[Report 1972] / School Medical Officer of Health, Cumberland County Council.

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CUMBERLAND COUNTY COUNCIL
EDUCATION COMMITTEE

The School Health Service 1972

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INDEX

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 1972.

The changes which these reports have, in past years, brought to your notice are now about to take place, and great care is being taken both nationally and locally to ensure that the School Health Service, itself a part of the child health service, will improve in the re-organised National Health Service. I have no doubts about this, but I also have no doubts about the necessity for even more particular attention being paid to ensuring easy communication both ways between the new Cumbria County Council and its matching Area Health Authority. This communication, both at administrative level and individual case level, is a responsibility of the specialist in Community Medicine, and the district community physician. I myself recognise difficulties only as opportunities when they are overcome, and am confident that the future of the school health service will more closely meet contemporary needs of school children.

The future links will include statutory committees of collaboration between the two authorities, and thus the change is going to be one associated with continuity, and where progress is to be equated with tradition.

The following pages indicate the prime importance of team work in all aspects of health care. The team including child, parents, teachers, doctors, dentists, nurses and members of professions supplementary to medicine, has been successful in its work in the past. In the future it is expected that, based increasingly on Assessments Units in District General Hospitals, it will continue as the basic unit of individual case diagnosis, treatment, and also for prevention.

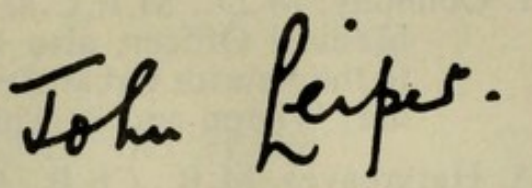
The success of the scheme to bring forward infants and young children for immunisation, by means of a computerised call up system at the appropriate time to the appropriate family doctor group practice premises, is now fully established and has meant the virtual exclusion of serious effects of communicable disease in the county.

The school doctor and nurse are emerging as specialists in Health Education matters but a great deal remains to be done in this regard — notably the evolvement of some system of whole life counselling which will bring home to children the contemporary health hazards, including that of cigarette smoking.

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 excellent work during a year with so much change in the air.

I am, Mr. Chairman, Ladies and Gentlemen,

Your obedient servant,



SCHOOL HEALTH STAFF
AS AT 31st DECEMBER, 1972

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., F.F.C.M., D.P.H., Q.H.P.

Deputy Principal School Medical Officer—

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

Area and District Medical Officers—

* J. Connolly, M.D., M.F.C.M., D.P.H., Northern Area Medical Officer; also Medical Officer of Health to the Penrith Urban District Council and the Border, Wigton and Penrith Rural District Councils.

* A. Hargreaves, M.B., Ch.B., M.F.C.M., D.P.H., Western Area Medical Officer; also Medical Officer of Health to Workington Borough and Port, Cockermouth Rural District, and Cockermouth, Keswick and Maryport Urban District Councils.

J. R. Hassan, M.B., Ch.B., D. Obst. R.C.O.G., Medical Officer of Health, Alston with Garrigill Rural District Council and General Practitioner.

* H. M. Marks, B.A., M.B., B.Ch., M.F.C.M., D.P.H., Southern Area Medical Officer; also Medical Officer of Health to Whitehaven Borough and to the Ennerdale and Millom Rural District Councils.

Medical Officers in Senior Posts —

* J. E. Ainsworth, M.B., Ch.B.
* J. E. M. Garland, M.B., Ch.B., D.P.H.
* M. P. McMillan, M.B., Ch.B.

* Approved for the ascertainment of educationally sub-normal children.

Medical Officer in Department—
K. R. Walker, M.B., Ch.B.

Principal School Dental Officer —
R. B. Neal, M.B.E., T.D., L.D.S., R.C.S.

Area School Dental Officer —
I. C. R. Crabb, L.D.S., R.F.P.S.

School Dental Officers—
K. M. Burnett, L.D.S.
J. Colvin, L.D.S.
Miss A. Corkhill, B.D.S.
A. B. Gibson, B.D.S.
A. M. Peck, L.D.S.
A.M. Scott, L.D.S.

Dental Auxiliary —
Miss F. M. Brydon.

MEDICAL AUXILIARY STAFF

Screening Assistants—
Miss M. Bell.
Miss L. Graham.
Miss D. Kidd.

Orthopaedic Physiotherapists—
Mrs C. M. Blair, S.R.Ph.
Mrs P. P. Bratt, M.C.S.P.
Mrs V. K. Freebairn, M.C.S.P.
Miss M. Sivewright, M.C.S.P.

Orthoptists —
Mrs J. A. M. Payne, D.B.O.
Mrs J. Scott, D.B.O.
Mrs J. E. Wilson, D.B.O.

Senior Speech Therapist —
Mrs E. M. Blacklock, L.C.S.T.

Speech Therapists—
Miss A. Bainbridge, L.C.S.T.
Miss E. B. Moon, L.C.S.T.
Miss A. M. Ross, L.C.S.T.

NURSING STAFF

Director of Nursing Services —
Mrs P. M. Botting, S.R.N., S.C.M., H.V. Cert., N. Admin. Cert. (P.H.).

Area Nursing Officers—
Miss J. M. Bailey, S.R.N., S.C.M., Q.N., H.V. Cert., N.D.N. Cert. (Northern Area).

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

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

Nursing Officers —
Miss C. M. Bannan, S.R.N., S.C.M., H.V. Cert. (Western Area).
Miss B. W. Knibbs, S.R.N., S.C.M., Q.N., H.V. Cert. (Northern Area).
Miss R. Sheppard, S.R.N., S.C.M., Q.N., H.V. Cert. (Southern Area).

Nurses' Qualification 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.
8. State Enrolled Nurse.
9. Bachelor of Nursing.

School Nurses—

Full Time

Miss B. M. Wesson, 1, 2, 3.	Northern Area

Part Time

Mrs J. E. Brown, 1, 3.	Cockermouth
Mrs K. Crook, 1.	Workington
Mrs M. E. Frain, 1.	Maryport
Mrs M. E. Sansom, 1, 2, 5	Workington
Mrs I. Warbrick, 1, 2	Whitehaven
Mrs A. Corkhill, 6	Ennerdale
Mrs M. M. Nelson, 1	Whitehaven
Mrs V. Burrows, 1	Ennerdale/Seascale
Mrs T. Rich, 1	Millom

Health Visitors/Health Visitor Assistants/School Nurses —

Northern Area

Full Time

Miss M. Butler,1,2,4	Longtown
Miss C. A. Gardiner, 1, 2, 3, 4	Penrith
Mrs M. Hedworth, 1, 2, 3	Wigton
Mrs D. M. Lancaster, 1, 2, 3, 4	Kirkbride
Mrs D. Lazenby, 1, 2, 3 4	Brampton
Miss E. A. Lockhart, 1, 2, 3, 4	Carlisle and Border
Miss K. M. Rigby, 1, 2, 4	Penrith
Miss P. B. Simpson, 1, 2, 3, 4	Dalston
Miss M. A. Tarr, 1, 2, 4	Penrith
Miss R. T. O'Farrell, 1, 2, 3, 4	Silloth
Mrs M. Whitson, 1, 2, 4	Brampton
Mrs D. Willan, 1, 2, 4	Penrith

Part Time

Mrs A. M. Douglas (relief) 1,2,4	
Mrs D. Edmondson, 1,2,4	Hesket
Mrs E. Eelbeck 1, 3	Aspatria
Mrs A. Gallacher, 1, 2 4	Alston
Mrs F. A. Gaskin 1, 2	Brampton
Miss E. Henderson 1, 2, 3, 4	Caldbeck
Mrs M. McCredie, 1,2,4	Lazonby
Mrs M. Sanderson 1, 2, 3, 4	Alston
Mrs M. Thorneley 1, 2, 4	Penrith

Western Area

Full Time

Mrs A. E. Campbell, 1, 2, 4	Keswick
Miss M. Casey, 1, 2, 3, 4	Keswick
Mrs J. V. Clark, 1, 2, 3, 4	Workington
Mrs A. R. Conway, 1, 2, 4	Maryport
Miss G. Davies, 1, 2, 3, 4	Workington
Miss A. Dixon, 1, 2, 3, 4	Cockermouth
Mrs J. A. Graham, 1, 2, 3, 4	Workington
Miss S. Hart, 1, 2, 4	Maryport
Mrs M. Hewitson, 1, 2, 4	Workington
Mr T. D. M. Holmes, 1, 3, 4	Workington
Miss A. Jackson, 1, 2, 4	Workington
Mrs M. Lythgoe, 1, 2, 4	Cockermouth
Mrs L. Messenger, 1, 2, 3, 4	Maryport
Miss M. P. Reynolds, 1, 2, 4	Cockermouth
Miss E. J. Surtees, 1, 2, 4	Workington
Miss L. Tracey, 1, 3, 4, 9	Workington

Part Time

Mrs A. M. Wandless, 1, 2, 4	Workington

Southern Area

Full Time

Mrs M. Ainsworth, 1, 2, 4	Whitehaven
Mrs I. M. Alcock, 1, 2, 4	Whitehaven
Mrs W. Batey, 1, 4	Whitehaven
Mrs E. Bowe, 1, 2, 3, 4	Millom
Mrs A. Donald, 1, 2, 3, 4, 6	Ennerdale
Mrs P. Fitzgerald, 1, 2, 4	Ennerdale
Miss M. E. Gibson, 1, 2, 4	Ennerdale
Miss J. Lancaster, 1, 2, 4	Whitehaven
Miss A. Parkinson, 1, 2, 4	Ennerdale
Miss M. Robinson, 1, 2, 4	Millom
Miss A. Singleton, 1, 2, 4	Whitehaven

Part Time

Mrs S. Miller, 1, 2, 4	Ennerdale

Dental Surgery Assistants —

Miss M. I. Stout, Senior Surgery Assistant

Mrs E. M. Byers	Mrs E. Hocking
Mrs V. A. Clark	Mrs M. Huddart
Mrs J. Goodwin	Miss M. Kennedy
Mrs M. Griffiths	Mrs J. Smith

GENERAL STATISTICS

The number of pupils on school registers on 25th January, 1973, was 41,997, compared with 41,377 in the previous year, an increase of 620.

In January, 1973 there were in the County:—

	Number	Pupils
Nursery Schools	3	90 plus 60 P.T.
Primary	206	24,619
Non-selective Secondary Schools	1	389
Grammar Schools	1	413
Comprehensive Schools	30	16,218
Special Schools	5	268
(One residential for E.S.N. Boys 9 - 16)		(70)
(One residential for E.S.N. Girls 9 - 16)		(36)

THE SCHOOL HEALTH SERVICE

In my report last year I commented on the fact that no decision had yet been forthcoming from the Government on the administrative future of the School Health Service, i.e. whether it should remain with local education authorities after the 1974 re-organisation, or become a responsibility of Area Health Authorities with appropriate professional and administrative links with the education authority. There had, however, been established a "Working Party on Collaboration" to prepare proposals for the necessary collaboration machinery between local authorities and health authorities for the future and a sub-committee of this working party was commissioned to examine and make proposals on the future school health service. In August, 1972, this sub-committee produced its first report and early in 1973 a further report has been made. The general upshot of the reports was that the School Health Service should become the responsibility of Area Health Authorities, and this main conclusion has been accepted by the Government.

The reports contained, however, a close analysis of the pros and cons of the whole matter and revealed not a little anxiety on the part of the Local Authority Associations about the satisfaction of the educational, as distinct from the medical, needs of the service. Out of this emerged a proposal, also accepted by the Government, that the whole field of child health services is ripe for a comprehensive review at national level and this is promised as soon as it can be put in hand. Again, the requirement of a Statutory Joint Consultative Committee was recognised between members of local education authorities and area health authorities to serve as a forum for planning and consultation. This is in line with a similar recommendation of the Collaboration Working Party in respect of Social Services and Environmental Health Services. It is very significant, however, that three members of the School Health Service Sub-Committee found it necessary to enter a note of dissent to the sub-committee's concluding section of their report, to the effect that they wished to see statutory "default" powers retained by local education authorities to provide a School Health Service directly, in the event of their concluding that the responsible area health authority was not according adequate priority to the School Health Service, or that adequate co-operation was not being achieved between the area health authority and the local education authority on the School Health Service. That such a minority recommendation should have been made is at least an indication that very careful collaboration arrangements will be necessary

in future to maintain a good school health service and good relationships between the two authorities and the professional staffs involved. I personally do not feel unduly apprehensive about this. It is, in my opinion, fortunate that the integration of the School Health Service and all other child health services has progressed so far already for this, I believe, has demonstrated the great advantage to the child of his health services being viewed and conducted as a planned unity, into which the services hitherto the responsibility of local education authorities have fitted, and will continue to fit, naturally as an essential element. While any separate establishment of a health service in schools would be a retrograde step, at the same time careful regard must be given to the genuine anxieties of workers in the educational field who have built up such good relationships over many years with fellow local authority professional colleagues in medicine, nursing and the other professions involved.

Some of the accounts given below by area medical officers and other medical officers in the department, of the development of services for the pre-school, and the school entrant, child re-emphasise the unity of purpose of these services for the continuing health care of children through into adult life. This theme has tended to dominate the child health scene in recent years, and my reports upon it to the Health and Education Committees.

Associated with the time scale of the Parliamentary legislative programme for re-organisation of local government and the national health service, informal forward planning groups have been at work in preparation for 1974 on both these fronts, although those in the local authority sphere have had a considerable 'start' on the health service machinery. Although the latter had not yet been formally proposed by the Government, my colleagues the Medical Officers of Health of the constituent authorities of future Cumbria got together early in 1972 and set up working groups of professional staffs to draw together facts and ideas on those parts of the future integrated health service, which are at present the responsibility of local authorities. One of these groups spent some time on the school health service and their conclusions will contribute to the wider-based discussions now going on in Joint Liaison Committees which bring together all three existing branches of the national health service at officer level, in anticipation of the appointment in 1973 of the shadow area health authorities.

An important practical issue in the future day-by-day collaboration between health authorities and local authorities, both in the education sphere and in the others, is the geographical definition of the administrative sub-divisions of the county of Cumbria from local authority and health service points of view. The decision having been taken nationally on district local authority boundaries, shadow local authorities will early wish to determine the administrative sub-divisions of the county, recommendations on which have already been made by the Cumbria Joint Committee. Since the determination of health districts will be mainly based on the catchment areas of district general hospitals there is almost certain to be something short of 'co-terminosity' of the 'ground-level' administrative areas for local authority functions, including education, and for health services. At this level, then, the risks of less well defined inter-professional working relationships will have to be faced and overcome at inter-personal level. I am sure this can be safely achieved but only with the requisite effort.

As indicated above, I believe the child health service developments of recent years have been in the right direction for the major administrative changes which are almost upon us. A full account was given in the report last year on the establishment on an area basis of regular Panel meetings involving health, education and social services departments to consider and co-ordinate the care of pre-school children who showed signs of suffering major handicaps, mainly in the area of mental development. These have continued successfully and it is already apparent that they will probably in future provide an equally suitable forum for discussion of severely physically handicapped children. It is very interesting and encouraging to see from the reports below of the medical officers working in developmental testing of young children, how this latter work is tying in with the Panel discussions of individual children and in due course with the continuing medical, psychological and educational care of handicapped children in school. The growth of pre-school developmental testing of children is a notable feature of child health services generally on the current scene and fully satisfactory methods of evaluating it are not yet available. While this is so and the future will no doubt hold a more sophisticated approach to this aspect of the work, I think there is wide consent that the elucidation of both frank and more minor handicaps before school entry can only be to a child's benefit even if the medical or educational means are not at hand to correct or ameliorate the problem.

The classical example of the young child with minimal brain damage who presents as a 'clumsy' child is much more likely to receive the required consideration and special help if it is appreciated by teachers and all concerned that his difficulty is of physical developmental origin. Only in time will techniques of special help and possibly equipment for such children be developed. The elucidation of the character of the problem must come first.

It was necessary to review the medical staff establishment in the light of all of this developing work and provision has been made for a further full time medical officer or part-time equivalent in the financial year 1973/74. This by no means satisfies the wishes of the area medical officers who organise this work but will help forward the service to some extent. Similarly, additional screening assistant time has been provided for to the extent of one full-time assistant.

I now give below the report from the western area on the growth of some of the activities mentioned above. This is provided by Dr Marshall, Medical Officer in Department, who writes:—

"The developmental testing of pre-school children in Workington is now settling down and beginning to work smoothly. The Medical Officer sees all At Risk and Handicapped children at suitable intervals and all the children at 6 months and 3 years of age; the Health Visitors complementing this work at key ages and referring the children into the clinics where necessary. The mothers are becoming increasingly aware of the service and its advantages and many are beginning to regard it as a step forward in community medicine.

The attendance rate is around 60%, the younger the children the higher the numbers attending. The defaulters are visited by the Health Visitors to encourage clinic attendance, but, in the event of a second failed appointment, the General Practitioner is informed. In this way most children are covered.

During 1972 a comprehensive filing system started at the Area Health Office, combining Health Visitor Records, Medical Officers' Developmental Clinic Notes, and any Specialist Reports including the Paediatrician Reports as the baby leaves the Maternity Department. These files are sent to the various clinics as the children are seen, and the Medical Officers' remarks made available to the Health Visitors before being filed on return.

Throughout the year liaison has been very good between the various sections of people concerned with the health and welfare of the children. There have been held throughout the Area during the year a number of multi-disciplinary panel meetings concerned with pre-school handicapped and potentially handicapped children, which as well as revealing facts of the environment, health and circumstances of the children discussed, thus enabling really constructive efforts to solve their problems, have ironed out a number of apparent difficulties between the services concerned. They proved immensely helpful in getting a full picture of the children concerned and helping them in the best possible way. This included passing on observations of the pre-school child to those who would be involved in education and to the Educational Psychologist. It became apparent that many of these discussed had delay in language development, and in particular the more retarded children. These the Educational Psychologist hoped to investigate before or soon after school entry. Once again, one could not help feeling how valuable a diagnostic nursery class would prove in helping to assess the difficulties of these children and to provide stimulation often lacking in their homes. Attached to a developmental assessment centre, such a class would be a great help.

It was agreed to refer any deafness found in pre-school children to the Medical Officer in Department specially trained in audiology, who would pass them on to the hospital E.N.T. Department where necessary, informing the General Practitioner of the action taken. Eye defects would be directly referred from the developmental clinic to the hospital, as before. Any delay in language development would be referred to the Speech Therapist by General Practitioner, Medical Officer or Health Visitor. The General Practitioners preferred any behavioural difficulty to be referred to them prior to any consultation at the Child Guidance Clinic. They also felt it would be more useful to inform them directly of any developmental abnormality picked up on routine examination, avoiding using the parent as an intermediary.

Although the number of 3 year olds attending the developmental clinics is only 60%, we feel that the school entry medical examination will eventually be foreshortened and facilitated as a result; only 40% requiring a full medical examination at that stage. Already, the observations made at the more leisurely 3 year old examination are proving most helpful to the School Medical Officer. Any minimal

physical or psychological defect which may give an educational disadvantage have been located and allowances can be made at school entry."

In the southern area 1972 has seen the commencement of a real effort to establish the beginnings of a pre-school developmental assessment scheme. Dr. McMillan, Medical Officer in Department, gives the following account of this:—

"1972 has been concerned primarily with the preparation of a regular system of developmental assessment of pre-school children in the Southern Area.

I attended a brief but intensive course on Developmental work in Edinburgh early in the year which was very useful.

It was decided to initiate a programme of developmental assessment based on the 'Milestone' reports of Health Visitors, done in association with the 'At Risk' Register, and the Medical Officer would see all such children for assessment at 3 years. This would then be enlarged to cover the whole 3 year population of the area. The choice of assessment at 3 years is a useful one from a School Medical Officer's point of view as at this age lesser degrees of hearing or visual defect or faulty speech can be picked up and dealt with before school. It also provides an opportunity to discuss future schooling with parents, e.g. the provision of special schooling for a severely handicapped child, or attendance at Nursery School of some children.

The information obtained on such assessments is of value in the cases of known or suspected slow development, and can be usefully relayed to the Paediatrician or General Practitioner looking after the child.

It is too early yet to assess the future value of this work as a screening procedure, as it is already apparent that the rate of attendance is very low, (less than 50% of children called up between September and December attended the clinic). The Health Visitors have largely been active in visiting mothers and explaining the purpose of the appointment, and in providing the milestone reports for the "At Risk' children.

A small proportion of speech defects have been found and noted for action later, and several children have been recommended for nursery school attendance, including, with the co-operation of nursery school staff, several handicapped children.

I have had a fair amount of contact with our two Nursery Schools at Millom and Cleator Moor, since they are part of the educational system, and school entrants' medicals have commenced at both schools. This does mean that children receive a pre-school medical at 3 years and the standard procedure is not always suitable at this age, nor are visual and hearing screening programmes used below 5 years of age. However, it does provide useful contact between mother, school and medical staff and could perhaps be combined with a form of developmental assessment. The schools provide valuable social and educational stimulation and one hopes that further nursery places may become available in other parts of the area, either as new schools or nursery classes such as those at Arlecdon and Kells Schools.

Another facet of the developmental assessments has been that I have been able to prepare reports on some of the children discussed at the panel meetings on the Potentially Mentally Handicapped initiated last year in this area.

We have continued to identify such children via hospital and Health Visitor reports and have held regular meetings with Health Visitors, Doctors, Social Workers, the Educational Psychologist and representatives of the Education Authority. The register has been classified by Practice and date of birth of children and contains at present 53 children from 10 Practices.

It has been possible to discuss children from each Practice at least once during the year and more frequently if necessary. I feel it is helpful to review each child of whatever age in a relevant Practice, and to review and reappraise the situation for that child if it changes.

I would also like to arrange a pre-school assessment of such children in conjunction with the Educational Psychologist, and a report with his help, and that of school staff after the child has been at school two or three terms. This might be helpful in deciding the course of action for similar children at a later date.

It has been noted during the year that as the training centres are now officially schools, parents have received forms offering school dental treatment for handicapped children, and several parents commented favourably on this. Such children are often in need of dental care and there are special problems associated with this in view of their mental and physical handicaps."

In the northern area geographical problems make it even more difficult to establish developmental clinics. In addition in this area reliance has to be placed to a greater extent on part-time medical officer time and, in these circumstances, it is more difficult to secure the desired specialist training for the professional staff concerned. However, an important start has been made by Dr. Garland. Dr. Connolly, Northern Area Medical Officer, writes as follows:—

"In the Northern Area, a Developmental Clinic for children aged 0-5 years, was established in Wigton in January, 1972. Children seen are confined to those who are patients of the local group practice (Drs. Dolan, Jones and Gray).

A register is maintained of children who qualify for examination and a record is kept of the outcome. Dr. J. E. M. Garland, a Senior Medical Officer, holds the clinics. She sees children of varying ages but particularly children of 6 weeks to 6 months, children of three years and 'at risk' children and also those children causing concern to a parent or family doctor. Examinations are carried out at the clinic in Birdcage Walk, Wigton, on alternate Tuesdays and on Thursday mornings.

The observations of the examining doctor are made on the health visitor's record card for the child, which includes the milestone assessments completed by the health visitor from time to time. All these documents are of considerable help to the doctor in her assessment of a child's development. Health visitors are involved to quite some extent in determining priorities of appointment and also, of course, because of their personal knowledge of the children, parents and home background.

It is not envisaged that there can be a comprehensive service of this kind for the whole area for some considerable time. The service has, and will, continue to be of a selective nature but it is hoped to extend the scheme to another practice in the area. With the knowledge and expertise which will have been gained in the examination of these children, we hope to have a useful specialist service which will cover children throughout the area, outside the particular practices in the scheme."

Dr. Garland writes as follows:—

"The Developmental Clinic held at fortnightly intervals in Wigton, has completed its first year — 165 appointments

were sent out and 127 of these (77%) were kept. This is a very encouraging attendance rate and gives evidence that the service is appreciated. The referral rate from this clinic has been very low, mainly because many of the children are already under observation or treatment by the General Practitioner, a Paediatrician or at an Eye Clinic. Very few new defects have come to light; nonetheless, it appears that parents are anxious to bring their children to the clinic for a general developmental check, in addition to the care they are already receiving.

Vision testing is carried out with all children and it was found that approximately two thirds of the children could be tested adequately by letter-matching at the age of three years. The other children were tested by toy-matching or other methods. No cases of severe myopia were found but two children were referred to the Eye Clinic in addition to four others who were already under treatment for squint.

A number of children will be reviewed after a period of some months or a year: the majority of these reviews are to recheck vision where letter-matching was not possible when first seen."

MEDICAL EXAMINATIONS:

The table at Appendix 'B' to this report shows the total numbers in each age group who received medical examination, or who, at the 'selective' age points, were 'selected out' as not requiring examination. The picture does not vary greatly from recent past years although the percentage 'selected in' for examination at the 8 years stage was higher at 45.2% than in recent years. I do not attach special significance to a single figure like this. The single most striking difference between this table and its counterpart for 1971 is, of course, the lower figures at the school leaving age reflecting the change in statutory school leaving stage. This slight easing of the medical examination situation in 1972 was utilised by the area medical officer, in a variety of ways, to press ahead with other priority work which might have been delayed, e.g. the extension 'downwards' by one year of the age of protection of girls against Rubella so that this is done routinely in the first year in secondary school.

The scheme in the northern area which was fully described in the report last year, for the 'pre-entry' examination of school children by the family doctor, went ahead further in 1972 and Dr. Connolly, Northern Area Medical Officer, comments on this development as follows:—

"By the end of the year, 17 family doctors in 7 separate practice groups were examining children at the age of 4½ years, in the pre-school medical scheme.

It is estimated that about half of the annual intake of children in the area into infant classes will, in future, be examined in this way.

Children are identified by the practice health visitor or, in one case, through the family doctor's own age/sex register. They are then invited to the surgery and have an examination by their own family doctor. His report is on the 10M school record.

In most cases, immunisation ' boosters ' are given or are arranged at this surgery visit.

At school, the usual audiogram and visual acuity tests are done and a questionnaire is completed by the parent. The majority of teachers have been very helpful in giving their remarks and an actual milestone of attainments at 5 years.

This whole process is followed by a selective examination of some of these pupils by a School Medical Officer during termly visits. Any serious problems of health or handicap noticed are, of course, dealt with as they are identified and these do not have to wait for the full chain of information to be completed.

Earlier enrolment at school is the pattern in many schools now and the comments of the family doctor at 4½ years have been most useful in some of the children with health defects or a handicap.

Defects found by medical inspection of pre-school children at age 4½ years during 1972

Code No.		Defect	Pre-School T.	Pre-School O.
4		Skin	—	—
5	Eyes	(a) vision	8	5
		(b) squint	—	—
		(c) other	—	—
6	Ears	(a) hearing	—	11
		(b) otitis media	—	5
		(c) other	—	6
7	Nose and Throat		—	—
8		Speech	9	2
9		lymphatic glands	—	—
10		heart	—	—
11		lungs	—	—
12	Developmental	(a) hernia	—	—
		(b) other	—	—
13	Orthopaedic	(a) posture	2	1
		(b) feet	3	7
		(c) other	—	—
14	Nervous System	(a) epilepsy	—	—
		(b) other	—	2
15	Psychological	(a) developmental	5	6
		(b) stability	—	4
16		Abdomen	—	—
17		Other	—	—
318 Children examined—155 boys 163 girls				,,

In the Keswick area the arrangements continue for the medical examination of school children by the family doctors. Efforts have been made during 1972 to overcome one of the main difficulties which arose, viz. that of communication between the teachers and the school health service personnel. Dr. Hargreaves, Western Area Medical Officer, contributes the following note on the situation:—

"This scheme is proceeding fairly satisfactorily, although this year the numbers have been very small owing to the raising of the school leaving age, with the result that no school leaver examinations have been carried out.

Because the medical examinations of the children are quite naturally carried out in the family doctor surgeries, one complication of this kind of scheme is the question of communication with the teachers and by the teachers.

We have circumvented this problem by continuing the termly visits to the schools by one of our school medical

officers; and by arranging with the school-teachers for a routine system of notification to ourselves of any children whom they observe to have defects or about whom they are in any way concerned. We then promptly liaise with the family doctor of the child in question.

There are no pre-school medical examinations carried out by the Keswick General Practitioners."

Writing above on work with pre-school children in the southern area, Dr. McMillan comments on the introduction of 'school entrant' medical examinations in the nursery schools in Millom and Cleator Moor. Since nursery school education is a rapidly extending field, this development will be kept under review with a view to determining the most useful pattern of medical care of children entering school at the nursery stage. It will be obvious how this ties in with the developmental examination described above in the case of handicapped or potentially handicapped children.

As a general policy it has recently been decided that medical examinations at the school entry stage should be carried out in the spring or summer terms.

The nature and number of 'defects' found at periodic or special medical examinations do not show any significant shift during 1972. While very many defects found are shown subsequently to be known about and under medical care, those discovered for the first time make an important contribution to the total value of the school doctor and nurses' visits to the school. They are by no means, however, their sole purpose there since discussion with, and advice to, the teaching staff on individual children constitutes a vital part of their professional activity.

A brief account was given last year of the plans for the introduction of the Employment Medical Advisory Service of the Department of Employment, whereby a new and potentially very fruitful relationship should be forged between school medical officers and the local Employment Medical Adviser. The latter, usually a general practitioner, will have a new responsibility for the health care in employment of young people up to the age of 18 years. This will provide a new and clear point of **medical** contact at the vital cross-over point between school and employment and will, of course, be of particular value in the case of young people with any degree of handicapping condition. At the time of writing this report several meetings with colleagues of the Department of Employment, both medical and in

the careers advisory service, have taken place and reviews arranged for six months time to re-assess the working of the new scheme. It came into operation officially on 1st February, 1973.

Employment of Children Byelaws

Total examined during the year	272
Total number of children involved	263

Examined for the first time	Re-examined	Re-examined twice
263	9	Nil

School Clinic Work

The figures are once again shown below of the numbers of children attending school clinics, the majority being cases for re-testing or fuller examination by the School Medical Officer:—

Clinic	New Cases	Total Attendances
Longtown	6	6
Park Lane, Workington	99	124
Wigton	6	6
	111	136

SCHOOL CLINICS

Defect Code No.	Conditions for which child attended	New Cases						Total Attendances					
		1972	1971	1970	1969	1968	1967	1972	1971	1970	1969	1968	1967
1	Cleanliness	—	—	—	—	4	—	—	—	1	—	7	—
2	Infestation	6	—	14	9	5	3	6	—	28	28	20	13
3	Skin disease	2	3	7	9	25	40	2	3	11	11	28	80
4	Eye disease	66	68	128	41	60	112	79	86	144	163	62	129
5	Ear conditions	11	6	29	10	20	31	16	21	64	33	47	82
6	Nose and throat conditions ...	2	1	6	3	8	9	2	1	6	7	11	13
7	Speech defects	1	13	17	7	25	8	2	14	19	10	28	18
8	Lymphatic glands	—	—	—	—	—	—	—	—	—	—	—	—
9	Heart conditions	—	—	—	1	—	1	—	—	—	1	—	1
10	Lung conditions	—	—	2	—	2	2	—	—	2	—	3	4
11	Developmental	—	—	10	—	3	1	—	—	12	—	4	1
12	Orthopaedic	3	1	5	7	13	8	4	2	5	8	13	9
13	Nervous systems	1	—	1	—	—	2	1	—	1	—	—	3
14	Psychological	11	8	35	9	17	17	13	12	42	10	23	27
15	Abdominal conditions ...	1	1	2	2	1	3	2	1	7	4	1	3
16	Weight	—	—	—	—	5	—	—	—	—	—	11	—
17	Other conditions	7	16	24	43	21	26	9	19	26	62	45	47
		111	117	280	141	209	263	136	159	368	337	303	430

SPECIAL SERVICES

There is no doubt that in the present day situation the greatest benefit from the activities of the professional staff of the school health service accrues to those children with defects of the special senses and to the psychologically disturbed, together, of course, with those who are frankly handicapped from whatever cause. Thus the services described in this section of my report represent a great deal of direct educational benefit to a great many children. It is particularly pleasing to be able so consistently to pay tribute to consultant colleagues in the hospital service for their co-operative working with the school health service in these fields.

Audiology Service

The basic statistics of this service are shown below in the simplified form introduced last year. Following publication of the report last year there was a request for these statistics to be shown by administrative areas and this is done as Appendix 'E' to the report (page 109).

In addition to these collated figures relating to the routine and selective audiometric examinations, it is usual to publish an account from each area medical officer of the audiology work in his area. This fills in a lot of very interesting and informative detail of this highly important work and is complemented by the combined report of the Teachers of the Deaf on their parallel activities in the teaching field. A very encouraging feature of their report is the extension of interest in the educational problems of the hearing-impaired child through the Teachers' Centres.

I give first below the description by the Western Area Medical Officer of the year's audiology work there. A special feature of that in 1972 was a sweep test of all aproximately 8 year old children (born in 1964) since there has been some evidence that there would be considerable benefit from such a further screening at around that age. It will be recalled that hitherto the only comprehensive screening of school children at any stage has been at school entry. Thereafter further testing has been as follow-up of previously diagnosed difficulty or as a result of special referral following a manifest or suspected problem. Dr. Hunter's comments below speak for themselves on this further 8 year old screening and the results shown on Table 'B' (page 29) indicate a valuable yield of problems but none of them of dramatic proportions. This raises the familiar problem with all screening procedures — how often, at what cost, for what yield? It is signifi-

cant that Dr. Walker, writing subsequently from the southern area also expresses a sense of need for a further 'sweep' around this age. At the present moment screening assistant time is just not available to establish a routine screening at 7 or 8 years but I hope it will be possible to repeat the experiment in 1973 also in the western area with a view to further evaluation.

HEARING TESTS—5 year olds and other school pupils

1. **ROUTINE EXAMINATIONS**

	5 year old Entrants	Children born 1966	1965	1964	1963	1962	1961	1960	Totals
Children Tested	3291	237	80	1183	47	49	23	156	5066
Children Re-tested	404	146	41	51	—	8	6	—	656

NOTE: The first line of this table will include children who, for one reason or another, have never previously had a hearing test.

2. **SELECTIVE EXAMINATIONS**

Children Tested	27	282	212	182	123	97	108	299	1330

NOTE: This table will include cases referred by Teachers, Parents, General Practitioners, School Medical Officers and others.

3. **OUTCOME OF EXAMINATIONS**

(Routine Group re-tests and selectives)

	No Defect	Observation (School Medical Officer)	Family Doctor (Treatment)	E.N.T. Specialist	Totals
Routine Group Re-tests	331	289	12	24	656
Selective Group	589	684	9	48	1330
					1986

4. Of the Grand Total of Table 3, 57 children were referred to the Peripatetic Teacher of the Deaf.

Dr. Hunter from western area writes:—

"The report for the year 1971 recommended that an additional year group (8 year olds) be tested because of some indication that cases of deafness were appearing between the ages of 5 and 8 years. In fact the figures at the end of 1971 showed that 36 cases of deafness had been discovered between the ages of 6 years and 8 years including four cases requiring the help of hearing-aids.

The children born in 1964 were, therefore, tested during 1972, a total of 1127 producing 44 cases of hearing loss. Twenty-nine cases reverted to normal hearing leaving eight unilateral and six bilateral mild losses, and one moderate bilateral loss. (See Table B on Page 29). These are all under observation including one high frequency loss (mild unilateral), one case of bilateral mild loss in which myringotomy has been done. The result of the otologist is awaited in the moderate bilateral case.

Parallel to these routine tests only nine cases emerged in the age groups 1964-1962 inclusive, being brought forward from various sources other than audiometric testing. It would be difficult to assess how many of the 1964 routinely tested group would have augmented these nine but it is likely that the extra routine testing anticipated the later emergence of cases of significant deafness. It would be reasonable to carry out in 1973 the testing of children born in 1965.

The total number of children tested was as follows:—

Table A

1. **Routine Examinations**

	5 year old entrants	Children born — 1966	1965	1964	1963	1962	1961	1960	Total
Children tested	1251	56	6	1127	—	—	—	—	2440
Children re-tested	70	20	2	44	—	—	—	—	136

2. **Selective Examinations**

Children tested	27	40	29	5	16	5	24	43	189

3. **Outcome of Examinations**

	No Defect	Observation S.M.O.	F.D. Treatment	E.N.T. Specialist	Total
Entrant Group	40	34	6	12	92
1964 Group	29	11	2	2	44
Selective Group	161	16	6	6	189
					325

4. Of the total in table 3, 2 cases were referred to the peripatetic teacher of the deaf.

In addition to screening by the medical officer, 14 were referred to the special audiology session held at area clinics where a medical officer with special knowledge of hearing and the peripatetic teacher of the deaf are in attendance and select cases for the audiology clinic at the hospital where they also attend.

Table B

By degree of severity measured in terms of decibel loss the cases fell as follows:—

	Entrants	1964 Group	Selected
Bilateral severe	—	—	—
Bilateral moderate	9	1	5
Bilateral mild	15	6	10
Unilateral severe	—	—	—
Unilateral moderate	3	—	3
Unilateral mild	25	8	10

To summarise the findings in 1972 it should be noted that of 1313, fifty-two had significant deafness — nearly 4.0% compared to 3.5% in 1971. In the extra routine group of 1964 (1127 tested) fifteen (1.3%) were found to be defective in hearing. In the specially selected group (from parents, teachers, etc.) a total of 189 produced 28 cases (14.8%).

Although final ascertainment of the type of deafness was not reached in all cases by the end of the year it is interesting to note that all except one of the perceptive types of loss came from the children tested as a routine — 3 bilateral and 4 unilateral cases from the entrants, one unilateral high frequency loss from the 1964 group, the one from the selected group being a doubtful mixed loss. It is likely that conductive losses, with attendant symptoms of pain, wax, etc. are more likely to be brought forward by parents than the perceptive type of loss with no symptoms until and if the deafness reaches the state where the child becomes inattentive and falls behind in his school-work.

Findings during the year.

A. ROUTINE ENTRANTS

Cases	Unilateral	Bilateral
Mild	25	15
Moderate	3	9
Severe	—	—

No case of severe loss was found. Fourteen cases were referred to the otologist including a bilateral mild case who had had A.B.O. haemolytic disease at birth and a moderate high frequency loss in a child who was premature at birth. In both these cases and in the other perceptive losses, hearing tests in infancy were recorded as normal. Findings in conductive losses included earlier mastoidectomy, old otitis media and recent affections of the middle ear. Two cases were fitted with Stopple tubes

and others noted for myringotomy or removal of tonsils and adenoids.

B. CHILDREN BORN 1964

	Unilateral	Bilateral
Mild	8	6
Moderate	—	1
Severe	—	—

Again no severe case was found. There was one case of mild unilateral perceptive deafness. Two cases were referred to the otologist — one conductive case was fitted with Stopple tubes and the other awaits an appointment.

C. SELECTED GROUP (specials from various sources)

	Unilateral	Bilateral
Mild	10	10
Moderate	3	5
Severe	—	—

No severe case or frank perceptive case was found. One mixed loss, bilateral, moderate severity was referred to the special audiology clinic. Seven cases were referred to the otologist. Two were fitted with Stopple tubes and five are under observation or await appointments.

D. OLD CASES

These cases were kept under review and practically all were retested by the audiometrician at least once during the year. Forty-five cases had reverted to normal hearing. In the group of mild losses 68 had improved, 29 were more or less static and 6 only had deteriorated. In the group of moderate losses 12 had improved, 20 remained static and 7 had deteriorated. In the group of severe losses (all unilateral) seventeen remained static (being mainly perceptive losses) and one conductive case and one perceptive case had worsened.

Thirty-two were referred or referred again to the otologist and six were fitted with Stopple tubes. Twenty-three cases were referred to the special audiology clinic. Thirteen were referred to family doctors because of subacute or chronic otitis media.

Six cases were fitted with hearing-aids during the year and two children came into the area so fitted.

Total State of Deafness in Children 0 - 16 years

The total state of known deafness in the Western Area including cases of profound degree (included under 'severe') is summarised below. Apart from two children under school age with hearing aids no case of significant loss appears to be under observation at present."

	Unilateral			Bilateral		
	Mild	Mod erate	Se- vere	Mild	Mod erate	Se- vere
a. New cases 1972 - entrants	25	3	—	15	9	—
b. 1964 group (new)	8	—	—	6	1	—
c. Specials (new - 1972)	10	3	—	10	5	—
d. Children with hearing-aids in school	—	1	—	2	18	13
e. Children in special schools	—	—	—	—	—	3
f. Children under 5 years with hearing-aids	—	—	—	—	—	2
g. All other cases under observation or treatment	65	21	16	40	18	—
h. Total state of deafness 0 - 16 years	108	28	16	73	51	18

The following report by Dr. Walker from the southern area highlights in a very gratifying way the advantages which flow from a secure link between a school medical officer specialising in such a field as this, and the clinical specialist in the hospital setting. When the teacher of the deaf can also be tied in with this arrangement the advantages are further augmented. Dr. Walker's report also raises afresh the question of special units for hearing impaired children and at the time of writing this report a meeting has been arranged to reconsider this matter. Taking part will be all those professionally involved including an E.N.T. surgeon.

Dr. Walker writes:—

"During the past year, 913 children entering infant schools had a screening test performed and it was found that 191 of these had a hearing loss on their first test. When this group was retested about eight weeks later, eighty-nine of them passed their second screening but 102 children still had some hearing loss.

Most of the defects were very slight losses over one or two frequencies and these were kept under observation.

Sixteen children had more severe losses and were called up to a special assessment clinic and it was found necessary to refer ten of them to the hospital for a Consultant's opinion. Six required operations involving their ears or the removal of their adenoids and tonsils. Two are being kept under observation by the specialist and two are waiting to be seen.

Hearing tests performed on the selective group of children accounted for the bulk of the work over the year. More family doctors are requesting tests. The results of these are sent to the family doctor who then deals with his own patient. Teachers and parents are becoming more aware of difficulties in hearing and are requesting tests more frequently. However, the majority of selected referrals still come from the School Medical Officers.

In the selected age groups there were 111 new referrals made and it was found necessary to call ten children to the special assessment clinic. All ten required referral to a consultant and six of them required operative treatment. In the other four cases the hearing losses were confirmed and the children are being kept under observation by the specialist.

Further screening was carried out on children who had been kept under observation in previous years. Most of these tests showed that there had been some improvement or that the condition had remained static. However, in twenty-four children there had been a definite deterioration and fourteen required hospital treatment. Many of these were children who had already had treatment in hospital. Many had already had their adenoids removed and their ears drained. Following this their hearing had returned to normal, but then had deteriorated again following a cold or infection. Most of these children came from the older age groups and most of them admit to going swimming with the schools. Perhaps many of these troubles could have been avoided if children suffering from nasal infections and colds did not go swimming. However, in most of these cases where the children were referred to the E.N.T. Department again, it was possible to improve their hearing once more.

Over the past year several points have become apparent. Schools are now taking entrants at a much younger age, and nursery education is extending. It is often very difficult to obtain a really accurate screening test on the younger child, and although it is important that every child should have his hearing tested on entering school, I feel that a second test at about 7 years old would be of value.

The other point to make is that at 4-5 years old on entering school many children have had no trouble at all with their ears or throat and pass their screening test when this is performed within a few weeks of their starting school. It is often after a few months in school that infections start to arise and a screening test at a later date would pick out these children and would be of more value.

In addition to the work in the schools and clinics, this year has brought a new development in the audiology service. I have been attending West Cumberland Hospital in the role of Clinical Assistant to the E.N.T. Surgeons. This closer contact with Mr. Black and Mr. Hand has meant that my work has been made more interesting and I have been taught a great deal that is proving very valuable. In this way I feel that the service I can give to the children and the advice which I can give to their parents will be of greater value. Both the children and parents seem to think that this liaison is to their benefit. Often they can be saved an extra appointment at either clinic or hospital but on the other hand if the clinical condition has deteriorated, then their hospital appointment can be brought forward and more urgent treatment given.

Apart from the two clinical sessions at the hospital each week, once a month we hold a meeting at which Mr. Black, Mr. Hill, teacher of the deaf, and myself discuss and deal with special problems which really need more time devoted to them than can be given in a busy out-patient clinic.

These very often concern children who have hearing aids and who attend ordinary schools, and whose performance may have suddenly gone right off. If the hearing has deteriorated and no further treatment is possible, it may be possible to modify and amplify the hearing aid and so improve the child's capability. Even if when assessed on a word list the improvement may be only 1% or 2%, this makes a very big difference to the understanding of a conversation and to the appreciation of words in context.

In other cases it may not be possible to improve the N.H.S. aid and it may be necessary to provide a higher powered commercial aid. Even when this has been done it may be apparent that the child can no longer manage in an ordinary school and that special schooling will be necessary.

This also brings to light the fact that children using hearing aids could benefit from more help. In this area at present

we have no special unit for deaf children and the decision lies between sending the child to an ordinary school or sending him away to a school for the partially hearing or the deaf. There are several children whose speech is relatively good and yet one feels that they are struggling at ordinary school, and a special unit could be the answer. The older pre-school child would also benefit from this type of unit. At present he relies on home visits from the Peripatetic Teacher of the Deaf, and in this widespread community it is not possible to give each child a great deal of time. In a unit the teacher's time could be spent to better advantage and the children would benefit in many other ways as well."

In connection with Dr. Connolly's brief report from the northern area, I draw attention to his mention of a very useful information sheet for teachers. This is published as an appendix to this report (Appendix 'F' on page 111).

Dr. Connolly writes:—

"The statistics this year are generally similar to those for the year before. The significant change has been in a higher referral rate to the Consultant Surgeons in the Ear, Nose and Throat Department. This does not reflect a deterioration in the health of the children but rather the increased interest of the Consultants in more minor degrees of hearing loss and better liaison on individual clinical problems where advice has been required.

It seems likely that in the future, there will be an increasing medical and educational emphasis on the child with a persistent minor hearing loss.

In conjunction with Miss Cronie, a joint information sheet was prepared for teachers in ordinary schools, relating to the child with hearing difficulties. This was given a general distribution to Head Teachers during the year."

Finally, I reproduce below the combined report of Miss Cronie and Mr. Hill, Peripatetic Teachers of the Deaf:—

"Pre-School Children

Work with pre-school children has included guidance to the parents of hearing impaired children in order to help them to carry through a programme of home training. An essential aid to this programme is the provision of an auditory training unit for use in the home. During the year we have been given a number of these pieces of equipment through the local branch of the National Deaf Children's Society

We are grateful to all the people who have worked so hard to make these gifts possible.

A considerable amount of assessment work has been undertaken with pre-school children and a particularly valuable development has been the establishment of assessment clinics in South and West Cumberland. These are held weekly during the school terms and involve co-operation between Dr. Walker and Mr. Hill.

Only two pre-school children, both from the Northern Area, have gone to special school during the year and the Northern Area has also lost one pre-school child through transfer to another county.

Children in Special Schools

Children from special schools were again seen during the summer vacation and contact with parents has been maintained by home visits and through the National Deaf Children's Society. We have both been able to visit some of the schools during the year.

Three girls and one boy have left school this year and all have been successful in gaining employment. One is now employed as a typist in a government establishment in West Cumberland, another is working as a non-medical auxiliary at the local hospital, another works in the computer department of the County Treasurer's Department and the other works with a firm of plasterers. It is pleasing that these severely handicapped young people have been able to obtain such satisfactory employment at a time when the level of unemployment is so high. It is in no small measure due to the close co-operation between the Welfare Officers for the Deaf, the Youth Employment Service and the Teachers of the Deaf.

Children in Ordinary Schools

This year we have continued our policy of helping children who have less severe bilateral losses and severe unilateral losses. **Most** of these children will not have hearing aids. To a large extent this will account for the significant increase in the number of children in ordinary schools in the 'up to 30db loss' category. We both feel that, whilst these children should be able to manage adequately in class, there is a need for supervision, in order to make teachers aware of their problems. In fact it appears that in our new open plan schools with their large open working areas, many of these children are having very real hearing problems.

Amongst the children with the most severe losses is one child who is waiting to go to a residential school and who is attending the local infant school in the meantime. The Headmaster of the residential school suggested that this was done not as an academic experiment but for social reasons. The results are at present most encouraging and we hope that it may be possible to develop this idea in the future.

This year hearing aids have been issued as follows:—

Northern Area	Western Area	Southern Area
2	4	2

In November a one day course was organised at Workington Teachers' Centre for teachers and Heads. The aim of the course was to give a basic understanding of the handicap and its educational significance. There was a good response with representatives from all types of schools throughout the country. We hope to extend this side of our work in the future, perhaps on an area basis through the local Teachers' Centres.

Tables below show the numbers of children in each group, as at 31st December, 1972. In the 'Ordinary Schools' table hearing loss in the better ear is averaged over the main speech frequencies (500, 1000, 2000 Hz).

1. **Pre-school Children**

Loss	**N**	**W**	**S**
Sub total	0	0	0
Profound	2	2	0
Partial	1	2	0
Unilateral	0	1	0
Under observation	10	2	2
	13	7	2

2. **Children in Special Schools**

	11	2	7

3. **Children in Ordinary Schools**			
Up to 30db	25	11	21
30 — 40db	8	2	8
40 — 50db	4	5	7
50 — 60db	3	3	4
over 60db	3	6	3
	43	27	43

Ophthalmology

As foreshadowed last year, efforts are now being made towards a regular vision test for all children at the ages of 5, 8 and 12, with colour vision being tested at 12 years also.

In the southern area the Keystone Vision Screener has been again brought into fuller use and Dr. Marks gives below an account of the pattern of testing she is at present working on.

"The school entrants have a visual acuity test, preferably during their first term at school and before the routine School Medical Inspection is carried out. This is done by the Keystone vision screener method.

Each eye is tested independently and the child is asked to identify letters, numbers or animals, and the result of the test is recorded on the 10 M form.

All the children with prescribed lenses have their visual acuity test(a) without lenses; (b) with lenses (wearing glasses). Any child who is unco-operative or who gives a reading with aid of glasses if necessary or any reading less than 6/9 in either eye, the screening assistant re-tests 10 - 14 days later. If the reading then obtained is still less than 6/9 in either eye, the School Medical Officer notes this reading and will refer if necessary to the Children's Eye Clinic.

The screening assistant carries out tests in other age groups of all 'observed' cases of reading of 6/12 or 6/9 in either eye at yearly intervals; if a lower reading is obtained this case is referred to the School Medical Officer.

Tests are carried out at yearly intervals on all the children wearing glasses and the results notified to the School Medical Officer; also all cases referred by teachers or parents to

the school nurse or this office are dealt with as soon as possible by the screening assistant, any defects being noted. The parent and teacher are then informed of the procedure regarding referral to eye clinic.

This method of vision testing has not been long enough in use to give comparable figures with other methods of screening, but we do find that the children are willing to co-operate in using the Keystone vision screener."

Once again Dr. Ainsworth gives a very interesting and satisfactory account below of her work in conjunction with Dr. Griffiths, Consultant Ophthalmologist:—

"The work, and week by week running of my school eye refraction clinic, is still continuing on the hospital premises in a very satisfactory manner. I continue to feel that there is a great advantage by having hospital contact with the Consultant Ophthalmologist DrGriffith. This immediate access to the Ophthalmologist when queries and problems arise would not be available with the same ease if I held my refraction clinic in isolation, e.g. in a local authority clinic, away from the hospital. Therefore, as a result of this, problems can be dealt with when they emerge during my clinic and this does not make it necessary to re-call cases on another occasion for further advice.

From this we have a most helpful liaison, and this is so very helpful in my work in the following ways:—

1. **With the pre-school child**

Here, I have found in our new venture — the pre-school developmental screening scheme which we are operating in the Western Area — that I can discuss with Dr. Griffith children we refer from the developmental clinics with possible visual developmental anomalies. This gives us a concrete basis to work upon by knowing whether there is a visual defect and if so, its nature, e.g. one pre-school child has been found after referral by Stycar vision testing from a developmental screening to have a fair degree of myopia. In this case I was able to discuss with the Ophthalmologist whether there would be any real handicap on entering school or not, and therefore whether we needed to be thinking of special schooling at a later date. Discussion of this kind is most valuable. In addition, one is able to pass on helpful information to the Consultant Ophthalmologist in being able to tell him details about the other spheres of a child's development, and he finds this information useful to him.

We do, in addition, have this same two-way exchange of helpful information in the special handicapped pre-school cases where I have been involved with detailed developmental testing in conjunction with Dr. Platt, the Paediatrician. This is a valuable link in our service to the handicapped children in this area that also have visual defects. It is also very noticeable when one is involved in this work, that a great number of these handicapped children have eye defects, and therefore come under the Ophthalmologist's care — as a strabismus (squint) in many cases, although some have nystagmus or refractive errors.

2. This link also applies not only in the pre-school service, but it extends to **the handicapped school child.** Here, where queries arise — such as any special advice required for the school — the Ophthalmologist is always available to give us guidance, and this is of great value and much appreciated.

3. Also, with 'normal' school children who are not handicapped, but have eye defects — either disease, injury, strabismus, or refractive errors — one has again the opportunity to discuss any queries here with the Ophthalmologist.

My school refraction clinic is still operating weekly, and here I see myopes, hypermetropes and astigmatic cases. Dr. Griffith is quite happy for me to see new cases as well in this clinic whom I think are refraction cases, and he is always available to consult if I need to about them. Dr. Hargreaves, Area Medical Officer, did circulate a notice to all medical officers referring children for eye problems, to send cases from approximately 8 years upwards suspected of refraction problems direct to my clinic as new cases. We would hope that this will develop."

Orthoptics

This highly important specialist service for children with squints operates almost entirely as a professional arm of the ophthalmology service of the hospitals. I have no doubt that this ensures the best service for the children who use it, as well as offering much greater job satisfaction to the orthoptists. Practically all consultant ophthalmologists' major sessions for pre-school and school children have an orthoptist in attendance and in addition the orthoptists have their own sessions for follow-up and treatment of cases.

Mrs. Wilson is now well established in the service in Cumberland and I am glad to be able to include in the report below her impressions:—

"Mrs Payne works four sessions per week and myself six sessions per week in Carlisle, one of mine being held at Portland Square Clinic. All others are held at the Cumberland Infirmary. I also work three sessions at the West Cumberland Hospital and one session at Workington Infirmary.

Since I came to Cumberland on completing my training in January, 1971, there has been a marked increase in the number of very young children being referred to the eye clinics, some as young as nine months of age, because either the parents or the general practitioner suspect that there is a squint present. Although a number of these turn out to be pseudostrabismus (i.e. only an appearance of a squint) the larger proportion of them do have a squint. With this early referral comes early treatment so that any amblyopia can be arrested, corrected and maintained in most cases. Also any operative treatment which is necessary can be carried out whilst the child is still young enough to develop some binocular vision once his eyes are correctly aligned.

This early referral appears to be largely due to developmental clinics although general practitioners now realise that the old adage 'nothing can be done until he starts school" is nonsense since the earlier the child receives treatment the better the chances of a good result."

It is very encouraging to have this evidence of a helpful link with the developmental clinics described earlier and to know that children are being referred for assessment and treatment earlier on account of squints. Sometimes health, and health service, education is an activity of many discouragements and it is heartening to all concerned to know of a positive impact in one important field such as this.

I have usually given a full list in this report of all the varieties of squint from which a child can suffer and the numbers of cases of each. I doubt whether this is very meaningful to most readers of this report and so I have omitted this highly technical list this year.

The number of children treated during the year is as follows:—

Number of children tested, showing those referred for treatment or observation

Year	Total No. tested	Referred for treatment	Referred for observation
1967	11,084	444	1,865
1968	10,064	310	1,197
1969	12,303	378	1,495
1970	14,297	339	1,363
1971	12,950	322	1,250
1972	11,853	230	1,015

Details of cases treated during the year:—

Total No. of Attendances 1972	3,637
No. of new cases seen	529
No. of new cases registered for treatment	305
No. of cases receiving treatment on 31st Dec. 1972	917

Discharges during the year:—

(A)	Orthoptically satisfactory	11
(B)	Not orthoptically satisfactory; but	
	(i) Relief of symptoms	13
	(ii) Comfortable binocular single vision intermittently	—
	(iii) Appearance satisfactory	18
	(iv) Treatment not completed	—
(C)	Failed to attend	11
(D)	not responding	4
(E)	Transferred	57

It must be remembered that other children are treated directly through the hospital service, mainly in West Cumberland, so that the above is not an exhaustive list of all child treatments.

Orthopaedic Service

The limited physiotherapy service based on clinics and some domiciliary visiting continues but, as described last year, with increasing emphasis on work in group practice premises. There are now four part-time physiotherapists involved in the county and work, mixed as between children and adults, could certainly be found with great benefit to the community if further physiotherapist time were available.

One important field in which there is a growing need is in the care of young severely handicapped children. This is a need which is being brought into sharper relief by the Panels meeting regularly in each area for the co-ordination of services for these young handicapped children. There is no doubt that a very searching appraisal of the comprehensive community needs in this field will be necessary early in the life of the new Area Health Authorities.

With this thought in mind some discussions took place during 1972 with colleagues in the hospital service in the Special Area and various measures will be tried to stimulate greater interest in training in the "professions supplementary to medicine". One of these is a study day in June, 1973, for the Association of Careers Teachers at West Cumberland Hospital.

Speech Therapy

Once again I am indebted to Mrs. Blacklock, Senior Speech Therapist, for a report on the work of this specialty during 1972 and for the statistics of work done. As will be seen, once again fluctuation in staffing levels have beset the service during 1972, although a reasonably good service overall has been maintained, and the therapists cope most imaginatively with the repeated limitations imposed on them. The balance of advantage in clinic treatment over school treatment is stressed but also the indispensable value of maintaining good contacts with the schools and teaching staffs. Mrs. Blacklock writes:—

"The first eight months of 1972 found us in the favourable situation of having the equivalent of 4½ full-time therapists in Cumberland. During this time and the latter part of the year, we were asked to join several combined case discussions, general meetings with other members of health teams and to talk to various groups of teachers, nursing clubs and school children and we had more time for school visiting. I think Miss Bainbridge's contribution in this report is an answer to those who try to persuade us to do more treating in schools. She says, as a recently qualified therapist, '1972 was my first complete calendar year in practice. It has been a very busy but varied and interesting year in Southern Area and as far as accommodation, equipment and contact with colleagues is concerned, the area is fortunate. But the problem of adequate coverage of such a scattered rural area exists here as it does in many parts of Cumberland.

In an attempt to attend to all children referred for speech therapy, rather than allow a waiting list to accumulate, I began to carry out some treatment in schools in early 1972, believing this to carry the strong advantage of having several children on the spot, good contact with teaching staff and, in particular, regular treatment for those children where parental co-operation is lacking. However, after a year of such organisation of work, I have finally reached the conclusion that it is **not** the answer and that on the whole, children do not respond to treatment as effectively as when seen under clinical conditions with consistent parental contact.

An analysis of school treatment versus clinical treatment based on figures at the time of visiting, shows clearly that the better responses have come from those children treated in clinics. I feel strongly that in future, while contact with teachers is vital, actual treatment in schools is to be avoided, unless it is geographically more convenient to do so.

At the time of writing, 19 out of 61 children are being seen regularly in schools and 42 in clinics. Assessments of degree of response are purely subjective but take into consideration length of treatment undergone so far, age, severity of defect, etc.:—

	No Response	Poor	Average	Good	Excellent
School (19/61) (to nearest 1%)	26%	22%	26%	16%	10%
Clinic (42/61)	9%	19%	36%	24%	12%

During this year, one child with a severe language problem has been assessed by Dr. Ellis at the Diagnostic Unit attached to the Royal Victoria Infirmary, Newcastle. Such assessments have proved of immense benefit to the therapists treating the children, as they have been given insight into every aspect of the child's difficulties that are preventing him from acquiring language in the normal way. It cannot be stressed too strongly how beneficial such assessments are to the therapist working in the field and it is felt that increasing use should be made of the skills of the members of this diagnostic team. There is no special unit for language disordered children in our area and we need as much support as we can get to treat these very difficult cases in often very unsuitable conditions. We have purposely resisted trying to categorise the types of defects this year. One factor being the number of children whose condition, at an early

age, may simply be a slightly delayed stage in maturation and because it is increasingly difficult to place speech defects in neat compartments now in the light of new thought, where much emphasis is being directed towards language development. Overall, we have seen 295 new cases and of those 122 were under five years of age. Last year the ratio was 112: 297.

The resignation of Mrs. Lahiff in August meant the curtailing of certain aspects of the service in the Workington area, because Mrs. Lahiff has not been replaced and the service had to be reorganised to allot some time to the Workington area at the expense of other areas. We were very sorry to have to close the language stimulation/assessment group which Mrs. Lahiff ran for nearly two years. The very close contacts with the medical officers in the Workington area have been maintained and are reflected in the high proportion of children referred under five years of age in that area. The figures for the whole county are shown and this trend for early referral is very satisfactory. The table shows the number of referrals under five years of age against the total of new cases at each clinic:—

Carlisle	9/33
Cockermouth	10/19
Workington	39/60
Wigton	10/21
Maryport	15/46
Aspatria	4/11
Penrith	11/24
Whitehaven	10/42
Egremont	7/16
Ennerdale District	3/5
Millom	4/18

The following table shows details of cases treated and attendances during the year:—

	Northern Area	Western Area	Southern Area	Total
On register 1-1-72	197	215	157	569
Admitted	89	132	79	300
Discharged	121	132	64	317
On register 31-12-72	165	215	172	552
Particulars of cases discharged:				
Normal	73	74	21	178
Improved, unlikely to benefit further	14	7	16	37
Lack of co-operation	28	42	18	88
Left school and/or district	6	9	8	23
Passed to teacher of deaf	—	—	—	—
Deceased	—	—	1	1
Total	121	132	64	317
Waiting list	4	2	—	6

Attendances:

Northern Area		
Allhallows		11
Abbeytown District		28
Aspatria District		251
Carlisle District		421
Penrith District		549
Wigton District		351
Western Area		
Cockermouth		339
Keswick		125
Maryport		307
Workington		987
Southern Area		
Cleator Moor/Frizington/Ennerdale		161
Egremont		302
Millom		251
Whitehaven		688
	Total	4,771

CHILD GUIDANCE

The general pattern of this service has not changed during 1972, Dr Wood, Consultant Child Psychiatrist, continuing to provide the medical service in East Cumberland, as also he does for Carlisle City, and the service in the west being shared by Dr Ferguson (and from November, 1972, his successor as Medical Administrator, Dovenby Hospital, Dr Short), Dr Burgess, Consultant Psychiatrist, West Cumberland Hospital, and Dr Wood. Dr Wood brings up to date in his contribution given below, the account he gave in last year's report of his work since coming to Cumberland.The emergence of the new assessment unit at West Cumberland Hospital is a very welcome and significant development.

Dr Wood writes as follows:-

"The main change which has taken place in the Child Guidance service during 1972 is that in May the base from which operations are conducted was transferred from the Central Clinic, Carlisle, to newly built accommodation at the Cumberland Infirmary. This accommodation is an extension of the existing Paediatric Out-patient Clinic and the the whole unit is intended to develop along the lines of a multidisciplinary assessment unit for children suffering from a variety of handicaps. The siting of the unit adjacent to the present paediatric ward has further facilitated co-operation between the Child Guidance and the Paediatric Services, and no doubt this trend will continue.

Apart from this change, the service has proceeded largely as it had done during 1971. Patients from the Northern Area have been seen in the clinics held at the Cumberland Infirmary, no particular session having been devoted specifically to County cases, and I think that a very satisfactory degree of co-operation between the clinic and the County Educational Psychologist, Dr. Blair Hood, has been maintained even though no formal meetings have been arranged.

The Social Work component of the service in the Northern Area had been provided largely by Mr. Thatcher, Senior Psychiatric Social Worker, Cumberland Infirmary, though, again, we have been able to co-operate satisfactorily with members of the Social Services Department whenever this has appeared to be appropriate.

As in 1971, a regular weekly session has been conducted at the Health Clinic in Penrith, and this has been expanded to two sessions on occasions, in order to cope with the demand at these times.

The number of new referrals has increased in 1972 to 80 (there having been approximately 60 in 1971), almost equal numbers having been referred by General Practitioners and by Local Authority sources. (This figure does not include the cases, numbering approximately 50, seen at Mill House).

As usual, the appointment failure rate has been quite high, 406 appointments having been kept out of 473 offered.

Throughout 1972, 2 sessions weekly have been conducted at the West Cumberland Hospital, Whitehaven, augmenting the service provided at Flatt Walks clinic by Dr. J. R. Burgess.

Patients were referred from the Southern and Western Areas and informal contact was made with the appropriate Educational Psychologist when necessary. This has, however, been more difficult than has been the case in the Northern Area, for various reasons. It becomes increasingly clear that a satisfactory Child Guidance Service cannot be developed in the West of the county on a part-time basis by someone based, and heavily committed clinically, in the East.

Circumstances are likely to change a little during 1973 when the Child Guidance Clinic at Ashfield School, Workington (being built by the Education Department) comes into operation. It is likely that one of the sessions at present being conducted at West Cumberland Hospital will be transferred to this Clinic where all referrals from the present Western area will be dealt with.

During 1972, the service continued to be handicapped by the lack of psychiatric in-patient facilities, difficulty being encountered particularly with children in the 12-16 year old group. Such children are often too difficult or too old to be managed in the Paediatric Ward but are still too young or immature to be admitted to adult in-patient facilities. It seems unlikely that there will be any change in this situation during 1973, though in-patient accommodation is planned in the Cumberland Infirmary development.

During 1972, a relatively small number of County children have been treated in the available in-patient facilities and a further, similar number have been placed in residential educational situations.

As in 1971, there have been regular weekly visits to Mill House Assessment Centre for the purpose of providing psychiatric reports on the children where appropriate, with additional broader involvement in the assessment procedure.

In 1972, weekly visits to Edmond Castle School have been carried out so far as has been possible, the emphasis having been on involvement in staff meetings rather than on interviews with individual boys."

As indicated above, Dr Ferguson was succeeded during 1972 by Dr. R. Short as Medical Administrator, Dovenby Hospital, and the latter has continued Dr. Ferguson's child guidance clinics. For 24 years Dr. Ferguson has taken a keen interest in child guidance work in West Cumberland and has conducted clinics for the education authority in Maryport, Workington, Whitehaven and Millom. Many children and parents over these years have had ample reason to be grateful to Dr. Ferguson for his wise and patient counselling and he will be very much missed. All will wish him a full and happy retirement. To Dr. Short we give a sincere welcome to Cumberland. I am already fully assured he will be a highly valued specialist member of the professional team which together works for the help of the psychologically dis-advantaged child.

It will be apparent from the figures in Table on P. 50, when compared with recent years, that there has been a falling off in referrals to the child guidance clinics in West Cumberland which are in the historical succession of the earliest education authority clinics. This is no doubt due to some extent to a shift of emphasis towards the clinics run at, or in conjunction with, West Cumberland Hospital by the consultant psychiatrists there. I am going into this further with the school medical officers and will be keeping the situation under review with the specialists concerned.

We look forward to the opening, during 1973, of the small child guidance unit in Workington to which Dr Wood makes reference in his report and which featured also in this report last year. A sketch plan of the unit is included as Appendix 'G' to this report. The small tutorial unit in Workington which is accommodated in a converted house has already proved most helpful as a day education unit for certain disturbed children in the area.

CHILD GUIDANCE CENTRES — STATISTICAL RETURN FOR THE YEAR ENDED 31-12-72

STAFF:	Northern Area: Dr. J. Wood, Dr. H. Blair-Hood, Mr. P. Thatcher	Maryport: Dr. R. Short, Mr. K. G. Hare	Workington: Dr. R. Short, Mr. K. G. Hare	Whitehaven: Dr. R. Short, Mr. S. Butterfield	Millom: Dr. R. Short, Mr. S. Butterfield	Total
Cases remaining on register at 1st January, 1972	122	25	142	114	39	442
New cases referred during year by:—						
Consultants or General Practitioners	35	1	2	—	8	46
School Medical Officers	7	—	2	—	5	14
Children's Officers	6	—	2	—	2	10
Parents	2	—	1	—	1	4
Schools	27	—	—	4	4	35
Probation Officers or Courts	2	—	1	—	—	3
Others	1	—	—	—	—	1
Cases re-opened during the year	—	—	—	2	3	5
Total cases on register during year	202	26	150	120	62	560
Cases dealt with and closed	—	1	3	36	5	45
Cases remaining under treatment on 31st December, 1972	195	25	147	84	56	507
Cases awaiting treatment on 31st December, 1972	7	—	—	—	1	8
	202	26	150	120	62	560
Interviews by Psychiatrists	406	7	30	76	38	557
Interviews by Social Workers	220	—	—	—	—	220
Interviews by Educational Psychologists	104	10	59	93	46	312

CHILD-GUIDANCE REGISTER 1968 - 1972

		1968	1969	1970	1971	1972
Total on Register during year	East	70	84	114	128	202
	West	618	208	252	338	358
		688	292	366	466	560
Total new cases during year	East	39	56	65	64	80
	West	113	76	77	90	38
		152	132	142	154	118

HANDICAPPED PUPILS

Continuing the emphasis of recent years in this field on co-ordinated assessment work amongst young children, I am glad to report that the area-based joint Panels on young handicapped children have proved very successful and the area medical officers comment briefly on these for 1972. It is very encouraging too to be able to include the comments of the Director of Education as representing the evaluation of these activities by his staff who attend. Mr Bessey writes:-

"With the diversification of responsibility for severely sub-normal children in 1971 arising from the transfer to the Education Department of junior training centres and the setting up of the Social Services Department, it was most important that the work previously carried out by the Health Department and now shared by three departments, should be co-ordinated and the level of assistance to parents and children maintained. To meet the needs of the pre-school child three inter disciplinary area groups were set up involving members of the three departments and also specialists in paediatrics and subnormality from the regional hospital board.

These regular meetings in each area have helped to provide a co-ordinated approach to the development of the whole child so that an overall awareness of the needs and difficulties of parents and children is available. The Educational Psychologist, for example, comes into contact with the child at an earlier age and with the help of colleagues parents are advised on how they can help their child educationally before he begins school.

One of the major benefits of these meetings is the early awareness of children who appear to be developmentally retarded but for whom an initial placement in a special school

is not considered appropriate. With this early knowledge it is possible to provide pre-school experiences in play groups or nursery classes where these exist. The infant school is also helped with the knowledge of the child beforehand thus allowing provision to be made for him if possible.

The importance of the group meeting is perhaps emphasised once the child enters special school when the level of communication is increased to bring in the head of the school and the overall progress of the child can be considered by all members. Such meetings help to provide additional support and guidance where this is required.

The panel meetings therefore fulfil a number of roles providing not only information and awareness from an early age but also a stimulus to action to meet the needs of the child and his parent, through the range of facilities which are available involving a continuous line of communication and corporate involvement."

And from the northern area, Dr Connolly comments:-

"Case conferences have continued on mentally handicapped and potentially mentally handicapped children.

During 1972 there have been meetings of the group each term at the Wigton Special School.

The Area Social Services Officer or his representatives, the Head Teacher of the Special School and the Educational Psychologist, the Consultant Paediatrician and the Area Medical Officer, have attended on each occasion. Some meetings have been attended by the newly appointed Consultant Psychiatrist and Medical Administrator at Dovenby Hall Hospital, Cockermouth (Dr R. Short), the Peripatetic Teachers of the S.S.N. children, the Matron of Orton Park Hostel and others who have made valuable contributions to the discussions.

Case conferences of this nature make real and viable discussion possible; a firm decision as to future action usually follows careful and considered assessments by everyone concerned - all to the benefit of the patient.

Apart from dealing with specific children and their problems, a great deal of co-ordination of action for mentally retarded children in general has come out of these meetings."

Similarly, Dr. Marks, Southern Area Medical Officer, writes:-

"During the year, we again held four case conferences to discuss this group of children.

The whole case load is divided into groups according to which general practitioner is involved. Each child, regardless of age, is reported upon and discussed at least once a year. These meetings are attended by the Paediatrician, representatives from the Family Health Care team and the three local authority departments of Health, Education and Social Services.

When we first held these case conferences, the need to discuss school placement for the oldest children had priority, but now all ages are considered at the meetings. This is helpful to both the Education and Social Services departments, especially when there has been a diagnosed severely sub-normal case who will need to be 'ascertained' in due course. This is one way of giving information to the other departments about the existence of such a child. The Director of Education does need this early information for future planning of special schools. Amongst the under fives there are ten probable severely sub-normal children and twenty-seven potentially educationally sub-normal children.

The Director of Social Services can also make forward plans to give the maximum help possible to this handicapped group of persons when they are children and then young adults."

It has become apparent at these meetings that there is ample scope for the consideration of the whole range of handicapping conditions in children, although the initial emphasis was on mental handicap.

Such activities on this fit in well to a developing pattern of services for these children and during 1972 real advance has been made by the hospital service in this field. This concerns the establishment at Cumberland Infirmary, Carlisle of an assessment centre attached to the paediatric department; and the fixing into the plans of the Special Area Committee of a similar unit for West Cumberland Hospital. These should develop on the focal points of specialist medical assessment work on handicapped and potentially handicapped children and increasingly draw together a wide variety of specialist professional disciplines into a truly multidisciplinary assessment activity.

I am grateful to Dr Elderkin, Consultant Paediatrician, Cumberland Infirmary, for the following note on the early days of the assessment centre.

"In May 1972 extensions to the Children's Out-Patients at the Cumberland Infirmary were opened as the first step towards the establishment of an Assessment Centre. The Centre provides accommodation for Dr Wood, the Child Psychiatrist and his Psychiatric Social Worker, and it is hoped eventually to recruit a Clinical Psychologist to complete this team. At the moment Joint Clinics are held to include the Paediatrician, Orthopaedic Surgeon and Physiotherapist, and it is hoped that multi-disciplinary assessment of children with complex disorders will increase."

With the increasing survival of children suffering such disability conditions as spina bifida, the management of the wheelchair case in school will become an increasingly familiar problem to teachers. This is, however, a limited problem since we know from overall national statistics that the maximum number of such children in this category in Cumberland schools at any one time is not likely to exceed 25. This does call for careful planning of appropriate school alterations as affected children appear in different situations and further discussion has taken place recently with the Director of Education on this matter. The increasing readiness of schools' staffs to deal with the complicated management of some of these children is very gratifying and I am indebted to Mr R.W.Jones, Headmaster of Silloth Secondary School, for the following note on the aspects of this problem which have affected him and his staff recently. The photograph on page 58 is of a child attending this school.

"Louise Lee is a Spina Bifida child whose handicap is sufficiently severe to justify special educational arrangements. Her parents were averse to the idea of her leaving home at eleven years of age, so the Local Education Authority arranged for Louise to start her secondary education at this school - the only single storey secondary school within reasonable distance of her home - involving a journey of ten miles night and morning by special transport. The driver has to assist the child both into and out of the mini-bus (this will present greater difficulty as she gets older) and on arrival at the school she transfers to her wheelchair. Louise has complained about travel sickness from time to time and this, plus indeed any other illness which may occur

during the school day, does present a real problem because of her disability and our inability to either contact her parents or convey her home immediately.

The girls in her own age group have voluntarily arranged a rota to give Louise help in movement about the school during lesson and meal times. She can manage to go to the toilet herself. Ramps have been placed at all external doors where there are steps, and these have been the only structural modifications we have had to implement.

She participates in all lessons with the exception of physical education. Her lack of experience in many aspects of school work make real progress limited but from a social point of view she is able to gain considerably from her involvement in most activities experienced by normal children."

The head of the domestic science department at the school also writes:-

"Teaching Louise Home Economics is not such a great problem. We are fortunate that our room is sub-divided into small kitchen units, one of which has a small dining table on which she can work. She can manage quite well sitting on a stool or chair. In that unit equipment is near at hand; the cooker has a pull-down door which is an advantage for her as the dish she is cooking can rest on the door when it is being put in or taken out.However she does find the height of the cooker a problem when wanting to use the hot plates or burners. It is easier for her to use a gas cooker because the controls are at a lower level. The height of the sink unit is also a problem; she does have difficulty in reaching the taps.

Actually preparing dishes is no problem to her, and she can work quite well sitting on the stool.Here other members of the class are most helpful and assist her when necessary. In our situation it is more convenient for a member of the class to take the ingredients to Louise and allow her to weigh them herself.

The emphasis should be on creating a realistic situation; individual kitchen units within the room are an essential to enable the child to work in a 'home type' atmosphere. We do find that the wheelchair which Louise has at present is rather large and does take up a lot of classroom space. She comes into the room in her chair and then manages to get from that to the stool. Her walking sticks are then

needed but she tends not to use them.Within the kitchen unit she can work her way quite easily from one piece of equipment to another. I think credit should be given to other members of her form who help her a great deal during the practical lesson.

She seems to enjoy the practical side of the subject enormously and her dishes are of an equal standard to the others in the class. Obviously because of her disability she works at a slower pace."

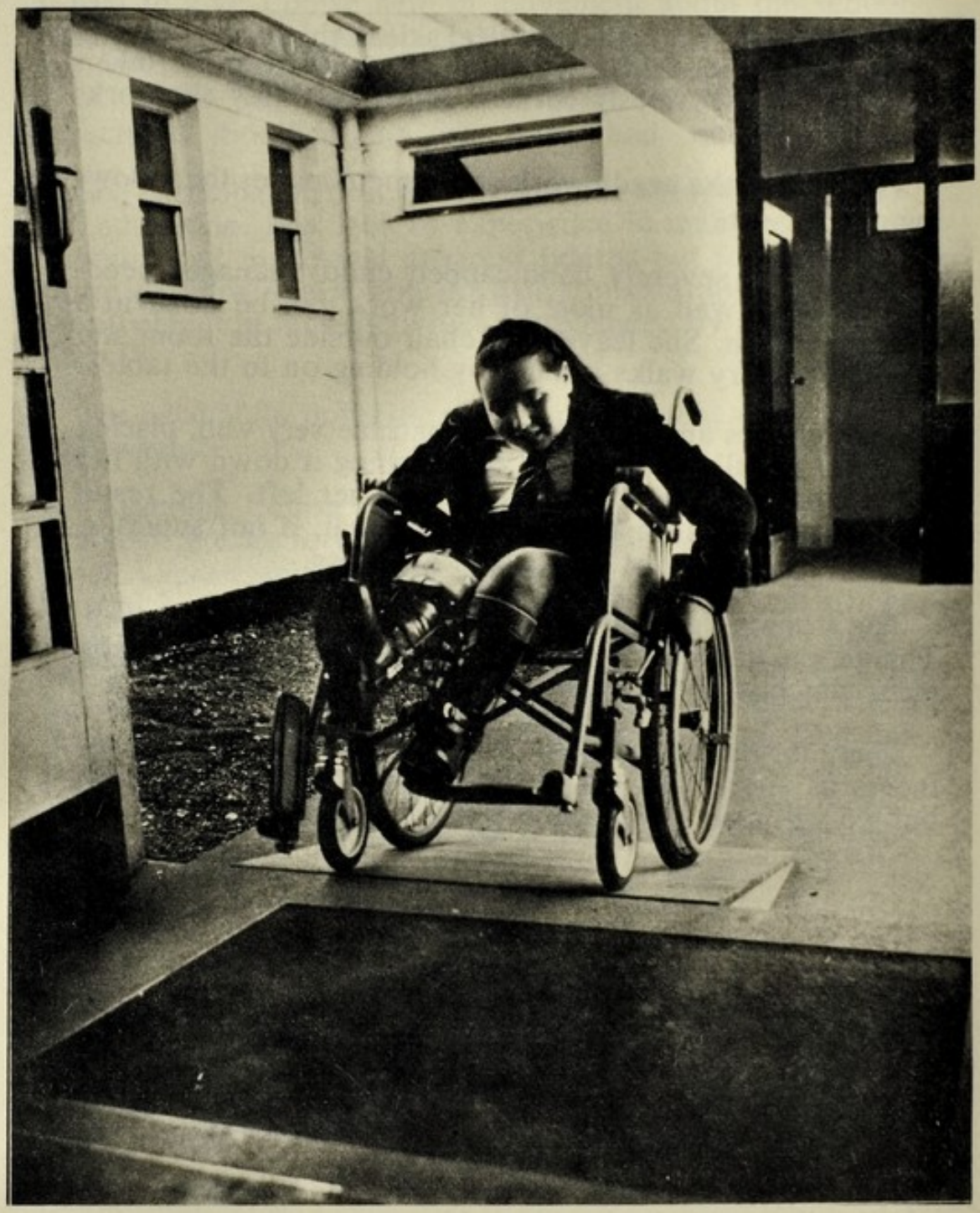
The head of the needlework department makes the following comments:-

"Louise, a severely handicapped child, manages needlework fairly well as most of her work can be done in a sitting position. She leaves her chair outside the room and when necessary walks around by holding on to the tables.

She manages an electric sewing machine very well, placing the 'foot pedal' on the table and pushing it down with her right hand, guiding the material with her left. The result she achieves in straight stitching is equal, if not superior, to that of the rest of the girls in her class.

The ironing board is rather high but she manages well. The girls in her class help her by bringing to her any equipment which is not to hand.

There is still the problem of Louise cutting out large garments as she is not tall enough to stretch over the table but we will meet this difficulty when it arises."



PHYSICALLY HANDICAPPED CHILD IN A COMPREHENSIVE SCHOOL

On the same topic, Dr McMillan, Medical Officer in Department, Southern Area, also writes:-

"The admission of children with fairly severe physical handicaps to normal schools has continued in this area, and has many arguments in its favour as the alternative is residential schooling in another area.

It is however, becoming increasingly apparent that some schools are less suitable structurally for children in wheelchairs or with calipers etc., and would be more expensive and difficult to modify than others. Although ideally such children would attend their local school with their neighbours and friends, it could be argued that there is a case in the future for modifying specific schools at each level of education, and providing transport for all handicapped children to attend a given sequence of schools from infant to secondary level."

On a more general plane, Dr Connolly writes below on the rather routine but extremely important matter of records and information on handicapped children which is kept under constant review by the Area Medical Officers:—

"During the year, there have been, as in previous years, several enquiries as to statistical facts on groups of handicapped children.

A new card system has been devised to give the facts about these children in a rapid, reliable way. All handicapped and potentially handicapped children are represented in these records and Areas' epidemiology of handicapping conditions in school children has been clarified.

All handicapped pupils' records have been reviewed during the year and in many cases the 'bring forward' or progress dates have been reviewed. General reporting has been stepped up on these cases and consideration has been given to the earlier informal notification of defects to educational staff, particularly with regard to those children not yet enrolled at school."

Owing to the raising of the school leaving age there were no handicapped leavers' case conferences during 1972. When these are resumed in 1973 they will have the added significance of the new links with the Department of Employment through the Employment Medical Advisory Service.

Children Suffering from Cerebral Palsy

The numbers in this category at 31st December, 1972, are as follows:—

Numbers of spastic children of school age:—

North Cumberland	13
South Cumberland	25
West Cumberland	12
	50

These may be divided into those:—

(a) Attending ordinary school	30
(b) Attending Percy Hedley School for Spastics, Newcastle	2
(c) At Residential Schools for the Physically Handicapped	3
(d) At Residential Schools for the Educationally Subnormal	—
(e) Attending Special School	11
(f) At Prudhoe Hospital	—
(g) Having home tuition	—
(h) Not attending school, not having home tuition	1
(i) Irton Hall	1
(j) Special Care Unit	2
	50

In addition:—

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

North Cumberland	1
South Cumberland	1
West Cumberland	1
	3

Handicapped Pupils in Special Schools on 25th January, 1973

		Boys	Girls
1.	**Physically Handicapped**		
	Pendower Hall School, Newcastle-upon-Tyne	—	1
	Irton Hall, Holmrook, Cumberland	6	—
	Percy Hedley School, Newcastle-upon-Tyne	1	1
	The Cedars Special School, Gateshead	—	1
	Lord Mayor Treloar, Froyle, Alton, Hants.	1	—
	H. K. Campbell School, Carlisle	2	1
	Moss Brook School, Norton, Sheffield	1	—
		11	4
2.	**Deaf**		
	Royal Cross School, Preston	1	5
	Northern Counties School, Newcastle-upon-Tyne	8	2
	St. John's School, Boston Spa, Yorkshire	—	1
		9	8
3.	**Partially Hearing**		
	Royal Cross School, Preston	—	1
	Northern Counties School, Newcastle-upon-Tyne	—	1
	School for Partially Hearing, Birkdale, Southport	1	—
	St. John's School, Boston Spa, Yorkshire	1	—
	Bridge House School, Yorkshire	1	—
		3	2
4.	**Blind**		
	Royal Normal College, Shrewsbury	2	—
	Worcester College for the Blind, Worcester	1	—
	Exhall Grange, Warwickshire	1	—
		4	—
5.	**Partially Sighted**		
	Derby School for Partially Sighted, Fulwood, Preston	—	1
	St. Vincent's School for Blind and Partially Sighted Children, Liverpool	—	1
	East Anglian School for Deaf and Partially Sighted Children, Great Yarmouth	2	—
		2	2

		Boys	Girls
6.	**Maladjusted**		
	St. Peter's Convent School, Wakefield, Yorkshire	—	1
	Camphill (Rudolf Steiner) Schools, Bieldside, Aberdeen	—	1
	Monken Hadley School, Corsbie, Newton Stewart, Wigtownshire	3	—
		3	2
7.	**Epileptic**		
	David Lewis Epileptic Colony, Warford, Cheshire	1	—
	Chilton School (Maghull Homes for Epileptics), Maghull, Liverpool	—	1
		1	1
8.	**Educationally Sub-normal**		
	Higham School, Bassenthwaite Lake, Cumberland	—	32
	Ingwell School, Moor Row, Cumberland	65	—
	Hensingham Special School, Moresby Road, Whitehaven, Cumberland	34	27
	Hensingham Special Care Unit	10	6
	Wigton Special School, Birdcage Walk, Wigton	26	13
	Wigton Special Care Unit	4	4
	Dovenby Hospital Special School, Dovenby, Cockermouth	30	17
	Allerton Priory R.C. Special School, Woolton, Liverpool	—	1
	James Rennie Special School, Carlisle	3	3
	York Day Special School, Carlisle	—	2
	Sunfield Children's Homes, Stourbridge, Worcestershire	—	1
		172	106
9.	**Delicate**		
	Windlestone Hall School, Rushyford, Co. Durham	1	—
		1	—

Educationally Subnormal Pupils

This section of my report was considerably longer than usual last year because of the changes which had taken place in the responsibility for the educational care of the more severely handicapped children in this category. The heads of the three 'special schools' (previously training centres) reported on their initial reactions to the changes. From the point of view of the school health service these changes have in no way adversely affected the health care of the children or the part which the school medical officers play in the continuing care of their mental development.

Last year the Director of Education contributed to this report at this point an account of forward plans for a further junior unit for educationally subnormal and severely subnormal pupils in Penrith, and I am glad to know that thinking is now towards the provision also, as soon as possible, of two day units for E.S.N. children attached to **secondary** schools in West Cumberland. I am sure this will provide a vital complement to the facilities at the residential schools at Ingwell and Higham, soon to be merged at Ingwell.

Another advance which will, I am sure, have far reaching benefits for the more severely mentally handicapped child is the appointment of two part-time peripatetic teachers to visit appropriate children at home where attendance at special school has not yet become possible for any reason. The contribution of these teachers has already proved most valuable in the panel meetings on mentally handicapped children.

The acceptance for service planning of mental handicap as a spectrum of handicap, including the educationally subnormal and the more severely subnormal, makes it appropriate to refer here to the publication early in 1972 of "Better Services for the Mentally Handicapped", a Government White Paper looking into the future of all provisions for this handicapped group. Arising out of this report two conferences have been held of education, social services and health department officers, together with interested hospital colleagues. This promises to lead to fruitful joint planning in various areas of services, particularly in the matter of day care for the grossly handicapped child. Strictly speaking, these children are the responsibility of the education authority for the provision of education, yet clearly the latter term is in a very special context for some quite helpless (mentally or physically) children. Nursing care certainly has to feature largely in their case and there is always some danger that

hospital and education authorities might fail to adequately co-ordinate their efforts and plans for this group. It is to the avoidance of this that discussions are taking place between local authority and **hospital** authority personnel.

I have already referred, in the context of the child guidance service, to the advent of Dr R.Short, Consultant Psychiatrist and Medical Administrator at Dovenby Hospital. I look forward to Dr Short playing a leading role in all of the future plans for the mentally handicapped in this area.

2 H.P. Examinations completed in 1972 under Section 34 or 57

Recommended Special School — E.S.N.	41
Recommended Special Class — E.S.N.	34
Reported unsuitable for education at school	1
No special educational treatment required	12
Decision deferred	9
	97
Number of boys on waiting list for Ingwell School	53
Number of girls on waiting list for Higham School	13

New Cases Referred in 1972

Placed under supervision for further investigation of intellectual capacity	53
Referred by:—	
School Medical Officers	10
Pyschologists and Teachers	43
Consultants and Hospitals	—
Health Visitors	—
Others	—
	53

DENTAL SERVICE

During the year two resignations of dental officers have occurred and we are now requiring two new ones to fill the vacancies. Unfortunately both appointments are in the West and South of the county and coverage of Maryport is almost impossible to arrange.

A dental auxiliary started work in Carlisle and Penrith areas and is proving a great asset to the authority. At present she is devoting her time to clinical dentistry, but it is hoped to start her on dental health education work in the near future. Application has been made to the New Cross School for another auxiliary for 1973 to work in West Cumberland. Having proved their value, one feels that an extension of their services would be good for the community.

It is a pleasure to welcome Dr. Scott Harden, consultant radiologist, to be adviser to the County on radiation hazards. Cumberland has always done its best to provide the fullest protection possible to both patient and operator in the dental clinics where X-Rays have been used and one can now be confident that the new code of practice will be implemented to the fullest extent. During periodic checks no operator has ever received a registrable amount of radiation when measured by a dosemeter.

Once more may a special plea be made for schools to stop selling cariogenic substances in their tuck shops. Everything is being done by means of fluoridation and education to reduce the caries rate, but it is an uphill task when schools encourage both bad eating habits (snacks between meals) and the wrong things to eat. If tuck shops continue in schools they should help the children and the dental profession by selling such things as nuts, potato crisps and fruit.

In looking forward to the future reorganisation of the National Health Service one can see many advantages to patients and also to those working in the scheme. Integration of services is a great step in the right direction and, as regards the school dental service, it will mean much closer liaison with the hospitals—if that is possible, as we already have such an excellent relationship. One sincerely hopes for more liaison with general dental practitioners. It is possible to envisage orthodontic clinics being held in areas such as Millom and a general raising of both standards and facilities. Although Cumbria becomes a fact on the 1st April, 1974, and the new Area Health Authority comes into being, it will be some years before all the problems are sorted out. Administratively Cumbria is a very difficult area because

of the geographical position and comparative isolation of some communities. Most people are convinced that many improvements can be made by employing resources to the full. Cumberland is the only local authority in Cumbria with a dental laboratory, so one can expect a large increase in the work load, especially regarding orthodontic appliances.

One area of the service which needs to be assessed carefully is the one concerning the mentally and physically handicapped. At present it is only in West Cumberland where a comprehensive service is in being. It is these patients who need and deserve the best possible conservative dentistry which can be provided, so that the possibility of them having extractions is reduced to a minimum, as many of them are totally unsuitable candidates for dentures. It is true that in many cases oral hygiene is of a very poor standard due to factors often beyond the control of even the most meticulous of parents, but even these could be helped if full facilities existed in each district for full conservative and prophylactic sessions under endotracheal anaesthesia.

More adequate provision should be made for the treatment of geriatric patients who live in private residences or old people's homes. Most general dental practitioners have surgeries upstairs and so, due to physical reasons, they are not able to attend a surgery for treatment. The hospital board has made provision for the treatment of the elderly in their care, but there are a great number of patients in urgent need of treatment who are unable to obtain it. Such problems as these could most probably be resolved by the Area Health Authority.

A visit was made to the County by Mr. Everett of the Department of Education and Science to inspect and advise on clinics and their equipment and also to discuss the work done by the dental staff for the year. In nearly all branches of treatment the authority was up to or over national average, but the quantity of pre-school treatment was very poor. This is expected to increase now that all three year old children are given the opportunity to be examined and their parents may opt for them to receive treatment at the clinics. Arrangements have been made to implement the suggestions for improving equipment and altering the consent forms to conform with the requirements of the Department.

I would like to end on a personal note and thank the matrons of many schools who have helped the dental service

so ably by assisting with dental health education work, trying to ensure a high standard of oral hygiene and, in many cases, seeing that dental appointments are kept.

Miss Ann Corkhill, B.D.S., Dental Officer at Cleator Moor and Salterbeck Clinics, writes:—

"The field of dentistry is undergoing a large number of changes at the present time. The changes include the attitude of the community. Although a comparative newcomer, I notice in three years a changing attitude to dentistry in the community I serve in West Cumberland. Parents are much more interested in the restoration of teeth rather than extractions and will readily accept more complicated and lengthy techniques to save permanent teeth. It may well be that the increased national health charges for dental treatment are making parents realise that regular dental treatment from an early age is desirable or it may be that more people are becoming affected by dental health education and wish to safeguard their children's teeth. The children themselves are very sensitive to their parents' feelings, and will readily accept treatments if their parents so wish.

Dentistry itself is changing. At present the trend is for more conservation than extractions, both of which are only remedial treatments after dental caries has taken place, but in the future techniques will depend on preventive measures with the ultimate aim of preventing caries. Fluoride is now widely recognised as reducing the incidence of caries and is being incorporated into our water supply. In the course of dental examinations I can see a marked improvement in the teeth of younger children in areas which have had fluoridated water for a number of years already. Unfortunately fluoride will not totally eliminate caries and work is now being carried out with sealants to coat fissures and cracks in teeth to prevent stagnation of food in these areas and thus prevent caries in those places.

Research has now isolated the organism responsible for caries, and it seems possible that future generations of children will receive vaccinations to protect them from caries, so that decayed teeth will become a thing of the past. In this event the need for dentists would not be eliminated — there would still be need for orthodontics and cosmetic surgery to improve the appearance of the teeth and also the treatment of gum conditions, which are in many cases precipitated by not cleaning teeth properly or not at all. This shows the increasing importance of dental health education not only in schools but also in the whole community.

This need not be confined to the dental surgery, but has to be backed up by all members of the family health team."

And from Penrith Mr. A. M. Scott, L.D.S., Senior Dental Officer, writes:—

"Children's teeth in Penrith and district show even more decay than 10 years ago. Although more teeth are being filled, it is still not possible to ensure that all pupils are dentally fit when they leave school.

Preventive dentistry must be practised whenever possible. Failing the major protective measure of a fluoridated water supply to create a more resistant tooth structure, other minor methods are being tried both inside and outside the surgery. Within the surgery the response to the inspection of 3 year olds has been encouraging, although the non-attenders may be the very ones most in need of early treatment.

Inhibition of caries in the fissures of pre molar and molar teeth by Fissure Sealants is being carried out in selected cases. Each tooth is cleansed, prepared, dried, and a type of resin applied, which is polymerized by ultra-violet light. This produces an extremely hard, but invisible shield over the area of tooth most at risk.

Preventive measures outside the surgery, where children must make a positive effort themselves to avoid caries and gingivitis (infection of the gums) is much more difficult. We endeavour to do this by visiting pupils in school, demonstrating plaque with disclosing tablets, discussing the evils of eating sweets and biscuits between meals and showing them how to brush their teeth correctly. A start was made on these lines by our previous dental auxiliary and head teachers very readily co-operated. We were recently joined by a new auxiliary, Miss Brydon, who is undertaking the major part of these preventive measures as well as helping with the practical dentistry. I hope head teachers will afford her the same facilities.

A most welcome late development (January 1973) is the opening of a new dental practice in Penrith and a start on modernising the surgery in Alston Cottage Hospital, where a general practitioner now visits once a week."

PREVENTION OF INFECTION

Arrangements for the call-up of children for vaccination and immunisation through the County Council's computer scheme continued satisfactorily throughout the year.

With the annual publication of the Community Health Immunisation and Vaccination Statistics by the Department of Health and Social Security concern was expressed by this authority that no account was taken of migration between authorities. Consequently, considerably lower results were being recorded for the county than was actually the case. It was stated that in the administrative county of Cumberland only 84% of those children born in 1969 were fully protected at the end of 1971. Computer records, on the other hand, confirmed that in fact 91% of those children born in Cumberland during the year were fully protected. It is hoped, however, that it will be possible to cope more efficiently with the problem of migration after 1974 on the basis of the new enlarged administative areas.

As forecast in last year's report, it is now possible to confirm that the proportion of children born in 1970 who are at present fully protected according to the vaccination schedule set out below stands at 91%.

Schedule of Vaccination and Immunisation Procedures

6 months	Diph./Tet./Pert. and Oral Polio
8 months	Diph./Tet./Pert. and Oral Polio
14 months	Diph./Tet./Pert. and Oral Polio
15 months	Measles
4 years 6 months	Diph./Tet. and Oral Polio

Diphtheria, Tetanus, Pertussis and Poliomyelitis

I show below the tables which have annually been shown of the actual numbers of protective procedures undertaken during 1972, the figures in brackets relating to 1971:—

Diphtheria Immunisation

The numbers of children immunised during the year were as follows:—

Primary Courses — pre-school children	3,048	(2,597)
Primary Courses — school children	287	(192)
Reinforcing injections — pre-school children	—	(57)
Reinforcing injections — school children	2,628	(2,678)

Tetanus Immunisation

During 1972 the following numbers of children were immunised:—

Primary Courses — pre-school children	3,048	(2,598)
Primary Courses — school children	316	(204)
Reinforcing injections — pre-school children	—	(67)
Reinforcing injections — school children	4,167	(3,304)

Whooping Cough Immunisation

The numbers of children immunised during the year were as follows:—

Primary Courses — pre-school children	3,048	(2,590)
Primary Courses — school children	18	(33)
Reinforcing injections — pre-school children	—	(46)
Reinforcing injections — school children	110	(333)

Poliomyelitis Vaccination

Primary Courses — pre-school children	3,075	(2,644)
Primary Courses — school children	332	(274)
Reinforcing injections — pre-school children	—	(26)
Reinforcing injections — school children	3,503	(3,121)

The increase in the numbers of children completing a primary course of vaccination and immunisation before starting school is most gratifying. No pre-school children were required to have a reinforcing injection.

Special point is given this year to these figures by the occurrence of several carriers of Diphtheria in the Northern Area of the county in November/December. An account of this is given by Dr. Connolly, Northern Area Medical Officer and Medical Officer of Health to the Border Rural District on page 73. From the point of view of immunisation figures the critical issue was the state of protection of the children attending the junior school concerned. It is highly gratifying that a close scrutiny of the immunisation records of the school population showed a fully up-to-date protection situation. Caution is always prudent in making claims in this field but it seems very reasonable to relate the early limitation of spread of this infection to the highly satisfactory protection state. The other message from the incident is more sombre. Diphtheria as a threat to child health and life is not dead and only the maintenance of a comprehensive

immunisation level in the child community will justify confidence in its limitation if introduced. The source of the infection in the carriers mentioned above was not discovered.

Measles

According to the current schedule of vaccination and immunisation procedures measles vaccination is recommended at 15 months of age. During 1972, 2,865 children were protected compared with 2,814 in the previous year. 93% of these children received their appointments through the computer call-up system.

During the year the possibility was raised of offering measles vaccination to 12 year old children in addition to the school entrants who have not already been vaccinated or have no natural immunity. In order to assess the need for such action it was agreed to conduct a pilot survey in the Cockermouth area of the county. Results showed that only 8% of the 12 year olds were at hazard and, therefore, it was decided to take no further action regarding vaccinating this age group on a county-wide basis.

Rubella

In 1970 the Joint Committee on Vaccination and Immunisation recommended that vaccination against rubella should be offered to all girls between their 11th and 14th birthdays, but that initially priority should be given to older girls, i.e. those in their 14th year. Supplies of vaccine, however, were not readily available until the beginning of 1971, when this authority commenced its programme of vaccination. During 1972, 2,378 girls received rubella vaccination — 144 more than in 1971. By vaccinating double year groups it is hoped that by 1974 the age at which rubella vaccination is offered will have been lowered to 11 years.

Tuberculosis

B.C.G. vaccination against tuberculosis was again offered during the year to 11-12 year old children. 3,915 children received a preliminary skin test and of these, 381, i.e. 9.7%, were found positive. The remainder who represent the majority susceptible to tuberculosis infection were offered B.C.G. vaccination, a total of 3,159 being, in fact, so protected. Twelve children were already under the care of the chest clinic.

Infectious Diseases

I am indebted to Dr. Connolly, Northern Area Medical Officer, for the following report:—

"1972 has been an eventful and interesting year in infectious disease epidemiology. There were two major incidents, both involving school populations:—

(a) In January, 1972, there was a case of smallpox in a 12 year old boy attending Ullswater Secondary School at Penrith.

On Friday, 28th January, the disease was diagnosed by the family doctor in Penrith and confirmed by the Smallpox Consultant, Langley Park Smallpox Isolation Hospital in Co. Durham was opened for the boy's immediate admission on that day. The disease had been contracted in Tunisia by a local boy on a short vacation, despite an up to date revaccination against smallpox. Apart from the usual family and community contacts, it was felt that the whole campus of pupils in the Ullswater (boys) school and nearby Tynefield (girls) Secondary Schools were at risk as the boy was at school whilst highly infectious for smallpox.

On Saturday morning, 29th January, a large group of people — medical, nursing and educational, met at Penrith Clinic and this team stayed fully operational until two weeks later when the likelihood of secondary cases had disappeared. This was very much a joint exercise involving the Penrith Urban District, Cumberland and Westmorland Counties and Penrith Rural and North Westmorland Rural Districts. One doctor described it as 'Cumbria in action'. Family doctors including retired colleagues, gave a great deal of assistance and the exercise was marked by a cheerful willingness to work hard and efficiently outside normal hours and with a disregard for normal employment boundaries.

The Youth Centre was offered by the Director of Education, as an Emergency Centre and being on the school campus, this offer was gratefully accepted. The Centre continued in use for the full fortnight.

One thousand three hundred pupils were vaccinated in the Ullswater/Tynefield Schools. This was the entire school population. Teaching staff were also vaccinated. A large number of people, including all the second year

boys, were placed under daily health surveillance and the Director of Education arranged for special transportation of these pupils on Saturdays and Sundays.

Two major problems during the fortnight were a large snowfall and the threat of electricity power cuts.

The end of the exercise coincided with the discharge from hospital of the smallpox patient. The boy was not seriously ill and made a good recovery and was re-integrated at once into school life.

(b) **Diphtheria:** Although there were no actual diphtheria cases, there was an incident in November/December involving five children, all carriers of diphtheriain the Houghton area, near Carlisle. Four of these were primary school children.

On the 14th November, a routine throat swab taken by a doctor showed the presence of the diphtheria organism in the throat of a girl aged 5 years. She was diagnosed a carrier of the disease. She attended the Houghton Church of England Primary School. Following the girl's admission to hospital and isolation of her family, one hundred and eighty children attending the school were examined and immunised against diphtheria. Swabs were taken from the nose and throat in each pupil. A similar procedure was followed with the school staff. Ultimately, the eight year old brother of the girl and another eight year old girl at the school, were also diagnosed as carriers along with a five year old girl and the sister of this 5 year old who was a pre-school child. Thus, a total of five children went into hospital, all as carriers of diphtheria and the three families involved went into temporary isolation.

The local village hall and the primary school, which is across the green, acted as centres for the swabbing and immunising work. The school staff and various voluntary workers who were involved at the village hall, provided tremendous assistance to the health team. It is a tribute to the work of local and more distant child health services that it was discovered that 100% of the children at the Houghton School had an adequate primary course of diphtheria immunisation. Especially so since this is, to some extent, a dormitory district for the City of Carlisle with quite a large movement of resident population. If this 100% protection had not existed, it is likely that under-immunised children might have contracted diphtheria.

Despite a great deal of investigation, no source of the diphtheria infection could be found."

CASES OF INFECTIOUS DISEASES IN CHILDREN AGED 4 - 14 YEARS, 1972

	Scarlet Fever	Whooping Cough	Measles	Dysentery	Acute Meningitis	Encephalitis	Acute Pneumonia	Food Poisoning	T.B. Respiratory	T.B. Meninges and C.N.S.	T.B. Other	Infective Jaundice	Diphtheria	TOTAL
URBAN DISTRICTS														
Cockermouth	—	—	3	—	—	—	—	—	—	—	—	—	—	3
Keswick	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Maryport	6	—	17	—	1	—	—	—	—	—	—	16	—	40
Penrith	1	—	2	20	—	—	—	—	—	—	—	—	—	23
Whitehaven	4	—	108	—	—	—	—	—	—	—	—	4	—	116
Workington	11	—	118	—	—	—	—	—	—	—	—	—	—	129
RURAL DISTRICTS														
Alston	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Border	—	—	8	—	—	—	—	—	—	—	—	2	2	12
Cockermouth	4	1	38	—	—	—	—	—	—	—	—	7	—	50
Ennerdale	1	—	75	1	1	—	—	—	—	—	—	3	—	81
Millom	—	—	9	—	—	—	—	—	—	—	—	1	—	10
Penrith	—	—	—	3	—	—	—	—	—	—	—	4	—	7
Wigton	3	—	72	—	—	—	—	—	—	—	—	12	—	87
TOTAL	30	1	450	24	2	—	—	—	—	—	—	49	2	558

SWIMMING BATHS

The Northern Area Medical Officer reports as follows:-

"During the year a very notable event has been the opening of the new swimming pool at Penrith. There have been no significant hygiene problems.

The Bath's Superintendent at the new Penrith pool is organising a handicapped children's swimming group in co-operation with the school health section and hospital and voluntary workers."

Writing about the Corporation Public Baths at Moorclose, Mr. Fogg, Chief Public Health Inspector, Workington, who supervises the hygiene on behalf of the Medical Officer of Health, comments:—

"Routine tests regarding the safety of the swimming bath's water were carried out, and in the main were found to be satisfactory. During the school summer holidays and due to the good weather, the learners' pool was being overused, but free residual chlorine levels were maintained, although at times low, and bacteriological tests carried out at this time showed negative for Coliform and Esch Coli. The pool water was also changed more frequently than usual.

There were a few individual complaints of sore eyes but as a system of recording chemical tests taken enabled the department to check the chlorine content and ph of the water at the time the complainant was in the pool, it was found in all cases that the cause of irritation was usually due to either excessive time spent in the water, or eye damage of poor resistance to chemical dosage levels below normal complaints level.

The overall hygiene of the baths was in the main satisfactory.

It was also necessary to recommend the removal of electric light switches from the shower area, and power points 6" above the floor from areas normally hosed down, to avoid a risk of electrocution; this work was carried out."

Of the fifteen samples of water taken from the Netherhall Schools Swimming Baths for bacteriological examination, only one sample proved to be unsatisfactory. A follow-up sample, however, was excellent.

Dr. H.M. Marks, Southern Area Medical Officer, reports that the hygiene standards in all the school pools in the southern area were well maintained in 1972

HEALTH EDUCATION AND THE WORK OF THE SCHOOL NURSE

Throughout the year school nurses and health visitors have been very active in promoting the health of school children. In the Southern and Western areas of the county, school nurses have undertaken the bulk of the routine school nursing duties which include screening procedures, regular health assessments and have assisted school medical officers at medical examinations and immunisation sessions.

Health visitors have maintained contact with head teachers who have appreciated their help and guidance on health and social problems. Close liaison has continued between the nurses and the school welfare officers.

During 1972 the rising incidence of head infestation caused national comment. School nursing staff, aware of this problem, have devoted much time to its control. The school nurses, based at Workington, report:—

"1972 was for us the year of 'malathion'. In the Christmas term we carried out an intensive campaign in view of the increase in actual head lice in relation to nits. Letters issued to parents in 1971 and early 1972 warning them of the situation seemed to have little effect in many cases even when followed up by individual health teaching to mothers who attended medical examinations.

Following routine health inspections in schools, a new instruction leaflet was given to every parent of an infested child. On completion of the treatment we followed up by examining the hair either in the clinic or in the home. All members of the family were encouraged to have treatment. This involved a great deal of extra work.

When parents did not co-operate warning letters were issued by the medical officer of health. It was necessary to exclude some children from school until treatment was concluded.

We find the younger school child becoming infested in the first instance by an older member of the family."

The introduction of the new treatment combined with continuing health teaching and the regular inspection of all school children gives rise to the hope that head infestation may be drastically reduced if not completely eradicated.

The vital role played by school nursing staff in the early detection of minor disorders through routine screening cannot be stressed too strongly. Testing of all 11/12 year old children for defects in colour perception is now in operation throughout the county. It is regretted that lack of staff has prevented the introduction of an annual vision test for all school children.

School teaching staff have again sought assistance from members of the nursing staff who have undertaken regular group teaching sessions on health and allied subjects. A total of 179 sessions were given during the year and it is interesting to note that head teachers are requesting our help with pupils of a younger age.

Mrs Sanderson, health visitor, Alston, has provided, in addition to her existing programme at Samuel King's School the following interesting programme for primary schools in her area:—

"Health Education Syllabus : Nenthead Primary School (7-11 yrs. old)

October	—	Care of the Teeth.
November	—	Good Diet for Healthy Bodies.
December	—	Prevention of Accidents in the Home. Film. (This film is also shown at Alston Primary School).
February	—	Personal Hygiene.
March	—	Care of the Body especially Feet.
April	—	"The Smoking Machine". Film. (This film is also shown at Alston Primary School).
May	—	First Aid — Bandaging, etc.
June	—	Swimming — Artificial Respiration — dangers of the countryside.
July	—	10-11 yr. girls. Menstruation. Having a Baby.

These talks are given on the first Tuesday in each month at 1.15 p.m."

Mrs Hewitson, health visitor, Workington, comments on her work:—

"Over the past year I have continued the courses on menstruation and personal hygiene, home safety, personal relationships and child care. All are very popular with the children.

I look upon the two courses on child care as the most important as all 14-15 year old girls at Salterbeck and Newlands Schools now do these courses.

At Salterbeck the course consists of five mornings and the pupils prepare a project book which I grade. This book is their housecraft project for the Certificate of Secondary Education.

At Newlands we do a much fuller course extending for varying periods over a full year. Seventy-seven girls took this course four failed, one was absent for the examination. This examination is the National Association for Maternal and Child Welfare.

Considering they are asked such questions as - 'The formation of a child's character happens naturally throughout a good upbringing. Discuss some of the important aspects of home life which influence character' , one feels very satisfied when the examiner's comment runs 'Exceptionally good work done by the majority of candidates and all did good work so that papers were a pleasure to mark. Love and understanding of children shown throughout, as well as very good knowledge of physical care. 'Of a less bright group the comment was 'steady, quite satisfactory work.'

A large percentage of these girls seem to get married and start a family one to two years after leaving school. I can only hope they put their knowledge to good use."

Miss Simpson, health visitor, Dalston, also prepared pupils for the National Association of Maternal and Child Welfare examination. Her syllabus included lectures on menstruation, human reproduction, pre-natal care, birth of a baby, post natal care and child management. Practical work was also included and covered bathing a baby and preparation of feeds. Visits of observation were arranged to a child health clinic, playgroup and day nursery. All the

girls were successful in passing the examination. Miss Hayes, Director of Nursing Services, who acted as examiner was impressed by the high standard achieved.

The national rise in the incidence of sexually transmitted diseases, especially amongst young people, has caused concern.

Mrs Parkinson, health visitor, Egremont, who has incorporated the subject in a series of talks comments:

"During the year I was invited to help with mothercraft classes at Wyndham School — the group, 14 years old, particular reference Family Planning and Immunisation.

After discussions with the teacher and in view of the present statistics, it was decided to include a talk on sexually transmitted diseases in the family planning talk.

I contacted the late Dr Bell who was very pleased that sexually transmitted diseases were to be discussed with this group — he provided some very useful material including booklets which had been produced for this age group. These were provided for use in class one week before the talk. Permission was requested from parents for their daughters to attend the class. It was interesting to note that there was only one refusal — this for a girl who lived with grandparents. The project was a success and the discussion group which followed showed that, not only had the information been needed but it had been understood.

This session was repeated at a later date with a larger, younger mixed group. I felt this was not successful, the children were too young to realise the social implications of sexually transmitted diseases and were too shy to join in any discussion. It was decided that in future the group should be smaller and not mixed."

At the Annual Educational Conference of the National Union of Teachers - Cumberland County Association - in Keswick in September, one of the courses offered was entitled "What Teachers should know about Drugs." This was the first time a course centred on a health education topic had featured on the conference programme, and it was undertaken by Dr. Terrell with some trepidation, ably assisted by Dr. A. J. Wood of the Health Education Council. The content and approach of the course was summarised as follows on the programme:—

1—Dependence in Society - Proportion and Perspective (i.e. Nicotine, Alcohol and other drugs).

2—Some fundamental issues involved.

3—Harnessing the teacher's existing knowledge and resources.

4—Audio-Visual Aids - a selection for appraisal.

5—Selective resource lists and materials.

Doctors and Nurses in the School Health Service in Cumberland will share in the talks, discussions and evaluation of materials.

The principal aims are to present and discuss some of the essential issues in health education on the addictive problems; and to explore the road towards an effective approach in schools."

Some 40 teachers entered for the course and most attended the majority of the sessions. These sessions were contributed to, most helpfully, by a wide range of professional colleagues from the professions of teaching, medicine, nursing and social work and the ready co-operation of police officers involved in the Cumbria Drug Squad was much appreciated. There seemed to be general agreement that a very useful insight was obtained by those teachers attending, into the attitudes governing the addictive problems of young people, and the approaches open to teachers to help in terms of both prevention and management of problems which have arisen. The essentially multidisciplinary approach to this type of problem was underlined.

It is hoped to arrange a similar course in 1973 though perhaps a little more widely based in health education topics.

DRUGS LIAISON GROUP

During the course of 1972 I had some discussion with the Chief Constable about the possibility of setting up a drugs liaison group in the county in order to bring together the various professional disciplines closely connected with the care and management of drug abuse, i.e. the drugs of habit formation and addiction. A meeting was called on Thursday, 30th November, 1972, at which representatives were present of doctors, the police, the Directors of Social Services and Education, the probation service and the pharmaceutical service. It was concluded that there would be benefit in such a group meeting regularly for a mutual exchange of appropriate information and the co-ordination of educational and other activities in this field, so that the various agencies concerned might be more mutually supportive in both prevention and treatment. At the meeting on 30th November, Dr. Terrell, Deputy County Medical Officer, was elected Chairman and Mr. N. V. Hutchin, Senior Probation Officer, as Secretary. The group is only concerned at present with the county of Cumberland since a very large body of people would have been involved if an attempt had been made to anticipate the whole Cumbria area, but clearly if the Committee proves helpful and generally successful it is anticipated that, in due course, it would be constituted on the basis of the Cumbria area which will be similar for local authority, health services, and police functions. I look forward to this group serving a more useful function in bringing together professional people with common areas of interest in this subject and yet with diverse responsibilities to the community and to individual persons. The legal responsibilities of the police and the personal care functions of doctors can readily come into some degree of conflict on this subject and I am sure that regular personal discussion of problems will be helpful here. It is already clear that the police in this area are deeply committed to preventive and remedial work in the management of drug offenders and a co-ordination of educational activities should prove very rewarding. At its second meeting, the group was honoured by the attendance of Judge R.R. Leech, judge of the Crown Court.

SCHOOL PREMISES

The undermentioned openings and closures were effected during 1972:—

Openings:—

Penrith, Wetheriggs Junior School

Seaton C. of E. Junior School

Moorclose Sports Centre

Tynefield and Ullswater Schools — Sports Hall

Closures:-

Penrith, County Girls School
Camerton Blanshard C. of E. School
Seaton St. Paul's C. of E. School
Talkin C. of E. School
Irton School
Whicham C. of E. School
Drumburgh School

The managers of Cleator Moor, St. Patrick's R.C. Junior School provided two temporary classrooms.

A large amount of minor capital improvement work was carried out to schools, the larger sites of which were:—

Warwick Bridge	Extensions and adaptations
Silloth Secondary	Adaptations to provide science lab.
Ewanrigg Junior	2 classroom extensions
Cockermouth Grammar	Instalment of adaptations
Hallbankgate	Internal toilets and adaptations
Penrith, County Infants	Scullery

Conversions were carried out to provide automatic central heating at Maryport C. of E. Junior and Infants and Moresby Schools.

Locally provided swimming pools were erected at Stainton C. of E. and Aspatria, Beacon Hill Schools.

MEDICAL EXAMINATION OF TEACHERS

Full medical examinations (including chest X-ray) are required for certain 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 24.

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 208 such questionnaires were completed.

In addition, 316 medical examinations were carried out of candidates for entry to teacher training colleges.

SCHOOL MEALS

The figures below show the number of day pupils taking a mid-day meal on a census day in October 1971 and October 1972. The charge for a meal was increased from 9p to 12p from the beginning of the summer term 1971.

Primary and Nursery Schools

Year	Number of Pupils Present	Number Taking Meals	Percentage Taking Meals
1971	21,566	17,664	81.9
1972	22,013	18,658	84.8

Secondary Schools

Year	Number of Pupils Present	Number Taking Meals	Percentage Taking Meals
1971	15,861	12,796	80.6
1972	15,933	12,988	81.5

All Schools*

Year	Number of Pupils Present	Number Taking Meals	Percentage Taking Meals
1971	37,520	30,551	81.4
1972	38,050	31,748	83.4

*Includes special schools

MILK IN SCHOOLS

	Oct. 1971	Oct. 1972
Pupils taking free milk on grounds of age, expressed as a percentage of pupils present**	88.2	91.1
No. of schools offering milk for sale:		
Primary	90	98
Secondary	11	8
No. of pupils buying milk:		
Primary	1,470	1,086
Secondary	142	72
No. of pupils eligible for consideration for free milk on health grounds (i.e. aged 7-11)	12,814	12,894
No. of pupils taking milk on health grounds (i.e. on Medical Officer's recommendation)	7	11
Percentage of pupils taking:		
Pasteurised milk	94	94.5
Untreated milk	6	5.5

**From September 1971 pupils have been entitled to free milk to the end of the summer term after they reach the age of 7.

APPENDIX 'A'

REPORT UPON PHYSICAL EDUCATION FOR THE YEAR ENDED 31st DECEMBER, 1972

The shaping, colouring and richness of the lives of our children in the years ahead will largely depend upon the co-operative efforts of both home and school. Parents are becoming increasingly aware of the contribution which physical education has to offer to the physical and social development of the child and of the need for their active support in the collective thrust which teachers are making, both in school and outside school hours, towards a satisfying and rewarding life. Here, physical education, as part of the broad spectrum of social education offers great scope for the promotion of physical wellbeing, social tolerance and understanding, individual or group participation and the development of leadership. Particularly during this year of "Sport for All" should we set our sights upon gearing the education system to produce the whole citizen — tuned for both work and leisure.

The advent of the nursery schools and nursery classes, plus the pre-school play groups, is welcomed, for now progression in physical education is complete: the play centred activity of these early years; the basic skill training of the primary school; the coaching, challenge and options of the secondary school and, finally, physical recreation in full measure at youth and adult level.

Swimming

The organisation of the Cumberland Schools' Swimming Association was changed this year and a Rest of Cumberland v Carlisle gala was substituted for the usual County gala. This meant that more children had experience of a competitive gala, and also that only competitors who were close to the standard lines laid down were taken to the Divisional Gala at Ellesmere Port on September 25th. A team of 17 swimmers were chosen and all managed to win through their heats to the final. As Division 2 is the most successful division at the National Championships, and the standard of swimming is very high, this was an achievement in itself. Four Carlisle swimmers, Leighton, Hurst, Wheeler and Sloane were chosen to represent the Division at the National Gala at Tynemouth in October.

Cumberland will shortly be leaving Division 2 and joining up with the North East. As this is a weaker division we may well have more representatives at the Nationals in future.

An A.S.A. Teachers' Course was held in Whitehaven at Overend School bath earlier in the year from April to June, run by the C.C.P.R.

Once again Helen Elkington visited the County. In May she took swimming coaching at Overend and Ehenside School baths. Synchronised swimming was introduced at Overend, for boys and girls together, and was a great success.

One new learner swimming pool has been completed in the County this year, at Stainton Primary School. A most successful swimming course was held at Stainton on Saturday, 1st July, in perfect weather, when Eddie Gorton, a National Technical Officer of the A.S.A. took time off from coaching "the possibles" for the Munich Swimming squad, in York, and came over to demonstrate methods of teaching swimming to primary school children of mixed ages and abilities. One group of non swimmers were all "off" at the end of their session. Mr. Gorton also spoke, and answered questions, after the practical work to a large number of teachers, and interested parents and children.

The A.S.A./E.S.S.A. distance certificates are still very much in demand and are awarded to children in vast numbers. To these certificates has been added, this year, a new version of the old County 1st Class Certificate, which has been brought up to date and includes some life saving.

Life Saving, personal survival and safety awards all form a very important part of swimming, and the Cumbria branch of the R.L.S.S. takes an active part in these activities. Among the members of the Committee are teachers, bath managers, policemen, and the women P.E. advisers from Carlisle and the County Education Authorities.

The Cumbria Branch held its Second Life Saving Competition in October at the new Penrith Swimming Pool where Mr. J. Muir, the bath manager, and his staff were most helpful. These competitions test the children on their knowledge of life saving and their ability and are not races.

The opening of the pool in Penrith has been of tremendous value to the schools in the town and surrounding district and many schools are now swimming for the first time. Mr. J. Muir teaches the primary school children and they have made wonderful progress. It is very quickly reaching the stage where all fourth year primary children will be swimmers before entering secondary school.

To the community pools at Lazonby, Brampton, Longtown and Cleator Moor has now been added Aspatria. In addition to offering a base for area school swimming instruction, these outdoor heated swimming pools, have already justified the sacrifice and effort shown by the communities in their determination to provide facilities for teaching basic aquatic skills and bathing. It is pleasing to record the voluntary work during public bathing sessions which now falls to officials of the amateur swimming clubs associated with the pools, and also to observe youngsters and families enjoying healthy sport from spring to autumn in a setting which is conducive to relaxation and leisure.

Association Football

The ability of pupils continues to improve and participation in the activities of the C.S.F.A. to expand, reflecting the widening interest and enthusiasm of boys and teachers. Four age groups are now covered by the Association. In the Under 18 Group two coaching courses were held, four county games arranged and the boys took part in the Festival of Football at Skegness. The Under 16 Group, in order to meet the needs of the raising of the school leaving age, have participated in the National Sponsored Pepsi Competition, a venture in which 30 schools took part. The Under 15 Group have also experienced a busy period with eight county games, two coaching courses and the Low Hamilton Trophy Competition. The Under 13 Group County Shield Competition attracted 32 schools and catered for some 400 boys.

Athletics

In cross country the girls' team retained the Minor Counties Trophy which had been won at Keswick last year. The boys' team experienced a poor season, losing two county matches and finishing low in the National Championships. These results were due to strong competition and insufficient regular training.

In athletics the county had an outstandingly successful year, beating Leeds in the intermediate age group, coming second in the National Championships Minor Counties Competition and gaining a number of gold and silver medals, and standard badges. The 58 points gained was the highest score ever achieved by Cumberland in the National Championships and was the direct result o the intensive training and coaching undertaken during and before the season.

The experiment in high landing areas at the County Sports Field undertaken by the Playing Fields Service has proved an economical solution to the problems of suitable landing areas for high jump and pole vault.

Badminton and Squash

These two court games are linked in this report to draw attention to two rapidly developing sports where, there exists close co-operation between schools and adult clubs. In the former sport, where the Authority's sports halls are used extensively for club purposes, the Cumberland and Westmorland S.B.A. has enjoyed an expanding and successful year. In addition to county junior and senior competitions, county fixtures and regular coaching sessions, the association entertained a Danish team and are also participating in the E.S.B.A. Award Scheme.

In the latter sport, where there has occurred an explosion of interest, courts are available for use by the Authority's schools at Brampton, Carlisle, Egremont, Wigton and Workington. Few teachers are trained to coach squash and the appointment of the national coach by the Squash Rackets Association will now rectify an urgent need in the county for pupils to be coached, particularly those who hope to proceed to colleges of further education where facilities for squash are most popular.

Cricket

The Cumberland and Westmorland Schools' Cricket Association have experimented with coaching of younger boys under the age of 13 years followed by an under 13 county game. On an Easter course the response from boys attending junior schools was most gratifying. At Under 15 level six county games were played and a week of cricket was organised during July to commemorate the 21st Anniversary of the Association. In the Senior Section nine county games were played and two boys were nominated for the E.S.C.A. Coaching Course at Crystal Palace during the Easter holiday. Teachers still express concern about the low standard of cricket facilities in schools and until these are improved it is unlikely that Cumberland boys will do themselves justice. Following the last report it is pleasing to record that Mr. G. W. Scott enjoyed a rewarding and successful term of office as Chairman of E.S.C.A., the first Cumberland teacher to hold this office.

Gymnastics

The boys Under 13 C.S.G.A. County Championships, held at the Nelson Thomlinson School, Wigton, in February,

produced a good entry. Generally standards were good and the competition close, with the Nelson Thomlinson School finishing in first place.

In December the Under 15 Championships were held at Caldew School, Dalston and the overall standard was rather disappointing. Moorclose School won both sections clearly.

The North Western Counties Champion School Competition was held at Dalston in April. Three County schools participated in this competiton which provided excellent experience for those involved.

There was a very good entry of schools for the girls Under 13 Championships which were held in February at Strand Road. The Over 14 Championships at Netherhall School in December were most impressive, with an excellent standard of competition maintained throughout the floorwork. This reflected the number of courses attended by teachers and gymnasts both in Cumberland and the North West Region. Certainly there is much greater coaching activity in the County than in previous years, with Mr. Birkhead, an international gymnast, a most willing coach and adviser.

In February, St. Aidans was the venue for the North West Individual Championships, where two Carlisle gymnasts were chosen to represent the North West in the National Championships. The North West Open Championships also proved very successful for Cumbrian Schools, where Harraby won the overall competition.

Hockey

Schoolgirl hockey has improved vastly in the County during the last twelve months thanks to the enormous encouragement given by their teachers.

The Open Hockey Tournament was held in Carlisle on February 12th, and was highly successful, due to excellent organisation. The White House School emerged as the champions.

Caldew School were the winners of the Open 1972/73 Tournament which was held at Egremont in November.

The two County Schoolgirl Hockey teams have enjoyed a very satisfactory season, and at the end of their tournament Cumberland shared top position with Lancashire and Northumberland.

Netball

The most outstanding event this season was the staging of the 2nd round of the National Schoolgirls' Tournament at Harraby School, Carlisle, when the two top teams in the Under 15 and Over 15 years Sections played against teams from the N.E. region, there being 12 teams in each section.

Cumberland also had two teams in the Inter County Tournament at Hull.

Our teams are playing very well in a new National County Netball League, and we hope the standard of play will be maintained.

An Umpires Training course was held in October, and the County Netball Tournament was held in November in Carlisle.

Rugby League

There were two highlights in the activities of the Cumberland Schools' Rugby League; the biennial visit of the Roanne (France) team upon a home-to-home exchange basis at Easter and the participation in the visit of the Australian Schools' Rugby League tour of Britain at Christmas.

In addition six county games have been arranged, regular coaching sessions have been organised and four boys played for England against France at under 16 level, a remarkable achievement for West Cumberland where this code of rugby is played.

Rugby Union

During the year the Cumberland and Westmorland Schools' Rugby Union have played no less than 16 County matches (15 and 19 groups) with 45 players from 16 schools being involved. Included in these fixtures were the self-supporting Easter Tour games in Leicestershire, (Nottinghamshire, Lincolnshire and Derby) and Cheshire, supported by six masters and 40 boys.

In addition to this programme and the domestic tournaments which occur regularly year by year the Union also organised on behalf of the R.F.S.U. the Northern Area 15 Group Trial. Three Cumberland boys were selected for this game and the same number for the 19 Group Trial played later in Leeds.

Some 15 teachers from the Twin Counties attended the second Area Coaching Course held at Durham University.

In the autumn the Cumberland and Westmorland R.F.U. Centenary Year brought the All Blacks to Workington for the match with the N.W. Counties. This game was attended by many teachers and schoolboys from both Counties.

The year ended on a high note with no less than 8 boys (plus two reserves) from Cumberland being selected to play in the 15 Group Northern Area Trial in Huddersfield.

Cumberland has always proved itself worthy of its reputation on the rugby field and again this year the standard of play reflects the high quality of coaching as well as voluntary effort which our teachers offer for Cumberland boys.

Table Tennis

The County Schools Annual Tournament was held in May at Overend School and was a great success, attracting individual boys and girls from all over the County. There is always great enthusiasm and support for this tournament.

Several coaching sessions have been held at Overend School during the year for children interested in Table Tennis from the Whitehaven area, taken by Mr. R. Rigg.

Boys and girls were selected to represent Cumberland in the County Junior Championships in February and after many years without a win, they beat Cheshire 2nd team 6 - 4. They also beat Durham 1st team by the same margin, for the first time ever, in December at Whitehaven.

Special mention must be made of the wonderful success of the Girls Under 15 team from Millom School who won the Northern Counties Schools Championships at Bishop Auckland, the North of England title at Bradford, and then went on to become the runners up in the All England finals at Stoke-on-Trent in May. This is an outstanding achievement and is due in no small measure to the efforts of Mr. J. Reed of Millom School.

Outdoor Pursuits

Cumberland is rich in natural resources and both primary and secondary schools continue to take full advantage of the facilities which the County offers for angling, camping, rock-climbing, canoeing, sailing, orienteering and ski-ing.

As a link with biology and environmental study six schools have taken part in an ecological survey of nursery streams coming within the jurisdiction of the Cumberland River Authority. As part of the project pupils undertook the re-

stocking of streams with sea trout and salmon as well as the tagging of migratory fish.

A number of schools encourage angling as part of the optional programme in physical education and it is hoped that this approach to ecology and fishing will encourage pupils to respect, understand and value their environment.

Full use has been made by the Schools Ski-ing Association of the artificial ski slopes at Cleator Moor and Carlisle; the skills learned on these nursery slopes, through coaching courses have been applied on the snow slopes of Cumberland, Scotland and abroad.

In June the English Schools' National Sailing Championships were held at Bassenthwaite Lake, the Cumberland Schools' Sailing Association being responsible for the organisation.

Canoeing, mountaineering and rock-climbing courses continue to be held for both pupils and teachers, and advantage continues to be taken of the many rock-climbing walls which have been pioneered and designed in Cumberland.

Cumbria Schools' Orienteering Association is now firmly established and arranged its first Annual Championships in Mitredale in May. It has also established a permanent training course in Setmurthy Forest near Cockermouth.

Recreational Facilities

Successful and satisfying participation in sport can only be achieved if the right quantity and quality of facilities are offered to the schools and to the community.

The year has seen the establishment of the Workington Sports Centre at Moorclose, administered by a Sports Director on behalf of a Joint Management Committee which has equal representation from Workington B.C. and Cumberland C.C. The centre comprises a sports hall, athletic facilities, hard porous area, playing fields, tennis courts, changing facilities and car park. A large swimming pool and learner pool, the property of Workington B.C., are also available adjacent to the centre. The facilities are used by two secondary schools during school hours and by the community at other times, thus offering a further example of joint provision and dual use for which Cumberland is well known and which is now being recommended by the Sports Council.

In accordance with policy established over the past 21 years the Education Authority has continued to provide secretarial and technical services for the Cumberland and Westmorland Playing Fields Association and grants are now available from the County Council for recreational facilities for adults and children at the rate of 10% of the capital cost up to a maximum of £2,000, for any one project. Attendant upon these services voluntary organisations in Cumberland have been awarded capital grants from the County Council totalling £550 during the year towards schemes costing £6,500. In addition, grants totalling £13,348 have been offered by the Sports Council towards schemes costing £44,116.

APPENDIX B

TABLE A—Periodic Medical Inspections

Age Groups inspected (By year of birth)	No. of Pupils who have received a full medical examination	Physical Condition of Pupils inspected		No. of Pupils found not to warrant a medical examination	Pupils found to require treatment (excluding dental diseases and infestation with vermin)		
		Satisfactory No.	Unsatisfactory No.		For defective vision (excluding squint)	For any other condition recorded at Part II	Total individual pupils
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1968 and later	348	348	—	—	3	41	44
1967	2178	2178	—	—	53	139	184
1966	1209	1209	—	—	35	91	112
1965	291	291	—	—	9	34	37
1964	1301	1299	2	1580	60	121	169
1963	216	215	1	102	14	14	26
1962	50	50	—	—	1	2	3
1961	209	209	—	452	12	18	30
1960	671	671	—	1697	32	22	54
1959	210	210	—	—	5	4	9
1958	1020	1020	—	—	12	6	18
1957 and earlier	319	319	—	—	3	—	3
TOTAL	8022	8019	3	3831	239	492	689

Table B—Other Inspections

Number of Special Inspections	116
Number of Re-inspections	4,154
	4,270

Table C — Infection with Vermin

(a)	Total number of individual examinations of pupils in schools by school nurses or other authorised persons	60,476
(b)	Total number of individual pupils found to be infested	1,004
(c)	Number of individual pupils in respect of whom cleansing notices were issued (Section 54(2). Education Act, 1944)	81
(d)	Number of individual pupils in respect of whom cleansing orders were issued (Section 54(3). Education Act, 1944)	1

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?	12.
(c) Are both boys and girls tested?	Yes.
4. (a) By whom is vision testing carried out? ..	School medical officers, school nurses and screening assistants.
(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 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	56
Errors of refraction (including squint) ..	1,837
Total	1,893
Number of pupils for whom spectacles were prescribed	1,279

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	29
(b) for adenoids and chronic tonsillitis	43
(c) for other nose and throat conditions	10
Received other forms of treatment ..	14
Total	96
Total number of pupils in schools who are known to have been provided with hearing aids:—	
(a) in 1972	12
(b) in previous years	80
Total	92

Table C — Orthopaedic and Postural Defects

	Number of cases known to have been dealt with
(a) Pupils treated at clinics or out-patients' departments	171
(b) Pupils treated at school for postural defects	1
Total	172

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	1
Scabies	29
Impetigo	15
Other skin diseases	10
Total	55

Table E — Child Guidance Treatment

	Number of cases known to have been dealt with
Pupils treated at Child Guidance Clinics	454

Table F — Speech Therapy

	Number of cases known to have been dealt with
Pupils treated by speech therapists	790

Table G — Other Treatment Given

	Number of cases known to have been dealt with
(a) Pupils with minor ailments	—
(b) Pupils who received convalescent treatment under School Health Service arrangements	—
(c) Pupils who received B.C.G. vaccination	3,149
(d) Other than (a), (b) and (c) above	—
Total (a) — (d)	3,149

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	5,438	5,566	1,407	12,411
Subsequent Visits	4,574	7,561	1,901	14,036
Total Visits	10,012	13,127	3,308	26,447
Additional courses of treatment commenced	118	126	63	307
Total courses commenced	5,556	5,692	1,470	12,718
Courses completed				7,206
Fillings in permanent teeth	2,692	10,004	3,378	16,074
Fillings in deciduous teeth	2,867	248	—	3,115
Permanent teeth filled	2,104	8,564	3,030	13,698
Deciduous teeth filled	2,665	231	—	2,896
Permanent teeth extracted	717	2,413	592	3,722
Deciduous teeth extracted	6,121	1,674	—	7.795
General anaesthetics	1,333	770	91	**2,194**
Emergencies	897	566	203	1,666
No. of pupils X-rayed				443
Prophylaxis				514
Teeth otherwise conserved				181
Teeth root filled				42
Inlays				5
Crowns				8

2. Orthodontics

New cases commenced during the year	145
Cases completed during the year	144
Cases discontinued during the year	30
No. of removable appliances fitted	402
No. of fixed appliances fitted	1
No. of pupils referred to Hospital Consultants	312

3. Prostnetics

	5 to 9	10 to 14	15 and over	Total
No. of pupils fitted with dentures for the first time:—				
(a) with full denture	—	—	3	3
(b) with other dentures	3	75	23	101
No. of dentures supplied (first or subsequent time)	6	131	53	190

4. Anaesthetics

General anaesthetic administered by Dental Officers	1,864

5. Sessions

	No. of clinical sessions worked in the year						
	School Service				M. & C.H. Service		
	Admin. Sessions	Inspections at school	Treatments	Dental Health Education	Treatments	Dental Health Education	Total Sessions
Dental Officers	350	284	3,181	14	156	—	3,985
Dental Auxiliaries	—	—	147	—	—	—	147
Total	350	284	3,328	14	156	—	4,132

APPENDIX C

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, 1972		(1) Blind (2) Partially sighted		(3) Deaf (4) Partially hearing		(5) Physically Handicapped (6) Delicate		(7) Mal-adjusted (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	1	1	5	30	1	—	40
	girls	—	—	1	—	3	—	4	21	—	—	29
B. How many children were newly placed in special schools or boarding homes?												
(i) of those included at A above	boys	—	—	1	—	1	1	4	9	1	—	17
	girls	—	—	1	—	2	—	1	8	—	—	12
(ii) of those assessed prior to January 1972	boys	—	—	—	—	2	—	—	17	—	—	19
	girls	—	—	—	—	—	—	—	6	—	—	6
(iii) TOTAL newly placed — B (i) and (ii)	boys	—	—	1	—	3	1	4	26	1	—	36
	girls	—	—	1	—	2	—	1	14	—	—	18

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

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
As at 25th January, 1972												
Awaiting places in special schools:												
(a) Under 5 years of age												
1. waiting before 1st January, 1972:—												
(i) day places	boys	—	—	—	—	—	—	—	—	—	—	—
	girls	—	—	—	—	—	–	—	—	—	—	—
(ii) boarding places	boys	—	—	1	—	—	—	—	—	—	—	1
	girls	—	—	—	—	—	—	—	—	—	—	—
2. newly assessed since 1st January, 1972:—												
(i) day places	boys	—	—	—	—	—	—	—	—	—	—	—
	girls	—	—	—	—	—	—	—	—	—	—	—
(ii) boarding places	boys	—	—	—	—	—	—	—	—	—	—	—
	girls	—	—	—	—	—	—	—	—	—	—	—
		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
(b) Aged 5 years and over												
3. waiting before 1st January, 1972:—												
(i) day places	boys	—	—	—	—	—	—	—	16	—	—	16
	girls	—	—	—	—	—	—	1	16	—	—	17
(ii) boarding places	boys	—	—	—	—	—	—	6	54	1	2	63
	girls	—	—	1	—	—	—	2	35	—	—	38

4. newly assessed since 1st January, 1972:—												
(i) day places	boys	—	—	—	—	—	—	—	3	—	—	3
	girls	—	—	—	—	—	—	2	6	—	—	8
(ii) boarding places	boys	—	—	—	1	—	—	1	18	—	—	20
	girls	—	—	—	—	1	—	1	7	—	—	9
5. Total number of children awaiting admission to special schools:—												
(i) day places	boys	—	—	—	—	—	—	—	19	—	—	19
	girls	—	—	—	—	—	—	3	22	—	—	25
(ii) boarding places	boys	—	—	1	1	—	—	7	72	1	2	84
	girls	—	—	1	—	1	—	3	42	—	—	47
6. Maintained special schools including attached units and hospital special schools:—												
(i) day	boys	—	—	—	—	2	—	—	91	—	—	93
	girls	—	—	—	—	1	—	—	63	—	—	64
(ii) boarding	boys	—	3	—	1	1	1	—	63	—	—	69
	girls	—	—	—	—	2	—	—	32	—	—	34
7. Non-maintained special schools including attached units and hospital special schools:—												
(i) day	boys	—	—	—	—	—	—	—	—	—	—	—
	girls	—	—	—	—	—	—	—	—	—	—	—
(ii) boarding	boys	3	—	8	3	1	—	—	—	1	—	16
	girls	—	2	7	2	1	—	1	1	1	—	15

8. Independent schools under arrangements made by the Authority:—												
(i) day	boys	—	—	—	—	2	—	—	—	—	—	2
	girls	—	—	—	—	—	—	—	—	—	—	—
(ii) boarding	boys	—	—	—	—	4	—	4	—	—	—	8
	girls	—	—	—	—	—	—	1	1	—	—	2
9. Special classes in ordinary schools (assume all day):—												
	boys	—	—	—	—	—	—	—	32	—	—	32
	girls	—	—	—	—	—	—	—	21	—	—	21
		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
10. Total on registers (6 to 9 above):—												
(i) day	boys	—	—	—	—	4	—	—	123	—	—	127
	girls	—	—	—	—	1	—	—	84	—	—	85
(ii) boarding	boys	3	3	8	4	6	1	4	63	1	—	93
	girls	—	2	7	2	3	—	2	34	1	—	51
11. Boarded in homes and not already included above:—	boys	—	—	—	—	—	—	—	—	—	—	—
	girls	—	—	—	—	—	—	—	—	—	—	—

12. 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	boys	—	—	—	—	—	—	—	—	—	—	—
	girls	—	—	—	—	—	—	—	—	—	—	—
(iii) at home	boys	—	—	—	—	—	—	—	9	—	—	9
	girls	—	—	—	—	—	—	—	7	—	—	7
13. Total number of handicapped children awaiting 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	3	3	9	5	10	1	11	286	2	2	332
	girls	—	2	8	2	5	—	8	189	1	—	215

APPENDIX D
SCHOOL HEALTH SERVICE CLINICS
AS AT 31.12.72

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

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

ASPATRIA:
- Dental — Each Friday — all day.
- Speech Therapy — Each Thursday a.m.

BRAMPTON:
- Dental — Each Tuesday and Wednesday — all day.

CARLISLE:
- Dental — Each Monday, Thursday and Friday — all day.
- Eye Specialist — Each Wednesday and Thursday a.m.
- Orthoptic — Each Wednesday a.m.
- Speech Therapy — Each Monday — all day.
- Orthopaedic Consultant — Mondays as required.
- Orthopaedic Aftercare — Each Wednesday as required.
- Hearing Tests — Each Tuesday — all day.

CLEATOR MOOR:
- Dental — Each Monday, Wednesday and Friday — all day.
- Speech Therapy — Each Tuesday p.m.

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

EGREMONT:
- Dental — Each Monday and Friday — all day.
- Speech Therapy — Each Friday — all day.

KESWICK:
- Dental (Hospital) — Each Thursday — all day
- Speech Therapy — Each Wednesday — all day.
- Hospital Eye Clinic — 1st Wednesday p.m.
- Orthoptic — 2nd Friday — as required.

LONGTOWN:
- Dental — Each Monday — all day.
- Hearing Tests — Each Friday a.m.

MARYPORT:
- Dental — as available.
- Speech Therapy — Each Monday — all day.
- Child Guidance — Alternate Mondays p.m.

MILLOM:

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

PENRITH:

Dental — 1st, 3rd and 5th Tuesday — all day; Each Wednesday, Thursday and Friday — all day.
Speech Therapy — Each Tuesday and Thursday — all day.
Orthoptic — Each Tuesday a.m.
Child Guidance — Each Monday — all day.

SALTERBECK:

Dental — Each Tuesday and Thursday — all day.

SEASCALE:

Dental — Each Thursday — all day.

SILLOTH:

Dental — Each Wednesday — all day.

WHITEHAVEN (FLATT WALKS):

Dental — Each Monday, Wednesday, Thursday and Friday — all day.
Whitehaven Grammar School — Each Tuesday and Wednesday — all day.
Overend School — Each Thursday a.m.
Child Guidance — Each Wednesday p.m.
School Clinic — Each Wednesday a.m.
Speech Therapy — Each Monday p.m.; Each Tuesday a.m. Each Wednesday — all day.

WIGTON:

Dental — Each Monday, Tuesday, Wednesday — all day.
Speech Therapy — Each Friday, 2nd and 4th Tuesdays a.m.

WORKINGTON (PARK LANE):

Dental — Each Monday, Tuesday and Thursday — all day; Wednesday and Friday by appointment.
School Clinic — 1st Wednesday and Thursday a.m.
Speech Therapy — Each Tuesday a.m., Wednesday p.m., Thursday a.m. and Friday — all day.
Child Guidance — Each Wednesday a.m.

WORKINGTON INFIRMARY:

Orthoptic — Each Monday and Wednesday — all day.

APPENDIX 'E'

HEARING TESTS— 5 year olds and other school pupils

1. ROUTINE EXAMINATIONS

		5 yr. old Entrants	Children born: 1966	1965	1964	1963	1962	1961	1960	Total
Children tested	N. Area	1127	159	65	50	46	44	21	156	1668
	S. Area	913	22	9	6	1	5	2	—	958
	W. Area	1251	56	6	1127	—	—	—	—	2440
	Total	3291	237	80	1183	47	49	23	156	5066
Children re-tested	N. Area	148	124	37	6	—	8	6	—	329
	S. Area	186	2	2	1	—	—	—	—	191
	W. Area	70	20	2	44	—	—	—	—	136
	Total	404	146	41	51	—	8	6	—	656

2. SELECTIVE EXAMINATIONS

Children tested	N. Area	—	131	85	72	58	35	50	201	632
	S. Area	—	111	98	105	49	57	34	55	509
	W. Area	27	40	29	5	16	5	24	43	189
	Total	27	282	212	182	123	97	108	299	1330

NOTE: This table will include cases referred by Teachers, Parents, General Practitioners, School Medical Officers and others.

3. **OUTCOME OF EXAMINATIONS (Routine group re-tests and selectives)**

		No Defect	Observation (School Medical Officer)	Family Doctor Treatment	E.N.T. Specialist	Total
Routine Group Re-tests	N. Area	173	152	4	—	329
	S. Area	89	480	—	10	579
	W. Area	69	45	8	14	136
	Total	331	677	12	24	1044
Selective Group	N. Area	351	246	4	31	632
	S. Area	77	34	—	10	121
	W. Area	161	16	5	7	189
	Total	589	296	9	48	942
					Grand Total	1986

4. Of the Grand Total of Table 3, 16 children from the Northern Area, 39 from the Southern Area and 2 from the Western Area were referred to the Peripatetic Teacher of the Deaf.

APPENDIX F

SUGGESTIONS FOR TEACHERS HAVING PARTIALLY DEAF CHILDREN IN THEIR CLASSES

1. The hard-of-hearing child needs a front seat, or a favourable position if the seats are not in rows. The nearer he is to the teacher the better he hears.

2. If the hearing is not equal in each ear, his better ear should be towards the teacher.

3. The child should have his back to the window and sit so that the teacher's face will be well illuminated.

4. The child should be encouraged to watch the teacher's face when the teacher is talking to the class.

5. The teacher should try to face the hard-of-hearing child as much as possible when speaking to the class. He should try to give important instructions from a position close to the child.

6. The child should be encouraged to turn round so as to see the faces of children participating in class activities. He should also be allowed to turn round when the teacher is not in front of him.

7. The teacher should not use loud tones or exaggerated lip movements in speaking to the child.

8. If a choice of teachers is possible, the hard-of-hearing child should be placed with the teacher who speaks slowly and precisely.

9. The child's hearing efficiency is apt to be overestimated because, when he pays attention, he apparently hears quite well. The teacher should remember that this child must use more effort to understand speech than the normally hearing child, and that his attention will be more difficult to hold.

10. The child should be encouraged to speak clearly; a hearing loss lasting for some time tends to result in a dull voice and inaccurate diction.

11. Interest in music should be encouraged, especially participation in vocal music.

12. Since a hearing loss is a defect which affects communication, the child should be encouraged to compensate by a more active interest in all language activities such as reading, spelling etc.

13. The child should be watched to see that he is not withdrawing from the group, and that he is not subjected to teasing or other unpleasant personal reaction to his impairment.

14. Any special attention to the hard-of-hearing child should be handled so as not to call attention to the defects.

15. Many hard-of-hearing children benefit greatly from using a hearing aid, but practice and training may be required before the full benefits appear.

16. Even with a hearing aid, all the above suggestions are still important.

17. A child who has been given an aid should wear it all the time during lessons unless other instructions have been given (e.g. not to wear the aid during sports or craft classes).

18. Most children now have post aural aids which are less conspicuous than the older type. Speaking quietly in the vicinity of the child will usually be all that is necessary to test the efficiency of the aid. If in any doubt, enquiries should be made about the efficiency of the batteries or mechanical function of the aid.

19. If a child is without his aid for more than three days, the teacher should ask him about it or let the teacher of the deaf know. In the event of breakages, there is a return service by first-class mail from the hearing-aid department of the Cumberland Infirmary which ensures that the child should not be without his aid for longer than this period.

20. The co-operation of teachers is invaluable in the service for hearing-impaired children.

    (a) any child suspected of having defective hearing, should be put forward for a hearing test when the Screening Assistant visits the school, or be listed for the health visitor's termly visit so that the health visitor can arrange a test.

(b) any child, known to have defective hearing, about whose progress (social or academic) the teacher is worried, should be referred to the teacher of the deaf.

If you need further information, please telephone or write to:—

JOHN CONNOLLY
Northern Area
Medical Officer

OR

OLIVE E. CRONIE
Peripatetic Teacher
of the Deaf

13/14 Portland Square,
Carlisle. CA1 1PZ

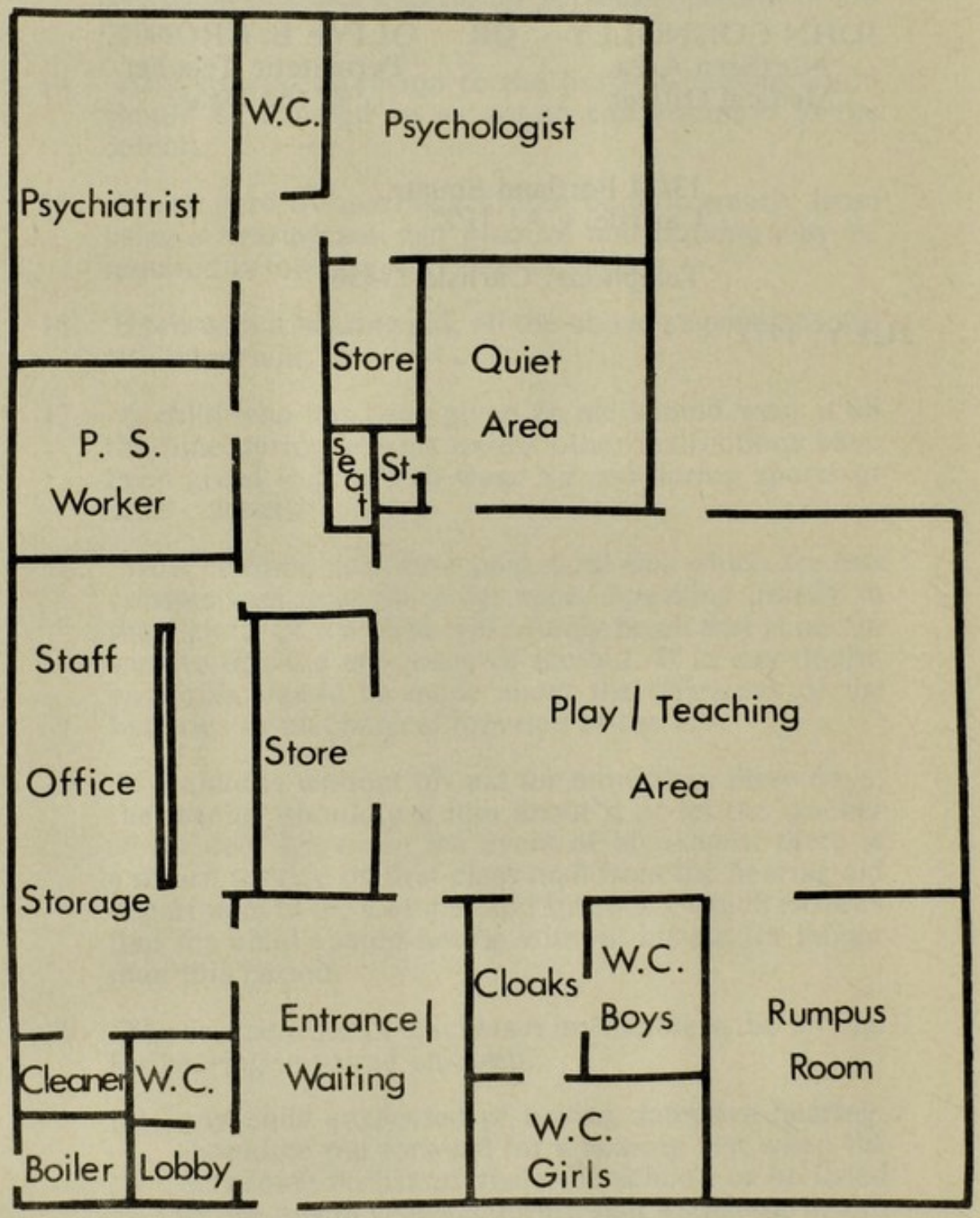
Telephone: Carlisle 23456

JULY, 1972

APPENDIX "G"

PROPOSED CHILD GUIDANCE UNIT

ASHFIELD, WORKINGTON



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