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THE HEALTH OF THE SCHOOL CHILD

IN DORSET

ANNUAL REPORT

of the

County School Medical Officer

for the year

1949

A. A. LISNEY, M.A., M.D., D.P.H.

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FOREWORD

In my Annual Report for 1948, I drew attention to the disturbing effect which the operation of the National Health Service Act had created by the disruption of the school dental service, and by the delay in the provision of spectacles for school children.

The school dental service was carefully built up over the past quarter of a century, with the result that we in Britain could justly claim that the facilities provided for supervision and conservative dental treatment were amongst the best in the world. This satisfactory state of affairs vanished within a short time of the inauguration of the National Health Service Act and the present position is nothing less than a disaster of very serious magnitude. The widespread deterioration in the condition of the teeth of our children which is now taking place will in time bring about a position which will be very difficult to tackle. Moreover, later in the adult life of those children who were deprived of preventive facilities during the past two years and, until the position can be retrieved, the constant attention which their teeth will require will throw an added strain on the private dentists.

As I pointed out in my last report the root of the trouble is that remuneration for private dentists working under the National Health Service Act was settled without any consideration whatever being given to salary scales for dentists working in the school medical service. The inevitable and natural consequence was that school dental officers forsook their appointments in local government and took up more remunerative employment to assist their over-worked colleagues in private practice. Even though this disparity in remuneration may be rectified in the near future the school medical service will almost entirely have to rely on newly qualified recruits to fill the many vacant appointments which exist at present. As there is a shortage of dentists in general, and as it is unlikely that many newly qualified dentists will choose the Local Government Service for their careers, it will be a very long time, possibly even another quarter of a century, before the high degree of efficiency of a few years ago will again be reached in the school dental service. In the meantime an ever-increasing strain will be thrown on both private and school dentists owing to the shortage which exists and will continue to exist in recruitment to the dental profession as a whole.

The position regarding the delay in the provision of spectacles for school children is no less serious, but it is a problem which can easily be rectified by an edict from the Minister giving strict priority, both in the ophthalmic examination of school children and in the provision of spectacles.

The Dorset child guidance service, which was making good progress, unfortunately came to a stand-still by the resignation of the consultant psychiatrist in September. It is hoped that it will not be long before the Regional Hospital Board are able to fill the vacancy and the County Council are able to make the appointment of educational psychologist whichthey have already approved. The problem of maladjusted school children, which provides fertile ground for the seed of juvenile delinquency and other undesirable manifestations to flourish, cannot adequately be tackled until the psychiatrist, educational psychologist and psychiatric social worker are working together as a team to combat them.

During the year the County Council approved in principle a scheme for the provision of health clinics in various parts of the county. Much of the work connected with school children can be carried out at these premises and the need for such clinics is becoming more and more urgent.

At the end of this Report appears a special article by Dr. Leonora S. Evans on the 'Age of the Menarche'. This is one example of the close liaison established between the County Health Department and the Institute of Social Medicine, Oxford University, to which the County Council gave their blessing during the year. I have given a more detailed account of this association in my Health Report for 1949, and I am convinced that in assisting in the field work of research, not only will many of the local problems be solved, but an important contribution will be made towards the future of preventive and social medicine, on the success of which medicine as a whole will benefit.

These and other aspects of the school health service are referred to in detail under the appropriate sections of the report, which has in the main been compiled by my deputy, Dr. J. L. Gilloran, assisted by Mr. V. W. V. Clarke in regard to the statistical details. Both to them, the assistant school medical and dental officers, and the staff of the school health section of the Department, I wish to tender my thanks and to express my appreciation for their loyal and willing support.

A. A. LISNEY,
County School Medical Officer.

August, 1950.

STAFF OF THE SCHOOL HEALTH SERVICE

School Medical Officer.
County Medical Officer of Health.

LISNEY, ARTHUR A., M.A., M.D., D.P.H.

Deputy School Medical Officer.
Deputy County Medical Officer of Health.

GILLORAN, JAMES L., M.B., CH.B., D.P.H.

Assistant School Medical Officers.
Assistant County Medical Officers.

ARMIT, ADAM, M.B., CH.B., D.P.H.
BLAKER, PERCY S., M.R.C.P., M.R.C.S., D.P.H. (*temporary*).
EVANS, LEONORA S., M.R.C.S., L.R.C.P., D.P.H.
LAWRENCE, IRA B., B.SC., M.B., CH.D., M.R.C.S., L.R.C.P., D.P.H.
O'KEEFFE, EDWARD J., M.R.C.S., L.R.C.P., D.P.H.
PEARSON, NOEL F., M.R.C.S., L.R.C.P., D.P.H.
SCOTT, GILBERT B., D.S.O., M.R.C.S., L.R.C.P. (*temporary*).

Senior Dental Officer.

PRETTY, PHILIP J., L.D.S.

Assistant School Dental Officers.

BRADLEY, STANLEY D., L.D.S. (Resigned 31/8/49).
HARDEN, BETTY E., L.D.S., B.CH.D. (Resigned 10/8/49).
HODGES, WILLIAM V. A., L.D.S.
KINGHAM, ROY V., L.D.S. (Retired 31/3/49).
MOON, H. I., L.D.S. (Resigned 28/2/49).

Consultant Psychiatrist.

RUSSELL, FENTON D., M.D., D.P.M., D.P.H. (Resigned 27/9/49).

Psychiatric Social Worker.

FILLITER, MISS ASTRID.

Superintendent Health Visitor.

RANKLIN, MISS I. F., S.R.N., S.C.M., H.V.CERT.

Assistant Superintendent Health Visitors.

HEATHER, MISS G., S.R.N., S.C.M., H.V.CERT.
MASON, MISS E. M., S.R.N., S.C.M., H.V.CERT. (Commenced 1/9/49).
PAYNE, MISS O. E., S.R.N., S.C.M., H.V.CERT. (Resigned 30/6/49).

School Nurses and Health Visitors.

ALLEN, MISS F. N., S.R.N., S.C.M., H.V.CERT. (Commenced 1/10/49).
BADSWORTH, MISS M. G., S.R.N., S.C.M., H.V.CERT. (Commenced 2/5/49).
BULLOCK, MRS. M. E., S.R.N., S.C.M., H.V.CERT.
CLACK, MISS K. D., S.R.N., S.C.M., H.V.CERT. (Resigned 11/12/49).
CRISP, MISS I. M., S.R.N., S.C.M., H.V.CERT.
FULLER, MISS M. E., S.R.N., S.C.M., H.V.CERT.
HARWIN-RICKETTS, MRS. M. V., S.R.N., S.C.M.
HENNESSY, MISS M., S.R.N., S.C.M., H.V.CERT. (Resigned 31/5/49).
JORGENSON, MISS P. K., S.R.N., S.C.M., H.V.CERT.
KENNEDY, MISS G. E. M., S.R.N., S.C.M., H.V.CERT.
KEOHANE, MISS M. E., S.R.N., S.C.M., H.V.CERT.
MASTERS, MRS. E. S., S.R.N., S.C.M., H.V.CERT.
MACK, MISS O., S.R.N., S.C.M., H.V.CERT.
MULLALLY, MISS M. M., S.R.N., S.C.M., H.V.CERT. (Commenced 11/4/49).
O'BRYEN HODGE, MISS M., S.C.M., H.V.CERT.
READ, MISS L. M., S.R.N., S.C.M., H.V.CERT.
TRUSCOTT, MISS M., S.R.N., S.C.M., H.V.CERT.

Speech Therapist.
O'Driscoll, Miss N. M., L.C.S.T.

Oral Hygienist.
Murton, Mrs. V. (Commenced 29/11/49).

Dental Attendants.
Grant, Mrs. O. (Resigned 12/2/49).
Hicks, Miss P.
Kershaw, Miss P. (Resigned 14/11/49).
McKinnon, Mrs. L.
Orme, Miss D. (Resigned 31/8/49).
Paley, Miss D., (Commenced 3/1/49).
Uncles, Miss M. C. H. (Commenced 11/5/49).
Wood, Miss A. B. (Commenced 8/6/49).

Poole Excepted Area.

School Medical Officer.
Poole Area Medical Officer.
Chesney, George, M.D., B.Ch., B.A.O., D.P.H.

Deputy School Medical Officer.
Assistant County Medical Officer.
Sinclair, James A., M.B., B.Ch., D.P.H.

Assistant School Medical Officer.
Assistant County Medical Officer.
McKenzie, Alistair C., M.D., B.Ch., D.P.H.

Dental Surgeons.
Hyland, Kenneth G., L.D.S. (Senior Divisional Dental Officer) (Resigned 30/4/49).
Allen, Robert, L.D.S.
Rimmer, William K., L.D.S.

Superintendent Health Visitor and School Nurse.
Kingsbury, Miss M. M., S.R.N., S.C.M., A.R.San.I., H.V.Cert.

School Nurses and Health Visitors.
Brooks, Miss H. E., S.R.N., S.C.M., H.V.Cert.
Davies, Miss B. M., S.R.N., S.C.M., H.V.Cert. (Commenced 1/2/49).
Koster, Miss I. F., S.R.N., S.C.M., H.V.Cert.
Kusel, Miss V. M., S.R.N., S.C.M., H.V.Cert.
Lever, Miss L. B., S.R.N., S.C.M., R.F.N.
Morris, Miss M., S.R.N., S.C.M., H.V.Cert.
Narbett, Mrs. V., S.R.N., S.C.M., H.V.Cert.
Phillips, Miss M. A., S.R.N., S.C.M., H.V.Cert.
Stapley, Mrs. M., S.R.N., S.C.M., H.V.Cert.

Dental Attendants.
Forrest, Miss G.
Mattinson, Mrs. E. T.
Nicholls, Miss R. N.

South Dorset Divisional Executive.

School Medical Officer.
South Dorset Area Medical Officer.
Wallace, E. J. Gordon, M.B., Ch.B., D.P.H.

Assistant School Medical Officer.
Assistant County Medical Officer.
Ward, Charlotte A. G., M.B., B.S., M.R.C.S., L.R.C.P.

School Dental Officer.

HOOKER, M. LINTON, L.D.S. (Retired 20/11/49).

School Nurses and Health Visitors.

ALLGOOD, Miss D. B., S.R.N., S.C.M., H.V.CERT.
BROCK, Miss L., S.R.N., S.C.M., H.V.CERT. (Commenced 4/7/49).
PORTER, Miss R. F., S.R.N., S.C.M., H.V.CERT. (Commenced 1/4/49).
RICHARDSON, Miss G. F., S.R.N., S.C.M., H.V.CERT.
SUNDERLAND, Miss D., R.S.C.N., S.R.N., S.C.M., H.V.CERT.
WHEELER, Miss C. R., S.R.N., S.C.M., H.V.CERT. (Commenced 2/5/49).

Dental Attendant.

KITCHEN, Mrs. M. E.

POPULATION

The population of Dorset as estimated by the Registrar-General in June, 1949, was 290,400. The considerable increase in the population is due to the fact that the Registrar-General has included a number of non-civilians whose children attend maintained schools. The Borough of Poole, with a population of 81,130, is an Excepted Area under the Education Act of 1944.

Schools and Scholars.

At the end of 1949 there were 260 maintained schools in the County. The types of schools can be seen from the following table:—

Type.	*Weymouth.*	*Poole.*	*County.*	*Total.*
Primary	26	22	179	227
Secondary Modern	4	6	6	16
Grammar	*2	2	13	17
	32	30	198	260

(* *Includes South Dorset Technical College*).

The average numbers of children on the school registers during the month of September, 1949, were as follows:—

Area.	*Primary.*	*Secondary Modern.*	*Grammar.*	*Total.*
County Districts	13,239	1,328	3,301	17,868
Poole Excepted Area	6,174	2,603	1,304	10,081
South Dorset Divisional Executive	3,666	1,204	*950	5,820
	23,079	5,135	5,555	33,769

(* *Includes South Dorset Technical College*).

The total of 33,769 pupils may be compared with the figure of 32,598 in 1948 and 30,644 in 1947.

CO-ORDINATION

It may appear to be a defect in recent administrative arrangements that the school health service, by being under the control of the Local Education Authority, is separated from the health and welfare services provided by the Local Health Authority. In actual fact there is no separation as the school health section is incorporated in the county health department and the county school medical officer is also the county medical officer of health.

Complete health supervision from birth to adult life is now established by virtue of the links between the maternity and child welfare services, the school health service and the youth employment service. The health visitors who visit the infants in their homes and advise on their care at child welfare centres also act as school nurses and weigh, measure and test the eyesight of the school children as well as advising their parents and attending to minor ailments. In their own areas the assistant county medical officers attend the child welfare centres and also undertake the school medical inspections at which the previous medical history of each child is always available.

It is desirable that a school should always be visited by the same doctor and an advantage if he is also the district medical officer of health who knows the schools and teachers in his area as well as the local general practitioners, so that a friendly interchange of information can take place in the interests of the children.

Complete co-ordination is thus achieved between the school health service and the environmental health services, both centrally in the health department and in the county districts, through the assistant medical officers and the health visitors.

MEDICAL INSPECTION

There has been no change in the arrangements for routine medical inspections during the year under review and all children attending maintained schools are now examined in accordance with the provisions of the Education Act, 1944, at the following times:—

(*a*) As school entrants at the age of five years. In the South Dorset Area a vision test is carried out at this examination, but in the other parts of the county this vision test is postponed until the child attains the age of eight years;

(*b*) During the child's last year in the primary school at the age of ten to eleven years;

(*c*) As school leavers. In practice this examination takes place at the age of fourteen to fifteen years as it is not always known which pupils will be remaining at school after the statutory school leaving age.

Special inspections are also undertaken once or twice a year, of all children found to have defects which require to be kept under observation.

In my opinion four inspections during a child's school career would be a better arrangement:—the first at five years as an entrant; the second at seven to eight years; the third at eleven after entering the secondary school; and the fourth during the last year at school at the age of fourteen years. In grammar schools it might be desirable to have a further examination during the last year or eighteen months at school and this could be linked up with the medical facilities now being made available at universities, training colleges and in industry.

The most important aspect of a medical inspection is, of course, the actual physical examination, but provision should also be made for private interviews between the doctor and the child, the mother, and the teacher. The pupil should be made to feel that the interview is designed for his welfare and that he can speak to the doctor freely and frankly with no fear of having his confidences discussed in front of his mother or teacher. While the doctor is engaged with the child it should be possible for the nurse to take the mother aside to obtain details of the family background or other necessary particulars and so leave the child free to talk privately with the doctor.

The weighing and measuring of school children and the testing of their eyesight at routine inspections is now undertaken in most schools in the county by the school nurses. During the year each school nurse was provided with a portable type of weighing scale which is used at the smaller schools; the larger schools possess weighing machines of their own.

At routine inspections in the scheduled age groups a total of 14,688 children were examined in 1949. In addition, 6,862 children were seen at special inspections and there were 5,296 re-inspections of children previously noted as being in need of observation.

FINDINGS OF MEDICAL INSPECTION

Uncleanliness.

Further efforts are required by all concerned in order to reduce this 'blot' on our health services. The children who are allowed by their parents to attend school in a dirty or verminous condition are generally speaking those whose parents are of low mentality or whose mother is a feckless type of housewife. Occasionally they are members of a problem family and are always giving trouble to district authorities, to the police and to the N.S.P.C.C. as well as to the education authority.

The welfare of children of problem families takes up much of the time of health visitors, welfare officers, N.S.P.C.C. inspectors and school attendance officers, but it does seem at present that frequent visits by these various officers is the only way to keep such people reasonably up to the mark. Too often the parents of such families are not interested in improving their conditions and are not amenable to training. Despite this they are often genuinely fond of their children who are frequently happy and contented, and routine visitation particularly by health visitors does help to ensure that the best is done for the children. Bad housing conditions are still the main problem associated with uncleanliness and skin diseases such as scabies and ringworm.

So far as the school is concerned, I think more could be done by teachers to stimulate a desire for cleanliness and this is particularly true in the case of the older girls who can be approached from the aesthetic aspect. Too many of these girls are found to have lice or nits in their hair and yet their desire to appear glamorous like their film star heroines can easily be aroused in support of hygienic principles.

General Condition.

The recording of the general condition of school children in the categories 'Good', 'Fair' and 'Poor' should be a useful index of their general health. Its value is, of course, dependent to a very large extent upon all medical officers who carry out school medical inspections adopting a similar standard of assessment. As it was only in 1947 that this classification replaced the nutritional standard it is possible that all school medical officers have not yet re-orientated themselves to the new system. Every factor having a bearing on fitness in childhood has to be borne in mind and the assessment is not made on height and weight alone.

In this connection it seems strange that in the new medical record cards no reference to the age of menarche has been included, although it appears that the average age at which menarche is reached in girls in this country is thirteen and a half years.

Table 2b in the Appendix of this report shows the number of children examined and classified during the year under review, while a comparison of percentages in each category for 1948 and 1949 is as follows:—

Age Groups.	*A (Good)*		*B (Fair)*		*C (Poor)*	
	1948	1949	1948	1949	1948	1949
	%	%	%	%	%	%
Entrants	49.41	54.0	47.46	43.8	3.13	2.2
Second Age Group	43.39	55.8	54.24	42.8	2.37	1.4
Third Age Group	51.65	68.7	46.39	30.3	1.96	1.0
Other Periodic Inspections ...	55.24	36.9	42.45	61.0	2.31	2.1
TOTAL	48.15	58.4	49.28	40.0	2.57	1.6

Minor Ailments.

Unfortunately the county is not yet provided with sufficient clinics at which minor ailments can be treated and some of the buildings used for this purpose are quite unsuitable. It is hoped that Swanage, which has no minor ailments clinic whatsoever and no facilities for school dentistry, speech therapy, refraction or child guidance, will in the near future be provided with a proper clinic building.

As an example of an unsuitable clinic, the building at Downe Street, Bridport, reveals obvious deficiencies to the most casual inspection. A slum property in a back street is no place in which to attempt to inculcate the principles of health and hygiene to school children.

The question of first aid for injuries received in school or at play is one of some importance particularly in the more rural schools. First aid equipment is supplied to all schools and head teachers are advised that when an injury appears in any way serious or if there is any doubt, then the advice of a doctor must be obtained. The county ambulance service is, of course, available in the event of serious accidents.

The attendances at minor ailments clinics during the year were 16,428 compared with 21,210 in 1948.

Tonsils and Adenoids.

Unhealthy conditions of the tonsils and adenoids are frequently first noted at a routine medical inspection. The presence of enlarged tonsils in a child used to be the signal for tonsillectomy, but in recent years the necessity for this operation has been questioned by a number of school medical officers. Perhaps one good feature of the recent prevalence of poliomyelitis has been the curtailment of such operations during the danger months of that disease and each case submitted for operation has had to be considered on its merits by the specialist. Many ear, nose and throat specialists are in favour of conservative treatment and believe that only tonsils which are obviously diseased demand operation. In this connection it is a common experience of school medical officers that tonsils noted at a medical inspection to be enlarged, may a year or so later appear perfectly normal and healthy and instances have occurred during the past year where children whose tonsillectomy has been delayed because of the risk of poliomyelitis have come up for re-inspection to reveal healthy tonsils.

Parents too often demand removal of tonsils as a cure for all ills from defective speech to bronchitis and asthma. The idea of eradication by the knife as a certain cure is still popular and acquiesence to the parent's wishes is not always of benefit to the child.

Another question arises when tonsils are found to be grossly diseased and infected and the child is obviously unhealthy, during the period of prevalence of poliomyelitis; should operation be undertaken in order to remove the source of infection and improve the child's health in view of the risk of post operative poliomyelitis of the bulbar type? There appears to be little doubt from American statistics that there is such a risk and in fact in June, 1949, a fatal case of poliomyelitis occurred in a Dorset child who a few days before had had an operation upon her neck. Reliable statistics in this country have still to be obtained and until these are available it is difficult to lay down definite rules.

The decision regarding operation must be made finally by the ear, nose and throat surgeon who will be aware of the risks involved by delay and who can obtain from the medical officer of health information about the prevalence of poliomyelitis.

Respiratory Diseases.

Although in school children tuberculosis is the most serious disease of the lungs likely to be discovered at a medical inspection, absence from or irregular attendance at school is most often occasioned by conditions such as asthma and bronchitis. An asthmatic child is not often so handicapped by his disability as to be categorised as a delicate pupil, but more than any other child is liable to periodic interruptions to his education. Such children are very often coddled too much at home and kept away from school for rather trivial reasons. Such coddling does little to help the child to overcome his disability and may in fact do harm.

Some help can be given to such children by means of special exercises and with the keen co-operation of the remedial exercises organiser it is hoped that the problem will soon be tackled energetically in Dorset and that remedial exercises classes for asthmatics will be instituted throughout the county. As well as improving the actual chest condition such exercises often help considerably to improve the child's confidence in himself, probably the most important factor in overcoming this disability.

Altogether 177 cases of defects of the lungs were discovered during routine inspections and 15 at special inspections; 35 of these were found to require treatment and 57 were kept under observation.

Vision.

The ascertainment of visual defect is a most important function of school medical inspections and hitherto unsuspected defects are frequently brought to light. A child whose sight is poor may fail to learn at school or may be unable to progress at the same rate as normal pupils and if this is not noted and corrected early in his school life he may be classed as a backward pupil.

The vision of every school child is tested by the time the age of eight years is reached and those in whom defects are discovered are referred to a consultant ophthalmologist, or to an assistant school medical officer experienced in refraction at one of the sight testing clinics in the county. Eye conditions such as squint are, of course, now treated by specialists of the Regional Hospital Board.

At periodic and special inspections 96 cases of squint were found to require treatment and 22 children had slight squints needing observation.

Other defects of vision requiring treatment numbered 1,178 and in addition 164 cases were reported as having some refractive errors necessitating observation.

External Eye Disease.

It is often found that little is done about minor conditions affecting the eyes and eyelids until they are noted at school medical inspections. This is particularly the case with blepharitis which is sometimes seen as an almost chronic condition. Conjunctivitis or 'pink eye' has not been common in recent years, but in view of its infective nature and liability to spread, especially in infant schools, cases are always excluded from school until the eyes are clear.

During the year 240 cases of external eye disease were referred for treatment.

Ear Disease and Hearing.

It is not always appreciated that hearing defects may be a cause of failure to learn and backwardness at school. Total deafness is usually obvious before the child commences his school life and can in fact be diagnosed before the age of one year, but milder degrees of defective hearing may easily be confused with educational subnormality or mental deficiency. Few handicaps are more difficult to ascertain and treat than a combination of deafness and educational subnormality.

The possibility of deafness should be considered by the teacher in all cases of educational retardation and the attention of the medical officer directed to any backward pupils at school medical inspections.

In many instances, for example where high frequency deafness is suspected, it will not be possible for a complete diagnosis to be made without full specialist investigation at a hospital with an audiometric unit. The hospital management committees in Dorset have notified me that facilities for such investigations are now available at the Poole General Hospital and at the Dorset County Hospital.

The number of children referred for treatment was 319, 34 cases from routine and 285 from special inspections. In addition, 30 children were kept under observation on account of hearing defects.

DENTAL DEFECTS

During the year under review the acute shortage of dentists employed by the Education Authority caused an almost complete cessation of regular routine dental inspections. Only in Poole, where two out of an establishment of three dentists remain, and in the Dorchester area, has it been possible to continue routine inspections.

So far few complaints are heard, and those chiefly from dentists in the general dental service who are unable to cope with the dental treatment of children, but the results will really become evident in future years when as in the early days of school dentistry, medical officers at routine inspections will be reporting more and more cases of defective and decayed teeth.

In 1949, as in recent years, only a few urgent cases were noted at school medical inspections and these were immediately referred to one of the clinics still in operation or to private dentists.

INFECTIOUS DISEASE

Apart from an increase in the number of cases of influenza, measles and mumps, the low incidence of infectious diseases in school children noted in my report for 1948 continued throughout the year under review and only one school had to be closed on this account. In that instance hygienic defects in the school premises provided the main reason for closure, in view of the risk to health whilst poliomyelitis was prevalent.

During the late summer and autumn months a number of cases of poliomyelitis occurred and although there were fewer cases in England and Wales than in 1947, yet 64 cases were notified in Dorset compared with 64 in 1947, the year when the disease first reached epidemic proportions in this country. Including one outbreak in a boarding school at Poole involving 7 pupils, a total of 25 school children developed the disease. The majority of these were mild cases with little or no paralysis, but there were 3 deaths amongst these 25 pupils.

A comparison between the exclusion certificates issued to schools outside thePoole Excepted and South Dorset Divisional Executive Areas in 1948 and during 1949 is as follows :—

Disease.	*Cases.*		*Contacts.*	
	1948	1949	1948	1949
Chickenpox	379	394	2	1
Coughs and Colds	117	111	—	—
Conjunctivitis	19	17	7	2
German Measles	11	14	—	—
Influenza	4	95	—	—
Measles	311	757	23	46
Mumps	262	926	1	2
Poliomyelitis	4	12	—	—
Scarlet Fever	47	39	23	49
Sore Throats	11	7	—	—
Whooping Cough	330	230	16	6
Other Diseases	79	89	12	14
Impetigo	107	75	—	—
Ringworm	17	35	—	—
Scabies	38	17	—	—
Verminous	168	141	—	—
	1904	2959	84	120

Number of Schools affected: 1948—148; 1949—149.

DIPHTHERIA IMMUNISATION

The notice sent to parents prior to a school medical inspection contains a reminder about the need for a re-inforcing injection against diphtheria if this has not already been given. The parents may choose to have this booster injection given by their own doctor, or by an assistant county medical officer either at the school or at a special immunisation session at one of the local health authority clinics.

The number of children who received such booster injections during the year was 4,168, and of the school population no less than 31,608 had completed a course of immunisation at some time before the end of 1949.

FOLLOWING UP

Much valuable work is done in connection with the medical care of school children by health visitors acting as school nurses. The school nurse is the main link between the teacher, the parent and the doctor and in addition to her duties at the medical inspection, the completion of the social history part of the school medical record card is her responsibility.

She follows up the medical inspection by visiting the homes to advise parents and when required, makes reports to the school medical officer. A tactful experienced health visitor can do much to ensure that children are properly cared for and that any necessary medical treatment is obtained.

In the course of these follow-up duties the school nurse has a vital part to play in the health education of the pupils and of the teachers and it is unfortunate that there are not sufficient health visitors to spend enough time on this aspect of their work.

The school nurses paid 1,063 visits to homes during the year in connection with following-up.

MEDICAL TREATMENT

For information about the medical treatment of school children the local education authority is now dependent upon the hospital authorities and in this field, especially in connection with case records, considerable improvement is possible in the co-operation between regional hospital boards, hospital management committees and health and education authorities. Where children are admitted to hospital all the relevant information should be made available to the hospital, both from private doctors and from the education authority. It is likewise important and in some cases vital, that information from the hospitals should be available to the school medical officer.

The improved standard of health in school children is very largely due to the follow-up and after-care work of health visitors and school nurses. This must be maintained in the future, and for this purpose it is essential that records of serious illnesses should be available to the school health service in order that the health visitors can be kept in touch with the children and their treatment in hospital.

So far as can be ascertained, all hospitals which treat Dorset pupils are co-operating well and are supplying me with the necessary information which is entered on the child's medical records. As so many children are now being referred to hospitals by their own doctors, reports from the hospitals are the only way in which details about the child's hospital treatment can be made available to the assistant school medical officers and school nurses. This applies to both in-patient and out-patient treatment, as in the case of the latter, information regarding ear, nose and throat, skin and other conditions may have a bearing upon a pupil's education. When they are fully informed of a child's disabilities, his teachers are able to make allowances and if necessary provide any special tuition which may be required.

Minor Ailments.

This is one aspect of medical treatment which has been retained by local education authorities, although, to a large extent, in many parts of Dorset, minor ailments are dealt with by the family doctor. His time can be spared, however, where clinics are available, as the treatment of cuts, abrasions and minor skin affections can easily be undertaken by an experienced school nurse and the advice of an assistant school medical officer obtained when necessary.

The minor ailments clinics provided in the county are as follows:—

Centre.	*Address.*	*Open on.*	*Times.*	*Doctor in attendance.*
Blandford	Salisbury Street	As required		No.
Dorchester	County Clinic,	Tuesday	2 p.m.	On call.
	Glyde Path Road	Thursday	10 a.m.	On call.
Poole	67, Market Street	Daily	9 a.m.	Mon. and Thurs.
	Shillito Road	Daily	9 a.m.	Tues. and Fri.
	Broadstone Women's Institute	Thursday	9.30 a.m.	Thursday.
	Hamworthy School	Tuesday and Friday	9 a.m.	Tuesday.
	Henry Harbin School	Thursday	9 a.m.	Thursday.
	Kemp Welch School	Monday and Friday	9 a.m.	Monday.
Portland	Tophill Secondary Modern School	Daily	9 a.m.	Special arrangement.
Shaftesbury	Minor Ailments Clinic, Secondary Modern School	Monday	9 a.m.	Monday.
Weymouth	Health Centre, Westham Road	Daily	9 a.m.	Mon. and Thurs.
	Wyke Regis School	Daily (except Friday)	2 p.m.	Thursday
	Broadwey Secondary Modern School	Monday and Thursday	11 a.m.	Mon. and Thurs.

Defects of Nose and Throat.

There was a distinct fall in the number of nose and throat operations amongst school children during the year, due chiefly to the postponement of such operative procedures while poliomyelitis was prevalent in the summer and autumn months.

Sometimes in connection with nose and throat defects more information is necessary from the hospital than the diagnosis alone and although information from the hospital may reach the general practitioner who arranges the admission, it does not always reach the school medical officer. This may be an important omission in the case of speech defects where the question of speech therapy is under consideration.

The assistant school medical officers noted 696 cases requiring treatment for some condition of the nose and throat. In addition, 451 children were reported as having a defect requiring to be kept under observation. Thus during routine examinations, 1,147 cases or 7.8 per cent of the total number seen at the periodic inspections were reported as having some defect of the nose and throat.

Tuberculosis.

The link with the hospital authorities in so far as tuberculosis is concerned is closer than is the case in any other aspect of medical treatment. By virtue of the fact that consultant chest physicians are officers both of the regional hospital boards and local health authorities, the treatment and preventive aspects of the work have not been separated, This is important in the case of school children where the early ascertainment of tuberculosis and its prevention by the supervision of contacts are features of school medical inspections.

All suspected cases are referred to the consultant chest physician and no difficulty is experienced in obtaining from him reports and recommendations regarding the future of the pupils concerned.

Skin Disease.

Impetigo and scabies continue to be treated at minor ailments clinics and by general practitioners.

As there is no skin specialist attached to the West Dorset Group of hospitals, all cases are referred to the consultant skin specialist at Poole General Hospital. No difficulty has been experienced in obtaining reports from him on all cases referred.

X-ray treatment of ringworm, which was required by a certain number of cases during the year, is now undertaken at Southampton and more delay has been experienced in dealing with such cases than occurred in the past when the Authority employed its own consultant. Further, full reports upon individual cases are not now received and the Authority is not notified when a child is free from infection and able to return to school.

Compared with 1948, when 168 cases of impetigo were reported, there were 276 cases in 1949; the figures for scabies are 82 in 1948, and 21 in 1949. With regard to ringworm 47 cases were reported in 1948 and 38 in 1949.

Ear Diseases and Defects.

Specialists are available both in West and East Dorset and to them all ear conditions are referred. The full reports received from the specialists are especially valuable where consideration is being given to the provision of speech therapy in children whose speech is defective on account of some degree of deafness.

So far as deafness is concerned, audiometric examinations can now be undertaken and will be of great value in differentiating between certain degrees of deafness and educational subnormality, thus assisting the school medical officer in his decision regarding the type of schooling required for such children.

DENTAL TREATMENT

The Senior Dental Officer, Mr. P. J. Pretty, reports upon the work of the dental officers in the county as follows:—

'During the year under review there has been a rapid disintegration of the school dental service. At the beginning of the year there were ten dental officers on the staff of the county. In order to provide a more complete and comprehensive service the establishment was increased to twelve, but owing to resignations the number remaining in the service at the end of the year was four; the majority of those who left transferring to the more lucrative general dental service. Allowing for the difference in hours worked in the two services the remuneration was not in proportion, and for this reason it was not possible to fill any of the vacancies in spite of repeated advertisements which were inserted in the professional journals and the lay press.

'It was not possible for such a small staff to carry out routine treatment satisfactorily, and the demand for emergency treatment steadily increased from all parts of the county. A certain amount of this type of treatment is always inevitable, but as prevention is the aim of the school service, it is appalling to think that it is increasing when the demand comes from many parents who are keen on their children having all the necessary treatment carried out at the earliest opportunity.

'School children are eligible for dental treatment under the National Health Service Act, but since its coming into force the general dental service has been very much overloaded; many practitioners are unable to accept any new patients for a considerable time and at best are only able to see really urgent cases of toothache, etc. It is essential for the health of the school child that the personnel in the school dental service should be appreciably increased in order that each child is inspected and, if necessary, offered treatment at least once a year.

'The demand for dental treatment has increased, but the number of dentists has decreased. It has, therefore, been decided by some local authorities, at the request of the Ministry of Health, to employ oral hygienists, some of whom had experience in the Dental Branch of the Royal Air Force during the war and have since had a refresher course. Those who have had no previous experience receive nearly one year's training at the Eastman Dental Clinic.

'They undertake scaling and polishing of the teeth and give instruction in the correct use of the tooth brush and in oral hygiene. They are employed at a centre where a dental officer is working to whom a patient may be referred should this be necessary. Although they cannot replace dental officers, they are able to increase the amount of work carried out, and the number of children treated annually.

'An establishment of three oral hygientists has been approved and one has already been appointed on a part-time basis at Dorchester and Poole. It is hoped later to employ her full time and engage two others when such arrangements can be made.

'Referring again to the number of dental officers employed, there were six in the county area, i.e. excluding the Poole Excepted and South Dorset Divisional Executive areas, at the beginning of the year, and only two at the end of the year. The effect of this decrease can be observed in the fact that only 7,802 children were inspected of the total school population of 17,868, in the county area, and there were only 7,766 attendances for treatment compared with 12,201 in the previous year.

'At the end of April the number of dental officers in the Poole Excepted area decreased from three to two and remained at this number until the end of the year. It was stated in the School Annual Report for 1948 that the establishment should be increased to four and it will be seen, therefore, that only half the requisite number of dental officers are employed.

'In the South Dorset Divisional Executive area the dental officer left in May and has not been replaced, although the establishment was increased to two. Practitioners in the town are unable to accept many new patients for complete treatment and usually only carry out relief of pain for them. The children who have previously attended the school clinic regularly for routine dental treatment are now no longer able to obtain this, and can only be accepted at the clinic for emergency extractions when one of the practitioners attends.

'Unless this progressive deterioration of the service can be halted and put on a sound basis the effect on the nation's health will be serious for some years to come.'

OPHTHALMIC TREATMENT

With the exception of the disintegration of the school dental service, the separation of ophthalmic treatment from the school health service is probably the worst feature of the National Health Service Act. That children should suffer nine months' delay in the provision of glasses, because of the rush by their elders for these free glasses during the first year of the Health Service was bad enough, but that no priority arrangements have yet been evolved is a shocking blemish on a so-called 'health' service.

Prevention of illness should be the key to any but a service for ill health and there are few defects which can be more easily prevented than the deterioration of a child's eyesight. It would need a Dickens to portray the children waiting for spectacles, in a number of whom the vision has further deteriorated during the waiting period, and new prescriptions have to be sent on their laggard way while the 'myope' mopes and the blackboard blurs.

The intimate connection between the detection and the correction of visual defects, including the provision of spectacles, should have been obvious to the planners of the Health Service. An ophthalmic service for school children should take priority over the provision for adults and should be provided at school clinics where all the information can be available to school doctors and nurses who, in the interests of the child, can advise the schools about the kind of tuition required in each individual case. The details of a child's visual defect should be available in full to the school medical officer when he advises the parent and youth employment officer on the choice of a career.

Ascertainment of Defective Vision.

Visual defects may be noticed first by the teacher or health visitor, or by a private practitioner, but in the majority of instances it is at a school medical inspection that defects of visual acuity are recognised. By the time he attains the age of eight years every school child has had his vision test and children found at these inspections to have visual defects are then specially examined at one of the refraction clinics of the education authority where glasses or other special treatment may be prescribed.

In addition to these arrangements, school children may now be referred to the consultant ophthalmologist of the Regional Hospital Board and, by arrangement, the findings of these specialists are made available to the school medical officer.

Provision of Spectacles.

Whether a child is examined by an assistant school medical officer at a refraction clinic or by a consultant ophthalmologist, his prescription for spectacles is taken to an optician who provides the spectacles in due course. In certain cases, as is done with adults, a child may be referred by a private practitioner direct to an optician who will himself test the vision and prescribe spectacles.

In view of the delay mentioned above in the provision of spectacles, it has been arranged that urgent cases should be notified to me by the assistant school medical officers and teachers and where I pass this information to the Secretary of the Local Ophthalmic Committee he is usually able to contact the optician concerned and expedite delivery.

During the year under review spectacles were prescribed by assistant school medical officers and by the consultant ophthalmologists for 1,868 children and from July 1st, 1949, to the end of the year 474 pairs of spectacles had been obtained.

Other Eye Diseases and Defects.

Actual diseases of the eyes, excepting of course minor conditions which can be treated at minor ailment clinics, are generally referred to the child's private practitioner. In the case of squint the advice of the consultant ophthalmologist may be obtained, but up to the present no provision has yet been made by the Regional Hospital Board for orthoptic clinics in Dorset. In view of the importance of orthoptic treatment for young children, it is hoped that this position will be remedied in the near future.

ORTHOPAEDIC TREATMENT

The arrangements made in 1948 with the South-West Regional Hospital Board, for the orthopaedic scheme in Dorset to be continued by the Bath and Wessex Hospital, have remained in force during the year under review. Thus there has been no change in the staff or in the clinics provided throughout the county and cases requiring long stay hospital treatment have, as in the past, been admitted either to the Bath and Wessex Hospital, or to the Swanage Children's Hospital.

It is anticipated that in 1950, the orthopaedic arrangements made by the South-West Metropolitan Regional Hospital Board for the county of Dorset will come into operation. The policy of the consultant orthopaedic specialists regarding the continuance of the clinics is not yet known, but it is presumed that the clinics will be continued as before, although, where possible, there may be some concentration on the hospitals. The main change in the arrangements will be that long-stay in-patient cases which were formerly sent to Bath will in the future be admitted to the Lord Mayor Treloar Hospital, Alton.

The attendances at the orthopaedic clinics throughout the year continued at a high level and at the same time, with the development of the remedial exercise classes in the schools, it was possible to relieve the clinics of many of the minor defects such as poor posture. This has resulted in it being possible for the orthopaedic physiotherapist to take on more cases of serious defects than formerly. Quite a proportion of these defects are now found to be a result of poliomyelitis during the 1947 and 1949 outbreaks, in addition to the congenital deformities, tuberculous spines and joints, etc.

During the year the physiotherapist has been able to concentrate upon the teaching of home exercises and great credit is due to the parents who have encouraged their children to persevere with such exercises.

REMEDIAL EXERCISES

Considerable progress has been made in extending remedial exercises facilities since Miss Sebestyen took up her duties as Remedial Exercises Organiser at the end of 1948 and on the developments during 1949 she reports as follows:—

'Remedial classes have progressed considerably during 1949, *and as facilities improve more classes are commencing, increasing numbers of children being recommended for inclusion therein. In addition, minor cases from the orthopaedic clinics are being absorbed thus relieving to some degree the strain on these clinics. Head teachers, in spite of many difficulties with accommodation and staffing, all co-operate to make remedial work a success and it is considered essential that remedial exercises should form an integral part of normal school life.*

'Facilities have been arranged at schools throughout the county in connection with the commencement and supervision of classes and it is interesting to note the keenness and enthusiasm shown by the remedial teachers themselves.

'Initial training courses were held at the Blandford, Dorchester and Wareham Modern Schools and were attended by thirty-eight teachers, which enabled new classes to be commenced. Refresher courses were held at Poole and Weymouth for teachers who had previously received training. In addition, talks and demonstrations were given to parents and teachers and suggestions made regarding the importance of sufficient sleep in the prevention of postural faults, and the necessity of correct shoe fitting in the prevention of foot trouble.

'It was emphasized that co-operation between parents and teachers is essential in this work, as exercises must be supervised at home to obtain satisfactory results; early treatment of these minor troubles can prevent the formation of irremediable defects which cause unnecessary suffering in later life. It is proposed to form remedial centres in those parts of the county where teachers have not yet received training.

'The number of schools where classes for remedial exercises are being held is as follows:—

County Area	32
Poole Excepted Area	17
South Dorset Divisional Executive Area ...	13'

SPEECH THERAPY

Miss O'Driscoll, the county speech therapist, reports upon the work during the year as follows:—

'1949 *has been a busy year for the speech therapy clinics. The number of sessions held per week has been* 10 *and the average weekly attendance has been approximately* 70.

'Though speech is generally taken for granted, as breathing or eating, the production of intelligible language is in fact a very complicated matter involving co-ordination between brain, lungs, larynx, lips, tongue and soft palate.

'So complex a process may fail by reason of inadequacy in any of these factors; therefore, in the case of a child with a speech defect, a detailed preliminary examination may be necessary.

'Before a boy or girl attends the speech clinic the procedure is roughly as follows:—

'The parent or the teacher is generally the first person to notice that a child's speech is defective, because they have the best opportunity for observing him. The next step is for the teacher to bring the child forward at a medical inspection, or for the health visitor to report the case to the school medical officer.

'The child is then examined by the speech therapist and his defect is classified according to type and degree. This interview may take place either in school or at the child's home. The problem is discussed with the mother and the teacher and advice is given about handling the child—for instance, when it is desirable to correct speech mistakes, when to pass them over, and how to adjust his environment so that the child may benefit as much as possible from treatment.

'If there is any doubt as to the classification of the defect, or as to its cause, the child is medically examined. The most usual examinations are by an aural consultant to eliminate the possibility of deafness; intelligence testing to eliminate mental defect and if necessary examination by a psychiatrist.

'It will be seen that the work of the speech clinic entails co-operation by many persons, parents, teachers, medical officers, health visitors and, most important of all, the child himself.'

OPEN AIR EDUCATION

At the present time schools of the open-air type are largely confined to special schools provided for delicate children. In the case of such children, the value of free exposure to fresh air and sunlight is easily appreciated. Many of the modern schools now being constructed are also designed on similar open-air lines and it is hoped that this feature will progress during the years so that all school children may benefit from education which, to as large an extent as possible, will take place in the open air.

CO-OPERATION OF PARENTS

In the early development of a child his parents and their attitude towards him are of more importance than anything else. In school he comes under the influence of teachers and other pupils, but the influence of interested parents is still dominant. Where children become difficult or get into trouble it is commonly found that the home background is at fault. Thus the co-operation of the parents and their understanding of the child's needs are essential for the proper health and well-being of the pupil.

It is, therefore, encouraging to note the willingness of so many parents to attend school medical inspections and to discuss their child's ailments and difficulties with the doctor. Very often advice and re-assurance is all that is necessary, but where actual medical treatment is required the reasons for this can be explained and the parents advised to consult their private practitioner.

A medical inspection is an excellent opportunity for the doctor to educate the parent in the principles of mental and physical health as applied to her own child. A few minutes private conversation with the mother should always be arranged and this is probably most conveniently held whilst the child is dressing after the examination.

CO-OPERATION OF TEACHERS

I should like to take this opportunity of thanking the teachers for their co-operation in the work of the school health service. The relationship between teachers and the health department has, I think, never been better and I do want them to know how much their work in connection with the health of the school children is appreciated. In future I hope to see closer co-operation between the teachers and the health visitors in the interest of the children and regret that the health visitors at present are unable to devote more time to their duties as school nurses.

Much valuable assistance is given by the teachers at school medical inspections, in the completion of certificates of exclusion from school and in the compilation of periodical returns, which have recently been simplified and reduced to the minimum necessary to maintain adequate medical records in respect of each pupil. The information contained in these records and the advice of the medical and health visiting staff are available at all times to teachers who may require guidance on the handling of particular pupils. Such advice is frequently required by the schools in the case of infectious diseases, particularly poliomyelitis and in the case of a child handicapped by some defect such as epilepsy where the attitude of the teacher and all his class mates may play an important part in the pupil's reaction towards his disability.

It is my desire that the teachers in this county should be kept as fully informed as possible upon all matters likely to have an effect upon their pupils' scholastic abilities and progress. In future when the new subsidiary medical cards are in use at all schools, the assistant school medical officers will make notes of any defects or matters of importance of which the teacher should be aware.

With large classes and the crowded conditions in many schools I sympathise with the extra difficulties borne by teachers burdened with backward and difficult pupils. Unfortunately, there are insufficient places in special schools for such children and often parents are unwilling to allow a child to go to a residential school outside the county. The opening of Clyffe House and Penwithen Hostel will help to some extent, but I am

afraid that there will still be many children who will require special tuition in an ordinary school. In order that the full extent of the problem may be known I would be glad if teachers would keep assistant school medical officers informed at school medical inspections of any such children. When a pupil is being examined with regard to his mental ability it would assist the medical officers greatly to have a discussion with the teacher and to hear the teacher's views on the question of providing special tuition in the ordinary school.

Since I have mentioned this problem of the backward and difficult pupils I would like to draw the attention of education officers and teachers to the remarks which follow and which may be linked up with what I have to say in connection with health education and educationally subnormal pupils.

The presence in ordinary classes of smaller or larger numbers of backward pupils must necessarily cast a shadow on the teacher's work and on the education of the other children. This is a position which appears unlikely to be resolved at an early date and it is the teachers themselves who must take the responsibility of producing, so far as possible, useful members of the community even though little can be achieved in reading and writing.

These dullards form a large minority in many of our schools and although they are frustrating to the school teachers' efforts in the direction of academic learning something useful can often be done with them. The fact that so many subnormals do relatively well in practical work on the land after leaving school points the way to the education they need. First and foremost they should be taught the daily routine of a civilised life; how to wash and keep clean, how to dress and eat properly, how to make use of household appliances, how to behave in the street, how their leisure time may be employed, how to be helpful and honest and to live as members of the community—all things which a normal child of normal parents learns as a matter of course at home, but which are not so easily picked up by the subnormal child and are often not practised in the families of such children.

The educational emphasis should be put on activities of a practical kind which, however, does not mean on arts and crafts, but on the simple requirements of ordinary life in the country. Reading, writing and arithmetic should be secondary subjects and should not be pushed beyond the ability of the child.

One other point of very great importance to a number of pupils is the question of defects of speech and, as in this case treatment can never be instituted too early in the child's life, it is essential that teachers should report such defects to the school medical officer at the very earliest possible opportunity. All defects of speech should be reported before the child reaches the age of seven years.

CO-OPERATION OF GENERAL PRACTITIONERS

It is a great pity that there has been no definite machinery for friendly co-operation between the school health service and the general practitioner. The family doctor in the past has received little or no information from the school medical officer about the health of his child patients and, on the other hand, the school medical officer was often not informed by the family doctor as to the reasons why a child was excluded from school. The relationship has now been improved so far as medical treatment is concerned by the fact that all children requiring treatment are referred to their own doctor in the first instance with a note about any disability discovered at the medical inspection. The question has been asked by some doctors as to whether the parents will pass on this note to their doctor, and it has been arranged that in addition a report is sent by the school medical officer to the doctor so that he can, if necessary, follow up the case if the child is not brought to him by the parents.

There is still a great need, however, for the general practitioner to be drawn closer into the school health scheme and for more friendly interchange between him and the school medical officers on such matters as exclusion from school, permission to play games, partaking in physical training, swimming, etc. In the case of epileptic pupils, the family doctor, sometimes after obtaining a specialist's opinion, is the only person able to judge how much the child's activities should be curtailed. Again in children suffering from asthma which varies so much in the disability caused, it is the family doctor who can advise regarding any particular care to be taken in school and whether remedial exercises provided by the education authority, which benefit a number of such cases, are suitable in any particular instance.

So far as hospital treatment and consultant advice is concerned in school children, the arrangement is working fairly satisfactorily in Dorset, whereby a child is referred to his private practitioner who decides whether to seek specialist advice or not. In a number of instances, however, general practitioners to whom children have been referred have requested that the arrangements for hospital treatment should be made by the school health service. Providing that the information about the case from the hospital to the school medical officer is also made available to the practitioner, such an arrangement might solve his difficulty in not knowing which specialist facilities for school children are provided by the hospital authority and which by the education

authority. During the year under review, for example, the education authority has been responsible for orthopaedic, ophthalmic, speech therapy, child guidance and other treatment, some of which in whole or in part may, in the future, come under the control of hospital management committees.

At present no arrangements have been made whereby a child's medical records after leaving school may be made available to the family doctor. It does seem desirable that some such provision should be instituted, otherwise all the information so completely collected is of no value to the future of the child in adolescence and adult life.

CO-OPERATION OF SCHOOL ATTENDANCE OFFICERS

When children are kept away from school on account of ill-health it is often necessary for the school attendance officers to consult the school health department. It is usually possible in such cases to obtain the opinion of the child's own doctor and quite often a genuine reason for absence from school is found to exist.

In one part of the county the duties of the school attendance officers have been complicated by certain doctors issuing certificates to the effect that the mother is ill and requires the child to remain at home to look after her. This is an entirely different matter from the child himself being ill and unable to attend school and is not normally accepted as a reason for non-attendance. Once the County Council scheme for domestic help comes into operation it should not be necessary to make allowances for this type of case, as a domestic help will provide far more assistance in a home than can a school child.

Much valuable work is done by the school attendance officers in an unobtrusive manner and I would like to record my appreciation of their co-operation with the health visitors.

CO-OPERATION OF VOLUNTARY BODIES

The N.S.P.C.C., British Red Cross Society, National Association for the Blind and various other voluntary associations are associated with the work of the school health service.

The co-operation between the officers of the N.S.P.C.C. and the health visitors is very good indeed and results in the close supervision of the problem type of family which is so important for the welfare of the children. Much can be done by the Society even without resorting to legal action in cases of child neglect, where parents refuse to obtain essential medical treatment for their children and where children are sent to school dirty and inadequately clothed.

The expansion of the County Council's care and after-care scheme by the British Red Cross Society during the year has benefited school children as well as other members of the community and in addition to clothing, blankets, welfare foods, etc., articles such as wheel-chairs and handicraft material are also provided.

For children handicapped by blindness everything possible is done by the National Association for the Blind to provide adequate training and care.

PROVISION OF MILK AND MEALS

The number of schools providing milk for their pupils and the average number of school children having milk at school during the last four years, were as follows:—

	1946	1947	1948	1949
Number of schools providing milk	268	264	262	260
Average number of children having milk ...	18,827	25,702	26,445	26,504

The grades of milk supplied during the same years were:—

	1946	1947	1948	1949
Pasteurised	147	167	161	174
T.T.	60	60	70	72
Accredited	38	21	19	6
Ungraded	23	16	12	8

Continued efforts are being made to arrange for improved supplies to schools still receiving accredited or non-designated milk, but as some of these are village schools with comparatively small numbers on the roll, it is not easy to arrange improved supplies because the amounts of milk required are so small that the payment received would not cover the delivery expenses to be borne by the suppliers.

The average daily number of meals served has increased from 19,672 to 20,505 during the year, the latter figure representing 60.61 per cent of the school population. Of the total number of meals, 18,900 are paid for by the pupils and 1,605 supplied free of charge.

During the year 20 new canteens were opened, 3 being replacements of old canteens, the others being entirely new centres. At the close of the year only 7 schools out of a total of 260 remained outside the school meals service and it is anticipated these may be supplied with meals in the first half of next year. In October the

Ministry of Education announced the curtailment of further building schemes in the school meals service and although this will mean that improvements in the way of better kitchen accommodation will be temporarily restricted, the number of schools still to be supplied with meals will not be affected. Arrangements will be made to supply these schools from existing canteens.

	1946	1947	1948	1949
Number of schools supplying meals	230	235	248	253
Average number of children having meals ...	15,776	16,065	19,672	20,505

HEALTH EDUCATION

Although lip service is paid to the value of health teaching in our schools, few positive steps have yet been taken generally to introduce instruction in simple health matters. The teachers, who are the ideal persons to give such instruction—and many of whom do so as far as they can within their school syllabus—require encouragement in this matter more than in any other.

Personal hygiene can and should be taught in the ordinary school class. Any teacher interested in the welfare of the pupils can impart the general principles of healthy living, including such matters as proper choice of food and clothing and the importance of fresh air and cleanliness.

The existence in school leavers of body odour, dirty necks, unkempt, unwashed hair, neglected finger nails, filthy feet and dirty torn clothing is a poor advertisement indeed for modern education upon which so much is spent annually.

To all interested in education I would cite a certain mental defective boy in this county aged eleven, well looked after and instructed by his mother, yet excluded from school because he cannot compete with and is the 'butt', of normal children. He illustrates what can be done by proper training even of a low intellect; he is neatly dressed, clean, tidy and polite, which is much more than can be said of so many of his intellectual superiors and contemporaries despite their academic learning.

It is time that health education was appreciated and made an essential part of school learning so that pride in personal appearance and dress might be given priority over the ability to fill in a football pool coupon or read the racing results. A re-orientation of education toward the true needs of the pupils is certainly required and those of below average intellect encouraged to take pride in themselves if not in their achievements.

Instruction in the principles of health and hygiene need not take up much time, provided that it is repeated often and suitable encouragement given, but it should never be crushed out of the curriculum altogether because of the number of academic subjects, some of which are of doubtful value to the average child. In this connection, the planning of a curriculum for any secondary school should always allow adequate time for domestic subjects and mother-craft.

I am always glad to advise and assist teachers who are interested in the health and well-being of their pupils and I trust that felicitous co-operation between the schools and the health department will benefit the children whose full mental, physical and spiritual development is our main concern.

PHYSICAL EDUCATION

The county physical training organisers, Miss H. Grimwood and Mr. J. Hayfield, report as follows:—

GENERAL.

'The improvement in the number of schools with surfaced playgrounds has been continued and most schools now have some hard surface. A few more halls have been hired for use by schools without indoor accommodation, but unfortunately there are many cases where there is no hall near enough for schools to use.

APPARATUS.

'More large improvised climbing apparatus has been introduced into primary schools and this has permitted a valuable extension to the range of training in the schools concerned.

SWIMMING.

'The excellent weather during 1949 *encouraged schools to make full use of the short swimming season. There was a slight increase in the number of children swimming, but there has been no improvement in the facilities available.*

CLOTHING AND FOOTWEAR.

'Plimsolls are now available for all pupils and this has led to a considerable improvement in footwork and general movement. Shorts or knickers and a vest are provided for most secondary schools and a start has been made in supplying this clothing to primary schools where there are facilities for changing.

STORAGE.

'The storage of equipment and clothing is still a problem in many schools but some headway has been made in a few schools by the provision of cupboards or stores.

PHYSICAL TRAINING FOR THOSE WHO HAVE LEFT SCHOOL.

'Some evening classes were held and physical activities are included in the programme of most youth clubs. The co-operation of the Central Council of Physical Recreation was appreciated in taking two short courses for leaders and senior club members in Weymouth.

OUT OF SCHOOL ACTIVITIES.

'The out of school activities organised by the teachers continue to increase and where they exist a keen spirit is obvious.'

HANDICAPPED CHILDREN

Blind and Partially Sighted Pupils.

Apart from their physical handicap, blind children suffer further educational handicaps all originating in their difficulty and slowness in learning to read without the aid of sight. These reading difficulties are followed automatically by other difficulties in writing and arithmetic.

In addition to their special needs in learning to read and write, blind children have special needs in physical education and in vocational training their needs and interests differ from those of sighted children. It is unfortunately a popular error to regard schools for the blind as institutions where basket making, knitting, boot repairing and piano tuning are taught. It must be remembered that the needs and interests of the blind are as varied as those of the sighted and their education must be based upon this.

As an aid to the provision of sufficiently wide educational facilities for these handicapped children it is essential that both blind and partially sighted children should be educated in residential schools with classes of between ten and fifteen pupils.

Before a child is admitted to such a school his general health, intelligence, aptitudes, educational attainments, needs and interests should be ascertained as accurately as possible and this is best done by a team which should consist of an ophthalmologist, the school medical officer and an educational psychologist.

In the case of the partially sighted, too great stress cannot be laid upon the importance of the early ascertainment of visual defect. Here again the advice of an ophthalmologist and an educational psychologist must be available to the school medical officer and the teacher when the needs for special education are determined.

In this county at the end of the year there were nine blind pupils in special schools. Of six partially sighted pupils, four were in special schools, one was awaiting admission and in the other case the parents had withheld their permission for tuition in a special school.

Deaf and Partially Deaf Pupils.

Tuition in special schools similar to those provided for the blind is required for deaf pupils. The teaching is, of course, different as the chief difficulty is in learning to talk and once this is overcome reading and writing follow, albeit at a slower rate than with normal pupils.

The figures quoted below for the numbers of partially deaf children ascertained in the county indicate that a number of cases are still being missed, because, based on recent investigations, the numbers of partially deaf pupils at schools in Dorset should be nearer 1 per 1,000.

By the end of the year there were 19 deaf pupils and one partially deaf pupil in special schools, while three deaf pupils and three partially deaf pupils were awaiting vacancies in special schools.

Delicate Pupils.

The category comprises those pupils who by reason of impaired physical condition cannot, without risk to their health, be educated under the normal regime of an ordinary school. The most common defects resulting in children being ascertained as delicate pupils are asthma, anaemia, malnutrition, and congenital cardiac lesions. Of thirty-one such pupils in the county, nine are at special schools and ten are awaiting admission, whilst in three cases the parents refuse to allow the child to go to a special school. Nine others attend ordinary schools where they are allowed special privileges, such as long rest periods, lying down, or being excused drill or games.

Diabetic Pupils.

There is only one diabetic pupil on the records of the Education Authority and she is at a special school for delicate children.

Educationally Subnormal Pupils.

The children in this category provide a challenge to education authorities which is only slowly being realised and is not yet being properly tackled. The pupils included are those who, by reason of limited ability or other conditions resulting in educational retardation, require some specialised form of education in place of that normally given in ordinary schools.

Recent research on this problem confirms that the most conservative estimate of the numbers of such children is between seven to ten per cent of all registered pupils. That means that if all the backward children in Dorset were reported by their teachers and ascertained by the assistant school medical officers, the total number of children requiring special education in the county would be about 3,000. At present only 355 such pupils have been ascertained.

The majority of educationally subnormal pupils are suitable for special educational treatment in the ordinary school, but there is no doubt that a proportion somewhere in the region of ten per cent of all such children require special education which cannot be provided in ordinary schools. In Dorset, therefore, when ascertainment is complete, we can anticipate having to provide for 300 pupils in special day or residential schools.

The much heralded opening of Clyffe House at the beginning of the next school year, with accommodation for 43 pupils, is obviously barely scratching the surface of the problem. It might be worth considering, as new schools are opened throughout the county and the general overcrowding is reduced, the possibility of converting some of the old school buildings into day schools for the educationally subnormal. No alterations to the buildings would be required as the important element in the teaching of such children is keen, interested, experienced teachers who can work wonders without resort to elaborate materials. Such teachers and buildings are readily available in many of the village schools which are now being closed.

Of the 355 ascertained educationally subnormal pupils in Dorset, only 25 are in special schools, whilst 111 children are awaiting admission and in 15 cases the parents refused to allow their children to go to a special school. The remainder are considered suitable for education in the ordinary schools.

There is thus a lot to be done in the way of ascertainment and in the provision of special schools, and as there are no special classes in any of the ordinary schools in the county, it appears that it will be a long time before the teachers can be spared the trouble and the better pupils spared the drawback, of having backward children in their ordinary overcrowded classes. The need for a special day school in Poole is really urgent and such schools are also necessary in Weymouth, Dorchester, the West and the North of the county. In the North an old village school such as Todber might prove most suitable.

Epileptic Pupils.

When under proper medical supervision and treatment the majority of children suffering from epilepsy are able to attend ordinary schools and participate in normal school activities. In order that such a child may not be made to feel unusual in class or be coddled in any way, the school is always visited by an assistant school medical officer who advises the teachers about the child and stresses the importance of not making a fuss should the child have a fit in school.

Under the aegis of the Dorset Education Authority there are only five epileptic pupils, of whom four are in a special school for epileptics and one is awaiting admission.

Maladjusted Pupils.

This category embraces those pupils who show evidence of emotional instability or psychological disturbance and require special educational treatment in order to effect their personal, social, or educational readjustment.

The majority of these children can attend ordinary schools during treatment if child guidance clinics are available. There are a number of pupils, however, who require more prolonged treatment and who respond better if they can be removed from unhappy or unsatisfactory home surroundings. Divorce, parental separation and faulty upbringing are the commonest causes of this kind of trouble and are responsible for the too frequent occurrence of children who are beyond their parent's control. For these pupils, special residential hostels are required where skilled tuition coupled with attendance at school will gradually bring about the necessary social and personal readjustment.

In Dorset, during the year under review, the child guidance service functioned effectively until September when, with the resignation of the psychiatrist, the service had to be suspended owing to the Regional Hospital Board being unable to provide a replacement, whilst the Education Authority could not obtain a psychologist. The opportinity was taken of releasing the psychiatric social worker for a year in order to enable her to take a course in mental health and child guidance work, which will in the future be of considerable advantage to her in carrying out her duties.

Since September very great difficulty has been experienced in obtaining psychiatric advice for school children. Two very difficult cases which arose in November were interviewed by the psychiatric team at Odstock Hospital, Salisbury, and Dr. Lendrum of the St. James' Hospital for Nervous Diseases, Portsmouth, later very kindly arranged for their admission to that hospital for essential psychiatric treatment.

The number of cases treated between January and August was 89 and the number of urgent cases awaiting child guidance investigation and treatment in the county at the end of the year was 32.

The absence of a psychiatrist and psychologist able to investigate children reported by parents, teachers and doctors to be maladjusted, has resulted in very few such cases being ascertained. Altogether 21 children were ascertained as maladjusted pupils and only 4 of these are in special schools, another 12 pupils are awaiting admission, while 5 are in ordinary schools awaiting child guidance treatment at home.

Physically Handicapped Pupils.

Children who by reason of disease or crippling defects cannot be satisfactorily educated in an ordinary school are included in this category. The majority of these pupils suffer from orthopaedic conditions entailing a long stay in hospital and their education is catered for by means of special hospital schools where, although the hospital is the responsibility of the regional hospital board, the school comes under the control of the education authority. Towards the end of the year it was possible to establish one such school in Dorset at the Swanage Children's Hospital and it is anticipated that this school will be available in future particularly when, with the establishment of the new orthopaedic service in the county, long stay cases will be able to be treated at that hospital.

By the end of the year a total of 35 pupils had been ascertained to be physically handicapped and of these 12 were in special schools and 23 were awaiting admission to special schools. Eight other cases were found to be suitable to continue at an ordinary school, and 2 were incapable of attending school.

Statistics.

Details of handicapped children examined and placed in the various categories during 1949:—

Blind	Nil
Partially Sighted	Nil
Deaf	1
Partially Deaf	2
Delicate	21
Diabetic	1
Educationally Subnormal ...	138
Epileptic	2
Maladjusted	10
Physically Handicapped ...	8
Multiple Disabilities	5
	188

Of the 138 educationally subnormal pupils, 94 were recommended for education in an ordinary school, 5 for education in a special day school and 39 for education in a special residential school.

YOUTH EMPLOYMENT SERVICE

The youth employment service which was fully reviewed in my Annual Report for 1948 had not come into operation by the end of the year, although close liaison has been effected between the Principal Youth Employment Officer and the school health service.

In order that the youth employment officers may have early information as to children who are about to leave school and who may require either sheltered employment, or who are considered unsuitable for entry into certain occupations owing to physical or mental handicaps, arrangements have been made whereby a special report form is completed in respect of each child and passed to the youth employment officer following the school medical inspection at school leaving age.

JUVENILE DELINQUENCY

This is a matter which is deservedly receiving much attention nowadays. The increase in juvenile delinquency is probably chiefly due to lack of proper parental control, sometimes occasioned by wartime separation. The lack of a stable family background appears to be the commonest factor in producing disturbances in childhood which may lead to delinquency.

All children need love and affection and in the natural security of the family should feel safe and protected against outside influences. Children whose parents are separated, or whose home life is disturbed by parental discontents and troubles, miss that natural security and tend to become neurotic and subject to vague fears which they do not understand. They miss the proper approach to life right at the start and by being unsettled and lacking a normal stable view of society they can very easily become anti-social.

It is in the family unit that children learn most by example and precept and the first step toward the prevention of juvenile delinquency must be to do everything possible to encourage stable family life. The education authority can help in this through its parent-teacher associations and also, in long term planning for the future, by encouraging health education in the schools with emphasis on proper community and family life.

So far as existing juvenile delinquents are concerned we are dependent upon an efficient child guidance team of psychiatrist, educational psychologist and psychiatric social worker, working in conjunction with the children's officer and the probation officer. In this connection I am pleased to be able to place on record my appreciation of the valuable work undertaken by Mr. J. W. Birch, the Senior Probation Officer and his staff.

Prior to the attendance of children at juvenile courts they are medically examined and during the year in the county, excluding the Poole Excepted and the South Dorset Divisional Executive Areas, 95 special reports were issued to the magistrates, giving details of any defects—physical or mental—which were found, including any important family history or other details affecting the welfare of the child.

HYGIENIC CONDITIONS OF SCHOOLS

Particular attention is paid by assistant school medical officers, whilst visiting schools for the purpose of school medical inspections, to the hygienic and sanitary conditions of the premises. In this connection luxury is not demanded, but ordinary common decency is essential. Adequate washing and lavatory facilities ought to be available in all schools and towels, soap and toilet paper should be provided. The classrooms themselves ought to be warm and well lit and free from disturbing noises from other parts of the building.

A most important consideration, sometimes neglected in schools, are facilities for the older girls to obtain and dispose of sanitary towels without giving rise to embarrassment. This is a question to which the medical officers have been asked to pay particular attention. Suitable bins or incinerators should be provided in the lavatories, which should be separate from those provided for younger pupils.

The careful supervision of school canteens is an important part of the work of the county medical and sanitary staffs, particular regard being paid to the prevention of infectious disease and food poisoning. It is a compliment to the canteen staffs in the county that I am able to record that no cases of food poisoning connected with school canteens occurred during the year.

Defects in any of these matters reported by the medical officers are investigated by the County Sanitary Officer and his staff and as the pressure of other work permits, a sanitary survey of all schools in the county is being undertaken.

THE AGE OF THE MENARCHE

(Special Article by Dr. Leonora S. Evans).

During 1949 an opportunity was afforded for the co-operation of the Health Department of the Dorset County Council in an investigation into the association of certain environmental influences on the age of onset of menstrual periods in girls. The survey, planned by Dr. Dagmar Wilson and Dr. Ian Sutherland, was conducted from the Institute of Social Medicine, Oxford.

The objects of the investigation as it related to Dorset were:—

(*a*) The comparison of the heights and weights of a group of secondary school girls at the age of the menarche with the heights and weights of a similar group in Oxfordshire;

(*b*) The comparison of heights and weights at the onset of the menarche in a group of public school girls, with similar groups of secondary school girls in Dorset and Oxfordshire.

Five secondary schools, representative of different areas and catering for children from a variety of social and economic environments, and one girl's public school in Dorset, were, with the permission of the respective head teachers, selected for the investigation. The necessary data were obtained with the help of the physical training mistress at each school, from approximately 1,550 girls, whose ages ranged from 10 to 19 years.

The particulars when completed were sent to the Institute of Social Medicine, Oxford, for analysis and they have kindly furnished the following reports:—

Comparison of heights, weights and attainment of the menarche in 14*-year-old girls from three groups of schools.*

Schools.	*Girls whose periods have not started.*			*Girls whose periods have started.*			*Percentage of girls who have attained the menarche.*
	No. Girls	*Mean Ht. (ins.)*	*Mean Wt. (lbs.)*	*No. Girls*	*Mean Ht. (ins.)*	*Mean Wt. (lbs).*	
Sherborne ...	25	63.3	110.3	48	64.3	125.4	65.8
Oxfordshire ...	53	62.2	100.9	212	63.6	117.2	79.3
Dorsetshire ...	39	60.9	93.9	210	63.0	115.6	84.3

This table shows three interesting factors:—

(*a*) Mean heights and mean weights are in each school considerably greater among those who have attained the menarche than among those who have not. The same is true of age-groups other than the fourteen-year-old girls;

(*b*) There is a definite relation between the mean heights and weights and the particular group of schools. Sherborne has the tallest and heaviest girls, Oxfordshire schools come next, while the other Dorset schools have the shortest and lightest girls. The same is true of age-groups other than the fourteen-year-old group, except that in one or two groups the Dorsetshire girls are slightly taller and heavier than the corresponding Oxfordshire girls.

(*c*) The suggestion that the taller and heavier girls may menstruate earlier is not borne out by the final column of figures. Sherborne has the smallest percentage of the fourteen-year-old girls who have attained the menarche and other Dorsetshire schools have the highest. The same ranking is observed in most other age-groups. The explanation may be that better child nutrition may lead to a postponement rather than to an advancement of the age of the menarche.

The investigation in Dorset is of particular interest as it affords, for the first time, the opportunity for studying comparative figures for groups of girls attending secondary schools and a group of girls of the same ages attending a public school in the county.

The ready co-operation of the head teachers, who made the investigation possible, is acknowledged with deep gratitude and the preparation of the necessary data, a lengthy and somewhat tedious task, by the physical training mistresses at the selected schools, is very much appreciated by those who planned the research.

STATISTICAL APPENDIX

TO THE SCHOOL MEDICAL OFFICER'S REPORT.

YEAR ENDED 31st DECEMBER, 1949.

The figures relate to the whole County.

TABLE I.

Medical Inspection of Pupils attending maintained primary and secondary schools.

A. *Periodic Medical Inspections.*

Number of inspections in the prescribed groups:—	
Entrants	4,760
Second age group	4,778
Third age group	4,531
Total ...	14,069
Number of other periodic inspections	619
Grand Total	14,688

B. *Other Inspections.*

Number of special inspections ...	6,862
Number of re-inspections	5,296
Total ...	12,158

C. *Pupils found to require treatment.*

Group. (1)	*For defective vision (excluding squint).* (2)	*For any of the other conditions recorded in Table II A.* (3)	*Total individual pupils.* (4)
Entrants	103	938	1,010
Second Age Group	281	562	807
Third Age Group	231	361	580
Total (prescribed groups) ...	615	1,861	2,397
Other periodic inspections ...	43	91	114
Grand Total	658	1,952	2,511

TABLE II.

A. *Defects found by Medical Inspection in the year ended* 31*st December*, 1949.

Defect or disease. (1)	*Periodic Inspections.* No. of defects. *Requiring treatment.* (2)	*Requiring to be kept under observation, but not requiring treatment.* (3)	*Special Inspections.* No. of defects. *Requiring treatment.* (4)	*Requiring to be kept under observation, but not requiring treatment.* (5)
Skin	30	12	371	1
Eyes—(*a*) Vision	658	105	271	36
(*b*) Squint	83	21	13	1
(*c*) Other	87	22	162	1
Ears—(*a*) Hearing	14	11	5	2
(*b*) Otitis Media ...	9	4	71	1
(*c*) Other	11	11	209	1
Nose or throat	470	433	226	18
Speech	37	18	16	4
Cervical Glands	7	25	57	2
Heart and Circulation ...	24	93	9	5
Lungs	23	154	12	3
Developmental:—				
(*a*) Hernia	18	13	2	—
(*b*) Other	36	47	7	9
Orthopaedic:—				
(*a*) Posture	214	66	170	13
(*b*) Flat foot	545	158	176	18
(*c*) Other	326	152	120	9
Nervous System:—				
(*a*) Epilepsy	3	4	3	—
(*b*) Other	4	4	—	—
Psychological:—				
(*a*) Development ...	22	15	151	3
(*b*) Stability	3	3	16	3
Other	76	198	2,318	11

B. *Classification of the general condition of pupils inspected during the year in the age groups.*

Age Groups.	*Number of pupils inspected.*	*A.* (*Good*).		*B.* (*Fair*).		*C.* (*Poor*).	
		No.	*% of Col. 2.*	*No.*	*% of Col. 2.*	*No.*	*% of Col. 2.*
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Entrants	4,760	2,571	54.0	2,082	43.8	107	2.2
Second Age Groups ...	4,778	2,665	55.8	2,045	42.8	68	1.4
Third Age Groups ...	4,531	3,112	68.7	1,372	30.3	47	1.0
Other periodic inspections	619	228	36.9	378	61.0	13	2.1
Total	14,688	8,576	58.4	5,877	40.0	235	1.6

TABLE III.

Infestation with Vermin.

(i)	Total number of examinations in the schools by the school nurses or other authorised persons	104,660
(ii)	Total number of individual pupils found to be infested	823
(iii)	Number of individual pupils in respect of whom cleansing notices were issued (Section 54 (2), Education Act, 1944)	3
(iv)	Number of individual pupils in respect of whom cleansing orders were issued (Section 54 (3), Education Act, 1944)	3

TABLE IV.

TREATMENT TABLES.

Group I. Minor Ailments (excluding uncleanliness, for which see Table III).

	Number of defects treated, or under treatment during the year.
(*a*) Skin:—	
Ringworm—scalp:—	
(i) X-ray treatment	8
(ii) Other treatment	—
Ringworm—body	30
Scabies	21
Impetigo	276
Other skin diseases	82
Eye Disease (External and other, but excluding errors of refraction, squint and cases admitted to hospital)	240
Ear Defects	270
Miscellaneous ... ... (e.g. minor injuries, bruises, sores, chilblains, etc.)	3,774
Total	4,701

(*b*) Total number of attendances at Authority's minor ailments clinics	16,428

Group II. Defective Vision and Squint (excluding Eye Disease treated as Minor Ailments—Group I).

	Number of defects dealt with.
Errors of Refraction (including squint)	1,922
Other defects or disease of the eyes (excluding those recorded in Group I)	66
Total	1,988

No. of pupils for whom spectacles were (*a*) Prescribed	1,868
(*b*) Obtained (from 1.7.49)	474

Group III. Treatment of Defects of Nose and Throat.

	Total number treated.
Received operative treatment:—	
(*a*) for adenoids and chronic tonsilitis	430
(*b*) for other nose and throat conditions	9
Received other forms of treatment	119
Total ...	558

Group IV. Orthopaedic and Postural Defects.

(*a*) No. treated as in-patients in hospitals or hospital schools	23
(*b*) No. treated otherwise, e.g. in clinics or out-patient departments	1,419

Group V. Child Guidance Treatment and Speech Therapy.

No. of pupils treated (*a*) under child guidance arrangements	87
(*b*) under speech therapy arrangements	115

TABLE V.

Dental Inspection and Treatment.

(1) Number of pupils inspected by the Authority's Dental Officers:—	
(*a*) Periodic age groups	12,861
(*b*) Specials	975
(*c*) Total (periodic and specials)	13,836
(2) Number found to require treatment	8,601
(3) Number actually treated	6,664
(4) Attendances made by pupils for treatment	15,186
(5) Half-days devoted to (*a*) Inspection	145
(*b*) Treatment	2,460
Total (*a*) and (*b*) ...	2,605
(6) Fillings: Permanent teeth	7,401
Temporary teeth	1,346
Total	8,747
(7) Extractions: Permanent teeth	1,441
Temporary teeth	6,689
Total	8,130
(8) Administration of general anaesthetics for extraction	2,626
(9) Other operations: (*a*) Permanent teeth	5,539
(*b*) Temporary teeth	803
Total (*a*) and (*b*) ...	6,342

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