protective injection in 1968 which they were due, will have the opportunity of receiving this in 1969. Thus the necessity is to make up the leeway in the current year.

The new schedule of immunisations which superseded its predecessor during 1968 will in due course alter somewhat the pattern of immunisation work in schools. When linked to the County Council computer which will bring forward appointments at the prescribed intervals for all children, with their family doctor, little if any immunisation work will actually be done in schools. This will, of course, take several years to gradually come about, and meanwhile the commencement of the computer based programme has had unfortunately to be postponed to mid 1969 at the earliest. This is because of technical and staff difficulties in computer programming and management.

Infectious diseases

The occurrence of notifiable infectious diseases in school children is shown in the table on page 75. The lower numbers of measles cases in 1968 compared with the previous year is only partly a reflection of the measles vaccination campaign. One could indeed have hoped for a more dramatic and immediate effect from the early stages of the campaign and parents must realise, as with Diphtheria, Tetanus and

Polio protection that it is essential that measles vaccination be taken up very conscientiously in order to virtually eliminate it as a distressing and sometimes dangerous infection of childhood.

Dysentery is more prominent again in the 1968 figures and it is disturbing to find so many cases in school children in the Cockermouth area which appears to have been particularly hit in 1968. Such an occurrence is a real challenge to the schools and school health service in an area (and a warning to others) to keep up every possible pressure towards a consistent high standard of personal hygiene amongst the children.

CASES OF INFECTIOUS DISEASES IN CHILDREN OF SCHOOL AGE, 1968.

	Scarlet Fever	Whooping Cough	Measles	Dysentery	Meningococcal Infection	Ac. Pneumonia	Food Poisoning	T.B. Respiratory	T.B. Meninges & C.N.S.	T.B. Other	Paratyphold	Infective Jaundice	TOTAL
URBAN DISTRICTS:													
Cockermouth ...	—	—	35	86	—	—	—	—	—	—	—	—	121
Keswick	—	—	—	—	—	—	—	—	—	—	—	—	—
Maryport	4	—	13	—	—	—	—	—	—	—	—	—	17
Penrith	2	1	4	6	—	—	—	—	—	—	—	2	15
Whitehaven	7	—	1	1	—	4	—	—	—	—	—	8	21
Workington	1	—	97	—	—	—	—	1	—	—	—	1	100
RURAL DISTRICTS:													
Alston	—	—	13	—	—	—	—	—	—	—	—	—	13
Border	4	4	15	3	—	—	—	—	—	—	—	—	26
Cockermouth	2	—	28	7	—	—	—	—	—	—	—	—	37
Ennerdale	4	—	4	5	1	—	—	—	—	—	—	4	18
Millom	4	13	7	1	—	—	—	—	—	—	—	—	25
Penrith	—	—	5	2	—	—	—	—	—	—	1	1	9
Wigton	5	3	52	2	—	—	—	—	—	—	—	—	62
Total ...	33	21	274	113	1	4	—	1	—	—	1	16	464

Swimming Baths

With the steady growth of schools in the county which have their own swimming baths (9 by the end of 1968) the need for sound arrangements about resuscitation of accident cases has become increasingly apparent—not, I am happy to say, as a result of any fatalities. Thus at the time of writing this report wide ranging discussions are being held and demonstrations of equipment arranged in order to arrive at a decision as to which piece of resuscitative apparatus is most suitable for swimming baths especially those remote from hospitals. The practical issues known in detail only to the baths superintendents are clearly of great importance here as well as the precise physiological efficiency of any piece of apparatus operated under ideal conditions.

The safety of the water of the pools continues to be watched over by the bath superintendents and the public health inspectors working closely together.

HEALTH EDUCATION AND THE WORK OF THE SCHOOL NURSE

Education in health matters may quite rightly be said to be but one aspect of education as a whole, and to require the co-operative effort of several professional disciplines. In the schools education in health tends today to pervade the teaching of many more subjects than it once did. Yet there is an area of this work where the special contribution of the doctor and the nurse cannot be made by anyone else and I am glad to report that the school health service has been active in this field again in 1968. The volume of health education work carried out by the nurse is always greater than that in which the medical officers are directly involved, and it is towards the facilitation of more planned and effective health education that changes in school nursing must be directed. This will, in my view, be best achieved by the health visitor or other nurse, trained in techniques of education, being enabled to make this contribution untrammelled by the more traditional "school nurse" duties associated with routine inspection work of vision, etc. During 1968 nine nurses have been appointed in different areas to undertake these duties and the health visitors working in the schools' catchment area, although as members basicially of a family doctor's team, have been able to re-orientate towards both health education and the strengthening of the links between the family health teams and the school community.

This latter role of the health visitor is one of great importance and will, in my view, be fulfilled in slightly different fashion in different types of school, the main difference being between the smaller more local infant and primary schools and the larger comprehensive units at secondary level. That good links should be forged between schools and family health teams is essential since, for the majority of the population, the services of community health and community education are the principal personal services of direct significence and immediate importance.

At the infant and primary level there will more frequently be direct contact between a pupil in a school and the health visitor associated with his family doctor. At all events only a small number of medical practices is likely to be involved amongst the pupils at most of these schools and one nurse can maintain the necessary liaison reasonably well. In the secondary schools I envisage the appointment of progressively more school matrons who will be necessary

for day to day and hour to hour services but whose duties must not become so involved with trivia that she cannot function as she should, as the main link between the school and the many family health teams represented by 1,500 or more pupils. I was particularly glad that the Southern Area Medical Officer was recently closely associated with the appointment of the matron to the new Whitehaven Grammar School. I trust that such matrons will also become progressively involved in health education work at the schools. This is obviously closely related to the schools' pastoral work and counselling which is developing apace, and also to the counselling work of the Marriage Guidance Council in the secondary schools. All these elements of health education can, and must, work together—and also with other social service agencies which are on the horizon. I refer primarily here to the development of social service departments in local authority if the Seebohm Committee Report is implemented by the Government.

In 1968 there have been in all 247 sessions devoted by nursing staff to health education in schools. Some nurses have, of course, a particular flair for this work and the duties of one such nurse, a health visitor, were adjusted to allow of spending 80% of her time on health teaching in schools.

Mrs. M. Hewitson gives an account of some of her work as follows:—

"I have continued, for the second year, courses for the 11-12 year old first year girls, about 280, in the three schools —Salterbeck Secondary, Newlands Comprehensive and Netherhall Comprehensive. This consists of three 1-hour sessions on a weekly basis beginning with puberty, menstruation and personal hygiene. The majority of these girls have not yet started the menses so the explanation is simple and discussion and questions encouraged. This is followed by good grooming and positive health which I call 'Basis for Beauty'. This covers care of the hair, teeth, skin, body, hands and feet, diet and posture.

"Seventy-five 11-12 year old girls at Salterbeck School also had two 1-hour sessions on home safety and simple first aid.

"Third year boys and girls at Salterbeck School had a film and talk on smoking. About 160 children were present. This year Netherhall has also requested that I do this. Thirty-five fourth year girls at Salterbeck continue their C.S.E.

course of six full mornings (9-30 a.m.—12 noon) which covers menstruation through to motherhood and child care. These are the girls who intend staying on at school at least one extra year. Newlands School continue their course based on the Newsom Report's recommendation that the planning of a wide programme of physical, moral and mental welfare was essential and that health education should no longer be left to the enthusiasm, apathy or discretion of individual teachers but planned to ensure a complete syllabus—that the child should be educated for living. There are about 40 girls in this class and I spend 6-8 full mornings covering the full cycle of life from menstruation and conception. These girls also help in infants' school and with the elderly, this being arranged by the school.

"All other fourth year girls (14-15 year olds) about 180-200 in all, in each of the three schools have a four-hour course (one hour per week) on much the same lines but more brief.

"The Leavers' Course at Netherhall, which consists of about seventy 14-15 year olds, continues to thrive. This again is based on helping the adolescent find his or her place in the family and the community: the change from school to work and the importance of right relationships inside and outside the home. As part of this course I give a talk on 'Personal Relationships in Marriage'.

"After the talks we break up into small tutorial groups.

"Other aspects of health education for young people in which I have become involved include the 'Towards Maturity' course at Netherhall School; parts of the Nuffield science course at Newlands School; Junior Red Cross Mothercraft; Schools Quiz Groups during 'Accident Prevention Work'.

"Altogether a very busy and I think profitable year; for so long it has been hard work pushing to get into schools and trying to be accepted by the teaching staff.

"Film projection is a practical problem and reduces the usefulness of this medium though help from teaching staff is often forthcoming.

"The children in school do enjoy health education talks and are very attentive but evaluation remains the toughest problem."

Similarly, Miss R. Sheppard, health visitor in Cleator Moor area, reports: —

"Special discussion groups are held, related to the needs and knowledge required by young people. The topics for discussion include alcoholism and its effects on people, drugs and the effects on family life, sex education and budgeting including hire purchase.

"Health education in schools is particularly useful in helping personal relationships and talking over with a group why some people act as they do. It does help the teenagers who are often quite surprised that grandma really cares about their welfare when she will not allow staying out late, etc.; they think that she just does not want them to have any fun.

"The school children enjoy someone other than the usual teacher and the school nurse has had other experience which the school child can appreciate as valid. It also forms a contact with the community services for the child and sets values which may be discussed. From the school nurse's point of view the work is interesting and gives her a better liaison with the rest of the school staff."

That the work of the school health service in this field is widely appreciated in the schools is very gratifying and I am indebted to Miss Windle, Headmistress of Tynefield School, Penrith, for the following comments: —

"Our health visitors have been towers of strength in building up our homecraft course. Here the girls are taught the value of creating good standards in the home, pre-natal and post-natal care of the baby, the bringing up of young children and child development. The health visitor comes in to talk about and demonstrate all these aspects of family life, she arranges visits to the school clinic where the different branches of the health service are explained, she examines for the practical examination of the basic certificate of the National Association for Maternal and Child Welfare which many girls take at the end of the school year. Emotional pressures of adolescence, stress at home, questions on sex, choice of partner, marriage, can all be discussed in a friendly, relaxed atmosphere and many fears are removed. The health visitor becomes a familiar and welcome part of the staff and a link is forged which might well be of vital importance to many girls when they leave school and set up homes of their

own. The Marriage Guidance Council give advice and help to the girls on this course but I feel sure that the time will come when the school health service, through doctors and nurses could also come in on this side. We feel that discussion of specific topics such as venereal disease could be undertaken more effectively by the school doctor than by a member of staff, and would be much appreciated."

One area, and a very perplexing one, in which the school medical officers are usually more directly involved is that concerned with smoking and health, and 15 schools were visited in 1968, usually using a film. I say this field is rather perplexing mainly because of the near impossibility of truly evaluating any effort. It is difficult to escape the rather depressing conclusion that, so long as precept by adults is not matched by example, it is too much to expect success in dissuading young people from smoking. Some would even claim that example is largely, if not entirely, irrelevant since the contemporary adolescent vogue for rebellion should counteract the effect of the example of abstinence! This I cannot accept, believing that most young people do, and always will, look for leadership, offered judiciously and with a light touch, by older people. In one large secondary school in the county free discussion at sixth form level with a medical officer, and not associated with any formal lecture, produced an interesting experience—at least for the medical officer! One suggestion which emerged was the possibility of harnessing by such means the "anti-smoking" lobby amongst the young people themselves. That this exists in most schools seems to be clear and perhaps more use could be made of this fact. Dr. Ainsworth, school medical officer in the western area, is keenly interested in this health education aspect of her work and writes as follows:—

"Another aspect of the school health service this last year has been continuing with the anti-smoking campaign when we were able. I have felt for some time that the last one or two years of junior school are the most valuable area in which to try to impress a child that smoking is not wise. However, the children of the first year in the secondary school do respond to an anti-smoking discussion and film, and do ask useful questions about smoking and its dangers.

"The main part of the campaign has been carried out with the children of the last year of junior schools in Workington—these schools include Seaton Junior, Great Clifton Primary, Moss Bay School, St. Mary's R.C., Harrington and

Ashfield Junior. I have also talked to the first year at St. Joseph's Secondary Modern.

"I think the most useful film we have yet given is 'Dying for a Smoke'. This film is modern and not 'stuffy' as some of the others we have given previously. It seems to hold the children's interest. They enjoy the film, are entertained, but they do receive the message and this became obvious as the film made a good basis for a lively discussion. The children asked many sensible questions and gave us an opportunity to elaborate on the points brought out by the film and why and what various points meant.

"It appears at the time the children seem impressed about anti-smoking but of course the true result is very difficult to know, but one continues hoping it will have some effect on the decision of these children whether to smoke or NOT to smoke and, therefore, on their future health."

At the time of writing this report a complete review within the department, and with the help of the Director of Education, is being begun of the content of health education programmes in the schools.

MEDICAL EXAMINATION OF TEACHERS

Full medical examinations (including chest X-ray) are required for certain senior teaching appointments, and for those either taking up a teaching post for the first time or who have had a break in service for a period of 12 months or more; the number of such examinations during the year was 106.

For teaching appointments other than above, the completion of a questionnaire and submission of a certificate of satisfactory chest X-ray is all that is required, and from the information supplied by the candidate an assessment is made whether a medical examination is necessary. During the year 88 such questionnaires were completed.

Two hundred and sixty-eight medical examinations were also carried out of candidates for entry to teacher training colleges.

Mr. Gordon S. Bessey, Director of Education, has supplied the following notes on school premises, meals and milk:

School premises

New premises were provided for the undermentioned schools:—

Welton.
Whitehaven Grammar.

Two new schools were opened in Workington—Ashfield Infants and Ashfield Junior—and St. John's Junior and Infant Schools were closed.

The undermentioned schools were extended and/or remodelled:—

Egremont, Bookwell.
Ingwell.
Seaton Infants.
Whitehaven—St. James' Infants.
Overend.
Wigton Thomlinson Junior.

A youth wing was erected at Derwent School.

The managers provided new premises for Borrowdale and Hutton Roof C. of E. Schools and Frizington St. Joseph's R.C. School.

Heating improvements were carried out at the undermentioned schools.

Allhallows C. of E.
Allonby.
Bassenthwaite.
Burgh-by-Sands.
Caldbeck.
Cargo.
Castle Carrock.
Hesket-new-Market.
Kirkandrews-on-Eden.
Millom Secondary.
Nenthead.
Newton Arlosh.
Oughterside.
Plumpton.

Improvements were carried out to the sanitary accommodation at Keswick, Brigham, Keswick St. John's, Penruddock, Lowca and Caldew Schools.

Bigrigg School was closed.

School meals

The figures below show the number of pupils taking a mid-day meal on a census day in September, 1968 and 1967. The charge for a meal was increased from 1/- to 1/6d. from the beginning of the summer term, 1968.

	Primary and Nursery and Special Schools			Secondary Schools			All schools combined		
Year	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
1967	21,048	18,454	87.7%	14,701	13,479	91.7%	35,749	31,933	89.3%
1968	21,074	18,673	88.6%	14,828	13,589	91.6%	35,902	32,262	89.8%

New building work together with adaptation and improvement of existing premises, has continued throughout the year. New kitchens have been provided at the following schools:—

St. James' C. of E. Infants' School, Whitehaven.
Ashfield Infants' School, Workington.
Ashfield Junior School, Workington.
Seaton Infants' School, Workington.
St. Joseph's R.C. School, Frizington.
Hutton Roof C. of E. School.

By the end of 1968 the number of kitchens producing meals had reached 147.

Milk in schools

The figures below show the number of pupils in schools maintained by the authority taking milk on a census day in September, 1968 and 1967. The provision of free milk for secondary schools ceased at the end of the summer term, 1968.

	Primary and Nursery and Special Schools			Secondary Schools			All schools combined		
Year	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
1967	21,048	'19,011	'90.3%	15,025	7,832	52.1%	36,073	26.843	74.4%'
1968	21,166	'18,784	'88.7%	—	—	—	—	—	—

The percentages of pupils taking pasteurised milk and untreated milk are as follows:—

	Pasteurised.	*Untreated.*
1966	92%	8%
1967	97%	3%
1968	97%	3%

Physical education

The greatest change which has taken place in recreation in the past two decades—and education has played no small part in this change—has been the increasing use of the countryside for leisure time pursuits. Further, as the motor car becomes an essential piece of family equipment, as the motor ways open up the speedy access of the industrial areas to the open country and as the working week through automation and other pressures shrinks to a probable 30 hours in the lifetime of pupils now at school, participation in rural leisure will multiply. Those activities, formerly the prerogative of the wealthy which make use of Nature's playground and which lend themselves to participation individually or in small groups, preferably mixed, are and will continue to be enjoyed by all in increasing numbers. In an area where natural beauty and variety of amenity attract the general public from far afield, it is important that the most economic use of land should be made, the natural amenities should be protected and the users trained to respect property as well as

to make safe use of the natural facilities with which Cumberland is so richly endowed.

This balanced outlook is being achieved by education through schools, co-operation with those voluntary organisations who are responsible for the development of outdoor pursuits and by the involvement of specialist enthusiasts and coaches in training schemes. The correlation between environmental education and physical recreation is being followed at the centres in Keswick, Eskdale and Matterdale, where pupils learn to value the freedom which the countryside offers and the lessons which it promotes.

Joint planning and dual use of facilities for educational and community use is now accepted as the only logical solution to a pressing social problem in a country where land is at a premium and development is so expensive. Cumberland has pioneered this policy in which experience has shown that the land allocated to schools for organised games will only meet the needs of the normal activities associated with the school curriculum.

The jointly planned swimming baths at Moorclose, Workington and Irthing Valley, Brampton, are under construction. The new swimming bath at Overend School has recently been opened and has already engendered much interest in water recreation at this school and Whitehaven Grammar School where an educational experiment in shared facilities (gymnasium, sports hall, swimming bath and playing fields) and shared staff is proving both economical and encouraging for the staffs and pupils of the two schools.

Under the Committee's policy for swimming, where numbers, finance and the geographical situation of the school justify, primary schools should be provided with heated outdoor plastic teaching pools of dimensions 48ft. x 24ft. x 3ft., or slightly less. Not only does such a pool offer on the school site facilities for the basic teaching of swimming, the principal purpose of this type of pool in a primary school, but it can also be an additional teaching aid and can broaden the approach to such activities as mathematics, science and hygiene.

The financial policy of the Education Committee is to encourage the capital provision of plastic pools in primary schools from voluntary funds and to assist by meeting the cost of site preparation, main services, adaptation of buildings

for changing and wind break screening. The regular maintenance of the pool is also accepted by the Authority through the school managers who are also responsible for its management. While accepting these principles and that children should be taught to swim as soon as practicable the Committee are handicapped financially in aiming for the ideal.

This has been the second season for the new Amateur Swimming Association and the English Schools' Swimming Association distance certificates and their popularity is reflected in the increased number which have been awarded during the year.

Cumberland Schools' Sports Associations have continued to be very active in 1968—in cricket, football, gymnastics, netball, rugby union, table tennis and swimming.

The Cumberland Schools' Swimming Association held its annual championships at Whitehaven in June and the team to represent the county at the Divisional gala at Wigan in September was chosen from the results of the local gala.

As a result of the gala at Wigan, Elise Irwin and Catherine Henderson were chosen to swim at the National gala at the Crystal Palace in October. They gained 2nd and 6th places respectively in their heats, both reaching the finals in the Under-14 age group. This was the first year that competitors in this age group had swum in the Divisional and National galas.

Special mentioned must be made of the great achievement of Wendy Burrell, a member of the Olympic team in Mexico, and the fastest European over the 200 metres backstroke distance.

The influence upon the developing character of the child, the social training which accrues through physical recreation, the sense of achievement and positive attitudes towards participation in post-school recreation and the development of initiative, moral and social attitudes and responsible behaviour are not to be measured by the results of county games, but accumulate through his daily experiences in contact with his fellows, on the games field, in the gymnasium, the swimming bath or the sports hall, on the mountain and the lake. Above all, the teachers who train and encourage boys and girls in physical recreation throughout their school life up to and including county level, have a large influence

on those qualities and attitudes so important in post-school life. It is pleasing to note that the Education Committee have recognised the value of this voluntary work in the past through annual grants to associations and that they have now agreed to extend their help by meeting the travelling expenses of teachers when concerned with the activities of the county associations.

Cumberland teachers are greatly encouraged by this recognition and have asked that their appreciation be recorded.

APPENDIX 'A'

Table A—Periodic Medical Inspections

Age Groups inspected (By year of birth) (1)	No. of Pupils who have received a full medical examination. (2)	PHYSICAL CONDITION OF PUPILS INSPECTED Satisfactory No. (3)	Unsatisfactory No. (4)	Pupils found to require treatment (excluding dental diseases and infestation with vermin) No. of Pupils found not to warrant a medical examination (See Note 1 above) (5)	For defective vision (excluding squint) (6)	For any other condition recorded at Part II (7)	Total individual pupils (8)
1964 and later	64	64	-	—	—	2	2
1963	1934	1934	-	—	74	93	166
1962	1355	1355	—	—	56	106	161
1961	210	210	—	—	8	17	25
1960	1252	1252	—	1775	83	172	251
1959	118	118	—	257	7	6	12
1958	21	21	—	—	1	1	2
1957	12	12	—	—	2	1	3
1956	829	829	—	1464	53	63	116
1955	81	81	—	208	5	1	6
1954	2316	2316	—	—	75	56	131
1953 and earlier	769	769	—	—	34	17	51
TOTAL	8961	8961	—	3704	398	535	926

Table B—Other Inspections

Number of Special Inspections	137
Number of Re-inspections	5753
Total	5890

Table C—Infestation with Vermin

(a)	Total number of individual examinations of pupils in schools by school nurses or other authorised persons	73770
(b)	Total number of individual pupils found to be infested	802
(c)	Number of individual pupils in respect of whom cleansing notices were issued (Section 54(2), Education Act, 1944)	4
(d)	Number of individual pupils in respect of whom cleansing orders were issued (Section 54(3), Education Act, 1944)	—

Table D—Screening Tests of Vision and Hearing

1.	(a) Is the vision of entrants tested as a routine within their first year at school?	Yes.
	(b) If not, at what age is the first routine test carried out?	—
2.	At what age(s) is vision testing repeated during a child's school life?	At ages 8, 12 and 15.
3.	(a) Is colour vision testing undertaken?	Yes.
	(b) If so, at what age?	15) When choice of occupation or career.
	(c) Are both boys and girls tested?	Yes) indicates testing advisable.
4.	(a) By whom is vision testing carried out? ...	School medical officers and school nurses.
	(b) By whom is colour vision testing carried out?	School medical officers and school nurses.
5.	(a) Is routine audiometric testing of entrants carried out within their first year at school? ...	Yes.
	(b) If not, at what age is the first routine audiometric test carried out?	—
	(c) By whom is audiometric testing carried out?	Screening Assistants.

Part II—Defects found by Periodic and Special Medical Inspections during the Year

Defect Code No.	Defects or Disease.	PERIODIC INSPECTIONS Entrants (T)	Entrants (O)	Leavers (T)	Leavers (O)	Others (T)	Others (O)	Total (T)	Total (O)	Special Inspection (T)	Special Inspection (O)
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
4	Skin	8	99	11	98	15	131	34	328	10	2
5	Eyes—a. Vision ...	130	433	82	360	194	787	406	1580	16	2
	b. Squint ...	18	43	3	10	10	32	31	85	2	—
	c. Other ...	2	22	1	4	2	18	5	44	—	—
6	Ears—a. Hearing ...	31	260	9	44	40	189	80	493	—	2
	b. Otitis Media	8	75	3	10	9	49	20	134	—	—
	c. Other ...	3	52	—	7	4	43	7	102	—	—
7	Nose and Throat ...	28	428	7	119	35	294	70	841	1	—
8	Speech	36	104	5	23	29	52	70	79	10	—
9	Lymphatic Glands	—	67	1	13	—	26	1	106	—	—
10	Heart	2	76	2	20	2	47	6	143	—	—
11	Lungs	10	177	2	52	5	151	17	380	1	—
12	Developmental—										
	a. Hernia ...	2	23	—	—	1	6	3	29	—	—
	b. Other ...	4	148	—	22	25	88	29	258	—	—
13	Orthopaedic—										
	a. Posture ...	—	8	2	22	2	16	4	46	—	—
	b. Feet	26	96	2	30	28	63	56	189	1	—
	c. Other ...	16	113	9	36	14	90	39	239	1	2
14	Nervous System—										
	a. Epilepsy ...	—	17	—	9	1	15	1	41	—	—
	b. Other ...	1	96	—	6	1	22	2	124	—	1
15	Psychological—										
	a. Development	1	44	—	26	7	82	8	152	—	—
	b. Stability ...	10	235	—	44	31	173	41	452	—	—
16	Abdomen	6	35	—	10	4	44	10	89	—	—
17	Other	—	84	6	72	13	161	19	317	12	—

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	—
Errors of refraction (including squint) ...	3199
Total	3199
Number of pupils for whom spectacles were prescribed	1535

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	5
(b) for adenoids and chronic tonsillitis	38
(c) for other nose and throat conditions	5
Received others forms of treatment ...	5
Total	53
Total number of pupils in schools who are known to have been provided with hearing aids:—	
(a) in 1968	5
(b) in previous years	75

Table C—Orthopaedic and Postural Defects.

	Number of cases known to have been dealt with
(a) Pupils treated at clinics or out-patients departments	416
(b) Pupils treated at school for postural defects	—
Total	416

Table D—Diseases of the Skin.

(excluding uncleanliness, for which see Table C of Part I)

	Number of cases known to have been dealt with
Ringworm—(a) Scalp	—
(b) Body	—
Scabies	8
Impetigo	1
Other skin diseases	36
Total	45

Table E—Child Guidance Treatment.

	Number of cases known to have been dealt with
Pupils treated at Child Guidance Clinics	206

Table F—Speech Therapy.

	Number of cases known to have been dealt with
Pupils treated by speech therapists ...	206

Table G—Other Treatment Given.

	Number of cases known to have been dealt with
(a) Pupils with minor ailments ...	12
(b) Pupils who received convalescent treatment under School Health Service arrangements	23
(c) Pupils who received B.C.G. vaccination	2129
(d) Other than (a), (b), and (c) above	—
Total (a)—(d)	2164

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

1. *Attendances and Treatment.*

	Ages 5 to 9	Ages 10 to 14	Ages 15 and over	Total
First Visit	4,935	4,731	1,127	10,793
Subsequent Visits ...	3,961	6,647	1,935	12,543
Total Visits	8,896	11,378	3,062	23,336

Additional courses of treatment commenced	80	165	96	341
Fillings in permanent teeth	2,469	8,947	3,237	14,653
Fillings in deciduous teeth	2,654	265	—	2,919
Permanent teeth fiilled	2,118	7,659	2,563	12,340
Deciduous teeth filled	2,522	264	—	2,786
Permanent teeth extracted	754	2,065	614	3,433
Deciduous teeth extracted	5,475	1,528	—	7,003
General anaesthetics	1,604	611	72	2,287
Emergencies	437	273	101	811

Number of Pupils X-rayed	208
Prophylaxis	389
Teeth otherwise conserved	627
Number of teeth root filled	21
Inlays	16
Crowns	10
Courses of treatment completed	7,060

2. *Orthodontics.*

Cases remaining from previous year	213
New cases commenced during year	163
Cases completed during year	89
Cases discontinued during year	7
No. of removable appliances fitted	258
No. of fixed appliances fitted	—
Pupils referred to Hospital Consultant	136

3. *Prostnetics.*

	5 to 9	10 to 14	15 and over	Total
Pupils supplied with F.U. or F.L. (first time)	—	2	1	3
Pupils supplied with other dentures (first time)	6	52	35	93
Number of dentures supplied	7	37	36	80

4. *Anaesthetics.*

General Anaesthetics administered by Dental Officers	1,468

5. *Inspections.*

(a) First inspection at school.	Number of Pupils	26,311
(b) First inspection at clinic.	Number of Pupils	2,251
Number of (a) + (b) found to require treatment		15,588
Number of (a) + (b) offered treatment		10,304
(c) Pupils re-inspected at school or clinic		516
Number of (c) found to require treatment		268

6. *Sessions.*

Sessions devoted to treatment	2,807
Sessions devoted to inspection	193
Sessions devoted to Dental Health Education	27

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, 1968:—		(1) Blind (2) Partially sighted		(3) Deaf (4) Partial hearing		(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 children were newly assessed as needing special educational treatment at special schools or in boarding homes?	boys	—	1	—	1	3	—	—	27	—	1	33
	girls	—	—	—	—	1	—	—	12	—	—	13
B. How many children were newly placed in special schools (other than hospital special schools) or boarding homes?												
(i) of those included at A above	boys	—	—	—	1	—	—	—	6	—	—	7
	girls	—	—	—	—	—	—	—	4	—	—	4
(ii) of those assessed prior to January, 1968	boys	—	—	—	1	2	—	—	5	—	—	8
	girls	—	1	—	1	—	—	—	4	—	—	6
(iii) TOTAL newly placed— B(i) and (ii)	boys	—	—	—	2	2	—	—	11	—	—	15
	girls	—	1	—	1	—	—	—	8	—	—	10

PART II

Children found unsuitable for education at school

During the calendar year ended 31st December, 1968:—

(i) how many children were the subject of new decisions recorded under Section 57 of the Education Act 1944? 16

(ii) how many reviews were carried out under the provisions of Section 57A of the Education Act, 1944? 4

(iii) how many decisions were cancelled under Section 57A (2) of the Education Act, 1944? 1

Handicapped Pupils awaiting places in Special Schools or receiving Education in Special Schools: Independent Schools; in Special Classes and Units; under Section 56 of the Education Act, 1944; and Boarded in Homes.

As at 23rd January, 1969:—		(1) Blind (2) Partially sighted		(3) Deaf (4) Partial hearing		(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 children from the Authority's area were awaiting places in special schools other than hospital special schools?		—	—	—	—	—	—	—	—	—	—	—
(1) Under 5 years of age												
(i) waiting before 1st January, 1968:—												
(a) day places		—	—	—	—	—	—	—	—	—	—	—
(b) boarding places		—	—	—	—	—	—	—	—	—	—	—
(ii) newly assessed since 1st January, 1968:—												
(a) day places		—	—	—	—	—	—	—	—	—	—	—
(b) boarding places		—	—	—	—	—	—	—	—	—	—	—
(2) Aged 5 years and over												
(i) waiting before 1st January, 1968:—												
(a) whose parents had refused consent to their admission to a special school												
(a) day places	Boys	—	—	—	—	—	—	—	3	—	—	3
	Girls	—	—	—	—	—	—	—	5	—	—	5
(b) boarding places	Boys	—	1	—	—	—	1	—	22	1	—	25
	Girls	—	—	—	—	—	—	—	20	—	—	20

(b) others												
(a) day places	boys	—	—	—	—	—	—	—	8	—	—	8
	girls	—	—	—	—	—	—	—	5	—	—	5
(b) boarding places	boys	—	—	—	—	—	—	—	12	—	—	12
	girls	—	—	—	—	—	—	—	5	—	—	5
(ii) newly assessed since 1st January, 1968:—												
(a) whose parents had refused consent to their admission to a special school		—	—	—	—	—	—	—	—	—	—	—
(a) day places	boys	—	—	—	—	—	—	—	3	—	—	3
(b) boarding places	girls	—	—	—	—	—	—	—	1	—	—	1
(b) others												
(a) day places	boys	—	—	—	—	2	—	—	1	—	—	3
	girls	—	—	—	—	—	—	—	1	—	—	1
(b) boarding places	boys	—	1	—	—	1	—	—	17	—	1	20
	girls	—	—	—	—	1	—	—	6	—	—	7
(3) Total number of children awaiting admission to special schools other than hospital special schools—total of (1) and (2) above												
(a) day places	boys	—	—	—	—	2	—	—	12	—	—	14
	girls	—	—	—	—	—	—	—	11	—	—	11
(b) boarding places	boys	—	2	—	—	1	1	—	54	1	1	60
	girls	—	—	—	—	1	—	—	32	—	—	33

B. How many pupils from the Authority's area were on the registers of:—

(i) Maintained special schools (other than hospital special schools and special units and classes not forming part of a special school) regardless by what authority they are maintained.												
day	boys	—	—	—	—	1	—	—	1	—	—	2
	girls	—	—	—	—	—	—	—	—	—	—	—
boarding	boys	—	—	—	1	—	1	—	49	—	—	51
	girls	—	—	—	—	1	—	—	33	—	—	34
(ii) Non-maintained special schools (other than hospital special schools and special units and classes not forming part of a special school) wherever situated.												
day	boys	—	—	—	—	—	—	—	—	—	—	—
	girls	—	—	—	—	—	—	—	—	—	—	—
boarding	boys	4	—	5	3	1	—	—	—	1	—	14
	girls	2	4	6	4	3	—	—	—	—	—	19
(iii) Independent schools under arrangements made by the authority.												
day	boys	—	—	—	—	2	—	—	—	—	—	2
	girls	—	—	—	—	—	—	—	—	—	—	—
boarding	boys	—	—	—	—	3	—	—	—	—	—	3
	girls	—	—	—	—	2	—	—	—	—	—	2
(iv) Special classes and units not forming part of a special school.												
	boys	—	—	—	—	—	—	—	7	—	—	7
	girls	—	—	—	—	—	—	—	—	—	—	—

C. How many children from the Authority's area were boarded in homes and not already included in B above.	boys	—	—	—	—	—	—	1	—	—	—	1
	girls	—	—	—	—	—	—	—	—	—	—	—
D. How many handicapped pupils (irrespective of the area 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	boys	—	—	—	—	—	—	—	—	—	—	—
	girls	—	—	—	—	—	—	—	—	—	—	—
(ii) in other groups, e.g. units for spastics, etc.	boys	—	—	—	—	—	—	—	—	—	—	—
	girls	—	—	—	—	—	—	—	—	—	—	—
(iii) at home	boys	—	—	—	—	—	—	—	—	—	—	—
	girls	—	—	—	—	—	—	—	1	—	—	1
E. Total number of handicapped children requiring places in special schools; receiving education in special schools; independent schools; special classes and units; under Section 56 of the Education Act 1944; and boarded in Homes.	boys	4	2	5	4	10	2	1	123	2	1	154
	girls	2	4	6	4	7	—	—	77	—	—	100

APPENDIX C

SCHOOL HEALTH SERVICE CLINIC AS AT 31.12.68

(Actual school clinic work as distinct from special clinics is being carried out either in conjunction with child welfare clinic sessions or as specially required).

ALSTON:
Dental—2nd and 4th Tuesday—all day.

ASPATRIA:
Dental—1st, 3rd and 5th Friday—all day.
Speech Therapy—Each Friday a.m.

BRAMPTON:
Dental—Each Wednesday—all day.
Speech Therapy—Alternate Tuesday and Thursday p.m.

CARLISLE:
Dental—Each Monday and Friday—all day.
At Eden School—as necessary.
At Caldew School—2nd and 4th Friday—all day.
Eye Specialist—Each Wednesday and Thursday a.m.
Orthoptic—Each Wednesday and Thursday a.m.; and each Friday p.m.
Child Guidance—Each Monday p.m.
Speech Therapy—Each Tuesday a.m.; each Thursday a.m.
Orthopaedic Aftercare—Each Wednesday as required.

CLEATOR MOOR:
Dental—Each Monday—all day.

COCKERMOUTH:
Dental—Each Tuesday, Wednesday and Friday—all day.
Speech Therapy—Each Thursday all day.
Hospital Eye Clinic—2nd Friday a.m.

EGREMONT:
Dental—Each Monday and Friday—all day.

KESWICK:
Dental—Thursday—all day.
Speech Therapy—2nd, 3rd and 4th Wednesday p.m.
Hospital Eye Clinic—1st Wednesday p.m.

LONGTOWN:
Dental—Each Monday—all day.

MARYPORT:
Dental—Each Wednesday and Thursday—all day.
Speech Therapy—Thursday p.m.
Child Guidance—Alternate Monday p.m.

MILLOM:
Dental—Each Tuesday and Wednesday—all day.
Child Guidance—Thursday p.m. as required.
Eye Specialist—1st and 3rd and 4th Friday a.m.

PENRITH:
Dental—1st, 3rd and 5th Tuesday, Wednesday, Thursday and Friday—all day.
Speech Therapy—Each Tuesday—all day; each Wednesday a.m.
Orthoptic—Each Wednesday a.m.
Orthopaedic—Each Friday a.m.

SEASCALE:
Dental—1st, 3rd and 5th Thursdays—all day.

SALTERBECK:
Dental—Each Tuesday and Thursday—all day.

SILLOTH:
Dental—Each Thursday—all day.

WHITEHAVEN (FLATT WALKS):
Dental—Each Monday, Thursday and Friday—all day.
Whitehaven Grammar School—Each Wednesday—all day.
School—Daily a.m. with medical officer attending each Wednesday morning.
Child Guidance—Each Wednesday p.m.; attended by Dr. Ferguson—Each Friday a.m. attended by Hospital consultant.

WHITEHAVEN (MIREHOUSE):
Dental—Tuesday, 1st, 3rd and 5th—all day.

WIGTON:
Dental—Each Monday and Tuesday—all day.
Speech Therapy—Each Friday a.m.

WORKINGTON (PARK LANE):
Dental—Each Tuesday, Wednesday, Thursday and Friday—all day.
School—Thursday a.m. (1st Monthly).
Speech Therapy—Each Monday and Tuesday—all day.
Child Guidance—Each Wednesday a.m.

WORKINGTON INFIRMARY:
Orthoptic—Monday, Tuesday and Wednesday p.m.; Thursday a.m.

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