

[Report 1960] / School Medical Officer of Health, Nottingham City.

Contributors

Nottingham (England). City Council.

Publication/Creation

1960

Persistent URL

<https://wellcomecollection.org/works/uxzpp3qc>

License and attribution

You have permission to make copies of this work under a Creative Commons, Attribution license.

This licence permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited. See the Legal Code for further information.

Image source should be attributed as specified in the full catalogue record. If no source is given the image should be attributed to Wellcome Collection.



Wellcome Collection
183 Euston Road
London NW1 2BE UK
T +44 (0)20 7611 8722
E library@wellcomecollection.org
<https://wellcomecollection.org>

14 NOV 1961

C I T Y O F
N O T T I N G H A M



E D U C A T I O N
C O M M I T T E E

PRINCIPAL SCHOOL MEDICAL OFFICER'S

ANNUAL REPORT

ON THE WORK OF THE

SCHOOL HEALTH SERVICE

FOR THE

YEAR 1960




Adopted by the Education Committee at
its Meeting held on 25th October, 1961.



R. G. SPRENGER, M.B., Ch.B.,
Principal School Medical Officer.

W. G. JACKSON, B.A., M.Ed.,
Director of Education.



Digitized by the Internet Archive
in 2018 with funding from
Wellcome Library

<https://archive.org/details/b29924923>

SCHOOL HEALTH SERVICE CONTENTS

	<i>Pages</i>
Accidents to pupils	32-37
Adult illiterates, classes for	24-25
Asthma and intelligence	42-44
Audiometry	25
B.C.G. Vaccination	47
Cardiac cases	28, 44-45
Chest radiography	47-48
Child guidance	20-22, 58
Cleanliness	31, 56
Colour vision	27
Convalescent homes	48-49
Deaths of children of school age	48
Dental inspection and treatment	49, 51, 60
Diphtheria immunisation	47
Ear, nose and throat, diseases of	12, 25, 58
Educational therapy	22
Electrical treatment	25-26
Enuresis clinic	45
Ewing School for the Deaf	14-15
Fat or overweight children	28, 29-30
Fluoridation of water supply	5, 50-51
Haemolytic streptococcal infection of removed tonsils	37-38
Handicapped pupils	13-20, 61
" " After-care committee	19-20
" " Dual or multiple handicaps	19
" " Employment of	16, 20
Heights and weights	41-42
Hostels for maladjusted children	22-23
Immunisation and vaccination	46-47
Infectious diseases	46
Lymphatic glands	12
Maturity, age of	41
Medical inspection	7-13, 55-60
" " the Clifton experiment	8-11
" " Accommodation in schools	11
Minor ailments, treatment arrangements	11-13, 59
Nottingham Children's Homes, Skegness	53
Ophthalmic service	11-12, 26-27, 57
Orthopaedic treatment	13, 27-28, 58
Paediatric consultative clinic	28
Physical education	52-53
Pipewood School	54
Plantar warts	11, 26
Poliomyelitis vaccination	46

CONTENTS—continued

	<i>Pages</i>
Rheumatic infections	37-38
School Meals Service	53
School Nurses	29-31
Sex distribution	39
Sex education	40-41
Skin conditions	11, 58
Speech therapy	12, 18, 23-24, 60
Spinal movements survey	6
Staff	3, 6-7
Swimming, facilities for	6
Thin children	28
Tongue tie	23-24
Tonsil and adenoid operations	25

Appendix

Minor ailments—treatment arrangements**	59
Medical inspection (Part I)	55-56
Defects found by medical inspection (Part II)	56-57
Treatment of pupils (Part III)	57-58, 60
Dental inspection and treatment (Part IV)	60
Handicapped pupils	61

CITY OF NOTTINGHAM

GENERAL INFORMATION AS AT 31ST DECEMBER, 1960

Population	313,760	No. of Schools	171
Area acres	18,364	No. on Rolls	51,691
Density of Population: 17.08 persons per acre		Average attendance	90.3%

CENTRAL SCHOOL CLINIC,
28 CHAUCER STREET,
NOTTINGHAM.

Telephone : Nottingham 43064.

SCHOOL HEALTH SERVICE

SPECIAL SERVICES SUB-COMMITTEE

(Municipal Year 1960-61)

Chairman : Councillor B. A. MORLEY

Vice-Chairman : Alderman J. LLEWELLYN DAVIES, B.A., M.B., B.Ch., F.R.C.S.

THE DEPUTY LORD MAYOR, Councillor JOHN W. KENYON, J.P.

(Chairman of the Education Committee)

Councillor W. DERBYSHIRE

(Vice-Chairman of the Education Committee)

Alderman Mrs. K. BARSBY

Councillor Mrs. G. M. F. HORNE

Alderman S. P. HILL

Councillor Lt. Col. G. H. C. NAPIER

Councillor W. R. CHURCHILL

Councillor H. WILSON

Councillor R. H. ELLIS

W. W. DIXON, Esq., M.Sc., A.R.I.C.

Councillor G. W. FISHER

J. D. SUNLEY, Esq., J.P.

STAFF (31st DECEMBER 1960)

Principal School Medical Officer :

R. G. SPRENGER, M.B., Ch.B.

School Medical Officers :

MRS. E. J. MORE, M.B., Ch.B., D.P.H.

W. M. HUNTER, M.B., Ch.B.

MRS. B. WARD, M.B., B.S., D.A., D.C.H.

R. H. BROWNING, M.B., B.S.

R. A. GARDEN, M.B., Ch.B.

Part-time Specialists :

(By arrangement with the Sheffield Regional Hospital Board)

G. GORDON-NAPIER, M.D., Ch.B., D.O.M.S. (Ophthalmic Surgeon)

J. HORTON YOUNG, M.B., B.S., D.O.M.S. (Ophthalmic Surgeon)

H. FRASER, M.B., Ch.B., D.O. (Ophthalmic Surgeon)

A. R. A. MARSHALL, M.B., Ch.B., F.R.C.S. (Aural Surgeon)

A. P. M. PAGE, M.D., M.R.C.P., D.C.H. (Paediatrician)

W. WAUGH, M.A., M.Chir., M.B., F.R.C.S., L.R.C.P. (Orthopaedic Surgeon)

A. GORDON, M.R.C.S., L.R.C.P. (Anaesthetist)

MRS. E. ARKLE, M.D., D.P.M. (Psychiatrist)

W. L. JONES, M.B., B.S., D.P.M. (Psychiatrist)

F. G. THORPE, M.B., Ch.B., D.P.M. (Psychiatric Registrar) (up to August, 1960)

T. W. ROGERS, M.B., Ch.B., D.P.M. (Psychiatric Registrar) (from November, 1960)

MISS U. E. BATT, L.R.C.P.S.I., L.M. (Registrar) (from September 1960)

Part-time Medical Officers :

MISS T. M. PHELPS, M.B., B.S.,

W. K. S. MOORE, M.A., M.B., B.Chir.,

J. L. K. WATKINSON, M.R.C.S.,

(M.O., Boots' College)

L.R.C.P.

MRS. J. G. S. WAUGH, M.B., B.S.,

F. G. A. ARMSON, M.C.R.S., L.R.C.P.,

M.R.C.S., L.R.C.P.

(M.O., Pipewood School until July, 1960)

MISS G. N. McCOACH, M.B., Ch.B.

S. J. HARRIS, M.B., B.S., M.R.C.S., L.R.C.P.

Audiometrician :

*E. F. WARD, M.S.A.T.

Dental Officers :

W. McKAY, L.D.S. (Principal School Dental Officer)

MRS. M. P. CHADWIN, B.D.S.

(resigned 31/3/1960)

MISS. H. WAIN, L.D.S.

(resigned 31/1/1960)

*V. C. CARRINGTON, L.D.S.

*N. E. CHETTLE, L.D.S.

*MRS. E. DURANCE, L.D.S.

*E. A. MEADOWS, L.D.S.

*MISS M. M. CLERKE, B.D.S.

*Child Guidance Centre :*MRS. J. FRY, M.A., Ed.B. (Senior
Educational Psychologist)MISS B. M. BALDWIN, B.A., (Child
Psychotherapist) (resigned 22/1/1960)MISS M. G. RICKETTS, M.A., Ed.B.
(Junior Educational Psychologist)
(resigned 31/1/1960)A. GORTON, B.A. (Junior Educational
Psychologist) (from 1/7/1960)MISS A. WATSON, M.A. (Psychiatric
Social Worker) (resigned 14/5/1960)MISS M. M. BEESON (Remedial
Teacher)MISS P. A. E. GRADY, L.C.S.T.
(Senior Speech Therapist)MRS. C. H. M. ALDRIDGE, L.C.S.T.
(Speech Therapist) (resigned
30/11/1960)MISS L. M. HARTLEY, L.C.S.T. (Speech
Therapist)MISS E. A. TARBOTTON, L.C.S.T.
(Speech Therapist) (resigned
31/1/1960)

MISS R. E. SIMMS, L.C.S.T. (Speech Therapist) (from 1/2/1960)

Administrative Assistant : D. R. FREER, D.P.A. (from 1/1/1960)*Superintendent School Nurse :* MISS F. PINDER, S.R.N., S.C.M.*School Nurses :* Nineteen full-time and six part-time*Nurses' Assistants :* Six*Clinic Attendants :* Nine part-time.*Dental Attendants :* Five full-time and one part-time*Clerical Staff :* Senior Clerk (G. E. D. HANCOCK) and twenty-four Clerks*Hostels for Maladjusted Pupils :*

ORSTON HOUSE—Warden and Matron : MR. and MRS. C. A. FITCH

THE GABLES—Warden and Matron : MR. and MRS. A. O. BROUGHALL

**Part-time Staff*

CITY OF NOTTINGHAM EDUCATION COMMITTEE

SCHOOL HEALTH SERVICE

REPORT FOR THE YEAR ENDED 31st DECEMBER, 1960

BY

THE PRINCIPAL SCHOOL MEDICAL OFFICER,

DR. R. G. SPRENGER

*To the Chairman and Members of the
City of Nottingham Education Committee*

LADIES AND GENTLEMEN,

I have the honour to present the 52nd Annual Report of your School Health Service.

I would like first of all to thank all members of the staff both professional and administrative for the way in which they continued the work of the department when I unfortunately was absent on sick leave for a period of several months. It was very gratifying on my return to find almost no back log with which I had to cope. My especial thanks are due to Dr. More for the able way in which she kept the work of the department flowing.

This has been a year in which there has been little exciting to report, and one in which the work has gone on steadily.

The dental department remains grossly understaffed and it has been impossible to do more than continue the hand to mouth existence of 1959 when we had a Principal School Dental Officer and four part-time officers. With this limited staff, it is impossible to keep up any policy which would cater for more than emergencies and a very little prophylactic work. The dental and medical profession are keen to support a scheme of fluoridation of the water supply but one has to bear in mind that this will not affect even the five year old group for some years and that, under the best conditions, it will reduce caries by only 50%. Even this would, of course, be well worthwhile, but it is to be hoped that improved dietary habits would also be possible, or that a fluoridated tooth paste especially for youngsters might be found to add enough fluoride to act as a prophylactic, and so prevent the wholesale absorption by all and sundry, and not only by those at risk, of a substance which will at least be quite expensive to add to the water supply.

The Mental Health Act 1959 came into force in December, and so far its requirements have made no difference to our work in dealing with the educationally sub-normal handicaps. It will, however, give parents the opportunity to appeal annually against a decision to leave their child out of the school educational system.

There is hope that additional swimming facilities will be provided in the City in the near future, but I still feel that small learner baths would be very helpful in getting rid of the fears of large quantities of water which many youngsters have. I well remember the fun and obvious enjoyment which infants in one of the poorer districts of the City used to have when they used a small bath in their school. The whole thing was quite unhygienic and frowned upon but it did improve the self confidence of many otherwise timid and fearful children. Fortunately, although theoretically unsatisfactory, there were no practical ill effects. I am not, of course, advocating this kind of thing but merely hoping that small learner baths, adequately chlorinated, will become more common.

We have continued to make use of the unique facilities of the School Health Service in continuing or starting investigations. Most of this can be done in the routine work of the department without creating difficulty as the collection of figures by the office staff is part of the requirement of the Ministry and our investigations, etc. involve very little extra work, but do add interest to it.

At the moment we are dealing with a number of investigations, the new ones being :—

1. The age of onset of puberty in girls.
2. Comparison of heights and weights of children of thirteen years of age in 1910 and 1960.

And we are continuing our interest in :—

3. Cardiac defects in school entrants and keeping an up-to-date register of these.
4. Our survey of children with limited spinal movement. With this we are including a general survey of all joint movements and noting whether children have a generalised limitation of all joint movements or whether any limitation applies only to one or two joints. Mr. Waugh, the Orthopaedic Consultant seconded to us by the Regional Hospital Board, has taken a very active interest in this and is giving us the benefit of his advice as well as actively participating.
5. Streptococcal infection of tonsils removed at operations and any possible connection with the frequency of rheumatic fever and similar manifestations.
6. Accidents—school, home and street—to pupils.
7. The numbers of overweight children (boys and girls) in schools and their age range.
8. Old and new cases of undescended testicles.

STAFF :

Part-time Consultants : There were no changes during the year except in the Child Guidance Clinic, where we were sorry to lose the services of Dr. Thorpe as Psychiatric Registrar. We welcome in his place Dr. Rogers, who took up his duties in November. The Regional Hospital Board also seconded to us the services of Dr. Batt, registrar on the staff of St. Ann's Hospital to assist in the Child Guidance Clinic.

School Medical Officers : We had a full complement for the whole year except for the long absence of the Principal School Medical Officer. In addition, Dr. Browning was involved in a car accident which kept him on sick leave for nearly two months.

School Dental Officers : Two full-time dental officers left in the early part of the year and since then the dental staff has remained at a very low ebb. We have only Mr. McKay, the Principal School Dental Officer, and five part-time dental officers (including one engaged solely on orthodontic work).

Child Guidance Centre : The Regional Hospital Board, as well as seconding a consultant psychiatrist, have now also replaced the psychiatric registrar so that we now have ten sessions a week of psychiatric time. I think this demonstrates that there is general realisation of the need for adequate psychiatric opinion in Child Guidance Centres.

There is, I am afraid, a marked shortage of auxiliary staffs in the whole world of Mental Health, e.g. we have been quite unable to replace the child psychotherapist who left early in the year, nor have we any fully qualified psychiatric social worker. (At the time of writing, I am able to report that we have a social worker full-time and one part-time, but we are fortunate in having some part-time services as mentioned above from the registrar attached to the children's residential unit at Mapperley. This unit is now officially a hospital school and the committee have appointed a master in charge).

In other sections of the Child Guidance Centre—i.e. Educational Psychologists and Speech Therapists—we have been able without too much difficulty to fill any vacancies which arose during the year.

Other Staff : On 1st January, 1960, Mr. Freer took over the post of Administrative Assistant from Mr. Thornhill, who had served in the department for very many years. I think it reflects well on Mr. Freer and his predecessor, and on those older (in time and not in age) members of the office staff who gave their ready co-operation, that the change was such a smooth one. At this point, it would not be right that I should not mention that Mr. Thornhill continues to enjoy his well earned retirement.

The Education Committee having decided to close down the Pipewood Camp School, our nurse who lived on the school premises has now returned to duty in Nottingham and taken the place of one who has left.

MEDICAL INSPECTION :

This routine work has continued during the year with no difficulty, but our figures are lower than in 1959, owing to loss of time due to illness among the medical staff. It is difficult to make comparisons as the staff shortage has meant our cutting out the inspection of many children in the 7-8 year group generally, but on the other hand, in the Clifton area, these, with others in the junior schools, have been put into special groups who may have been seen as often as every term.

There still continues to be criticism of routine medical inspections and the fact that large numbers of children are seen who have no disability worth noting would seem to justify this. And yet, especially with the Entrant examination, if one asks parents what they feel about this, it is

rare indeed to get any other answer than that these examinations are well worthwhile and help considerably in reassuring parents about their child's condition and health.

Very much the same attitude applies at Intermediate examinations and one must constantly bear in mind that a word in the right place with a parent may well be the means of imparting some real health education.

With regard to the Leaver examination where, I am afraid, few parents turn up, this remains important from the need to give advice about employment, not only to the child but also to the Youth Employment Service who are particularly concerned in all cases where there may be some limiting defect. It has to be borne in mind that youngsters can often manage a fairly normal school life, but conditions like asthma, defective eyesight or colour vision, difficulties over hearing, etc., may all create problems in the world of employment.

The Clifton Experiment.

Reference has been made in my last two annual reports to an experiment being undertaken in the junior schools on the Clifton Estate. The principle underlying the experiment is to replace the conventional routine Intermediate medical examinations of all pupils at about the ages of 7 and 11 by an arrangement whereby the school doctor sees only those children in actual need of examination. Such children may be seen every term. The Committee agreed to try out this experiment and I am now in a position to make an interim report. (Although this annual report is for 1960, I have covered the progress of the experiment up to the middle of 1961 for the sake of continuity).

It will be recalled that each term, children were seen in the following groups :—

- (a) Those under observation for some particular defect (including handicapped pupils).
- (b) Those who may be causing anxiety to parents or teachers either physically, mentally or socially.
- (c) Those who cannot take part in physical activities.
- (d) Neglected children and those whose homes are known to be unsatisfactory.
- (e) Those whose attendance is unsatisfactory.
- (f) Those about whom the School Nurse has expressed concern.

What is necessary to ensure success ?

- (a) Keenness and interest on the part of the Head Teachers and their staffs. They are, in the main, the people who bring children to our notice in the first place. Waning enthusiasm on their part can kill the scheme.
- (b) Keenness and drive on the part of the School Medical Officer and School Nurses. Doctors report that their work in the experiment is "very trying."
- (c) As a complementary factor, good relationships between teaching and medical staffs. This can only be brought about satisfactorily if there is continuity. From our side, we have failed to some extent in that "our man" was absent for quite long periods.

Advantages of the scheme.

- (a) From the common-sense point of view—those children most in need of medical supervision get the doctor's time, and probably more of it than under the conventional system. These frequent visits of the Medical Officer have an improving effect on the chronically ill-cared for and unsatisfactory families, keeping the youngsters cleaner, tidier and more acceptable in the schools.
- (b) School Medical Officers are able to discuss cases, on the spot, with Head Teachers. (This can also be done at the conventional periodic inspection; but not at a clinic, to which a child requiring treatment between periodic inspections would normally be referred).
- (c) School nurses have less routine work to do. They do not have to "prep" a school, as they do prior to a periodic inspection. (But it may have to be decided that vision and heights and weights of *all* children will have to be checked by the School Nurse at times when intermediate inspections would normally be held).

Disadvantages of the scheme.

- (a) The major criticism by the doctors is that too much is left to chance. The scheme depends, in the first place, largely upon the Head Teachers' initiative, but even if the initiative is there, the medical experience clearly cannot be—so there is a serious danger that some children who ought to be seen may not even be referred. In the second place, if a child is referred for a particular defect (e.g. flat feet) which has been noted by the Head Teacher (or other person) then the School Medical Officer will naturally concentrate on that defect. But meantime, some other more serious defect, (such as hernia or cardiac) may be missed.
- (b) Successful operation of the scheme depends to a large extent on continuity—the same doctor seeing the pupils and maintaining contact with the staff. While we may have had more than our fair share of bad luck, experience has shown that it may be difficult to use the same doctor for a long period.
- (c) Parental reception of the scheme is mixed. Some parents are gratified at "never having had it so good." On the other hand, some parents have taken a poor view of taking time off from work, only to have five minutes or less with the doctor over, for example, their child's flat feet.

Conclusion.

- (a) How far has the scheme been successful? So far, the keenness and drive required by the schools has been adequate. But is it not a debatable point as to whether they will be maintained? Below is a summary of the cases seen at each school over the past two years. From it can be seen differing degrees of initiative on the part of the schools and perhaps a tendency to refer fewer children than originally. But the experiment has not yet really had time to settle down, and the statistics may not be conclusive.

- (b) Are the advantages of seeing children with known defects regularly equalled or even outweighed by the "chance" element referred to above? There is a great deal to be said for the conventional pattern, which at least ensures that *all* children are thoroughly examined at regular, if less frequent, intervals. And moreover, the old system does place the responsibility fairly and squarely on the medical officers. The doctors themselves are not unanimous. The doctor who steered the scheme—with some absences—during the first twelve months or so thought it serves its purpose. Two other doctors, who "stood in" for quite long periods are firmly in favour of the old scheme.

<i>School</i>		<i>Autumn</i> 1959	<i>Spring</i> 1960	<i>Summer</i> 1960	<i>Autumn</i> 1960	<i>Spring</i> 1961	<i>Summer</i> 1961
A							
Follow-ups .. ..	..	22	16	18	31	37	34
Supt. Nurse's list ..	..	5	5	3	8	10	10
Handicapped Pupils ..	..	3	1	—	2	3	2
H. T.'s requests ..	..	59	11	1	23	13	29
		89	33	22	64	63	75
B							
Follow-ups .. ..	..	49	34	37	13	32	34
Supt. Nurse's list ..	..	7	8	9	5	9	10
Handicapped Pupils ..	..	1	2	3	2	5	5
H. T.'s requests ..	..	10	12	—	10	6	7
		67	56	49	30	52	56
C							
Follow-ups .. ..	..	34	31	14	30	31	35
Supt. Nurse's list ..	..	7	5	—	7	9	8
Handicapped Pupils ..	..	2	1	2	2	1	4
H. T.'s requests ..	..	17	17	4	9	15	14
		60	54	20	48	56	61
D							
Follow-ups .. ..	..	21	14	12	13	12	23
Supt. Nurse's list ..	..	—	3	3	4	4	6
Handicapped Pupils ..	..	3	2	—	4	5	4
H. T.'s requests ..	..	13	6	1	7	8	3
		37	25	16	28	29	36
E							
Follow-ups .. ..	..	24	—	33	10	32	21
Supt. Nurse's list ..	..	1	—	1	2	3	4
Handicapped Pupils ..	..	3	—	2	2	2	2
H. T.'s requests ..	..	46	—	5	3	11	—
		74	—	41	17	48	27
F							
Follow-ups .. ..	..	21	18	8	22	25	19
Supt. Nurse's list ..	..	3	3	2	1	1	2
Handicapped Pupils ..	..	—	—	—	1	—	—
H. T.'s requests ..	..	—	1	—	1	—	—
		24	22	10	25	26	21

<i>School</i>	<i>Autumn</i> 1959	<i>Spring</i> 1960	<i>Summer</i> 1960	<i>Autumn</i> 1960	<i>Spring</i> 1961	<i>Summer</i> 1961
G						
Follow-ups	28	—	21	4	15	19
Supt. Nurse's list ..	—	—	—	—	2	3
Handicapped Pupils ..	1	—	—	—	1	2
H. T.'s requests ..	12	—	2	12	1	9
	<u>41</u>	<u>—</u>	<u>23</u>	<u>16</u>	<u>19</u>	<u>33</u>
H						
Follow-ups	25	28	36	25	24	23
Supt. Nurse's list ..	5	5	5	6	6	10
Handicapped Pupils ..	1	2	3	3	3	4
H. T.'s requests ..	16	3	1	—	1	—
	<u>47</u>	<u>38</u>	<u>45</u>	<u>34</u>	<u>34</u>	<u>37</u>

Where do we go from here? Clearly, our conclusions so far are inconclusive, and the Committee propose to continue the experiment for another two years or so, after which I shall report again.

Accommodation for Medical Inspections in Schools.

Most medical inspection work is done in the schools and accommodation is usually satisfactory, but in some—especially the older schools it is not very satisfactory, and I would put in a plea for improved facilities when the question of building improvements is being considered. When making this complaint, I do not wish to be critical of the attitude of Head Teachers, most of whom go out of their way to arrange the best possible accommodation for the medical officer and parents, at times even to the extent of giving up their own rooms.

Some Notes on Findings at Medical Inspections. (See Appendix, Part II, Tables A and B).

Skin Conditions : There is a slight increase in the numbers showing these defects. It is difficult to give a reason for this but on going into the diagnosis in a small group, it looks as though warts, both general and plantar, and foot infections are the reason for this.

We continue the electrical ionisation of warts of all descriptions, I have written some notes about this under "Electrical Treatment" which are to be found on Page 26 of this report.

Eyes :

(a) **Vision :** If one compares the figures for 1959 and this year, there is some slight increase in the figure of those requiring treatment.

The figures for examinations by the consultants remain fairly even over the years, varying between 4,600 and 4,900 annually between 1957 and 1960. The number of referrals from medical inspections for eye examination also alters little from year to year, being for the above period between 500 and 600 annually.

(b) **Squint :** The youngsters with this defect alter little in number also over the years. If anything there is a tendency for a reduction, and also treatment is probably being undertaken in the pre-school period. For the most part, the condition is a family one and children in these families are the ones at risk and can be seen and checked early.

(c) **Other :** In this small group, one finds youngsters with ptosis (drooping upper lids) and other defects of the lids. It is here that the work of the plastic surgeon can be most useful, converting an obvious defect into normality.

Ears :

(a) **Hearing :** We continue to keep a sharp lookout for any child with a possible hearing defect. Wholesale audiometry is time consuming and does not, like visual testing, always give us an exact result. We still select our cases for audiometry and include all children at risk. All children with delayed or defective speech development, those who have had encephalitis or meningitis, those with recurring or persistent otitis media, and any suspected by teachers or educational psychologists of having hearing difficulties or fleeting concentration, have audiometry and indeed may have it repeated regularly to check on possible changes in their hearing.

(b) **Otitis media :** It is disappointing to note no continued fall in the incidence of this condition, which can especially affect those who may wish to go into the services as either boy entrants or apprentices. None of the Services will accept youngsters showing signs of this condition, although it may create no real difficulty in civilian life.

Nose and throat : The number of children showing conditions affecting either or both nose and throat continues to fall, and our own waiting list of children for tonsil and/or adenoid operation has fallen considerably.

Speech : Medical Officers have, I am afraid, considered speech difficulties and their treatment as something mysterious and beyond their capacity to deal with, let alone take any interest in it until recently and they are now noting more youngsters with speech defects.

Lymphatic glands : It is interesting to note that not a single child in the entrant group and only one in the leaver was noted as needing treatment for enlarged glands (and I think that one, when operated on, showed some evidence of malignancy).

Heart : Some tendency to an increase in numbers may be due to regular observation of those known to have or suspected of having cardiac defects. I have given some details of cardiac cases on Page 44.

Lungs : There seems to be a general tendency for less lung involvement. This group is almost entirely bronchitis, as one would expect with antibiotics being so effective and rapid in their relief of the acute conditions which youngsters suffer from—repeated attacks can, of course, lead to chronic bronchitis.

Developmental conditions :

(a) **Hernia :** It is interesting to note that no leaver was found to have this condition.

(b) **Other :** Includes undescended testicles in which we are continuing to take an especial interest.

Orthopaedic : There are definitely many fewer serious orthopaedic defects, but there is still much of a minor nature, especially foot defects such as hallux valgus which is building up difficulties later in life. This applies particularly to older girls who will wear fashionable shoes, especially with stiletto heels which undoubtedly increase the deformity.

Nervous system :

Epilepsy : A lower figure in this group is probably a good sign.

HANDICAPPED PUPILS:**Blind :**

Residential Special Schools	5
-------------------------------------	---

The total has increased by one, a boy who has had operation for a cerebral tumour which left him with blindness (optic atrophy).

Partially sighted :

Residential Special Schools	3
Ordinary Day Schools	19

The severely involved remain the same in number. The group in ordinary schools, however, has decreased in numbers. We continue, of course, to observe them annually, and especially note their educational progress. This number includes our albino children.

Deaf :

Day Special Schools	27
Residential Special Schools	3
Independent Residential Special Schools	1

The total remains the same as last year but eight have left in the meantime and their places taken by newcomers in the lower age ranges.

The City children who have left (two boys, one girl) have been placed in satisfactory employment with one exception, namely a boy with a dual handicap who was both educationally sub-normal and deaf and quite unable to communicate with anyone except by gesture.

Partially deaf :

Day Special Schools	11
Residential Special Schools	2
Ordinary Day Schools	52

There is little change in the numbers in our Day School for the Deaf.

One is often asked who are partially deaf as opposed to deaf and the simple answer is that the latter do not learn normal speech even with all the help that the latest electrical aids can give.

The large number in ordinary schools is under careful observation by their teachers who know them, and by Medical Officers, etc., periodically. It is unusual for any of these to have or to develop such a severe hearing loss as to need their transfer to our Day Special School.

The Ewing School was opened in September, 1960 and is fitted with all the latest equipment to help the handicapped. Placed far enough away from the main road so that traffic noise is not noticeable, and with sound and resonance proofing on floors and ceilings respectively, the school is able to make use of an excellent loop system and has also been fitted with communal aids of an extremely high quality. Each child has a set of ear phones and the phone to each ear can be controlled individually by the child himself who also has his own microphone so that he can hear his own voice, something which has helped each child to develop better tune in his voice.

The Head Master of the Ewing School, Mr. J. R. W. French, has supplied the following notes. I would like to add that Mr. French's use of the term "to stimulate their hearing" is a good one and probably more correct than other terms used in the field of hearing defects and the education of the deaf.

The Ewing School for the Deaf

"The new equipment and conditions in which it can be used in this new building, to which we moved in September, 1960, has been of great benefit to deaf children living in this locality.

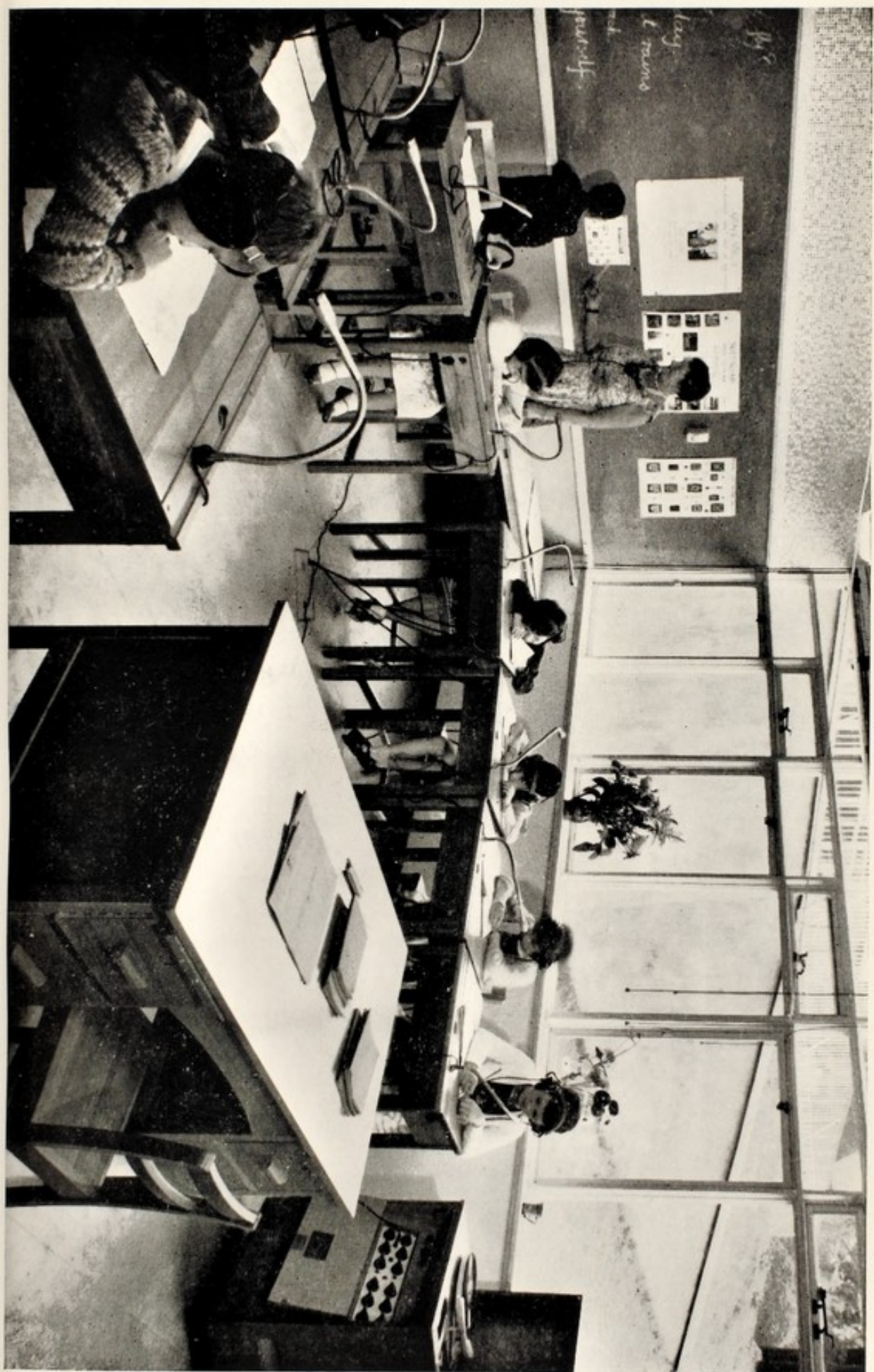
These benefits we feel have been both social and educational. The beautiful surroundings and pleasing building have had a good effect on the children's behaviour. The opportunities for recreation and games have benefited the children physically, but most of all, the opportunity for the human voice to be powerfully amplified so that children can use what hearing remains to them, has been the greatest gain.

The comprehensive hearing aid provision has resulted in these improvements :—

1. Production of better voice by deaf children.
2. It has aided them in their comprehension of what is said.
3. It has helped to produce better speech.
4. It has aided the children's acquisition of language.
5. It has enabled the children to enjoy auditory stimuli by using gramophones, films and music.

The school has attracted a good deal of attention with articles in both the national and local press and in foreign magazines. We have been visited by the B.B.C. for items for both sound and television programmes. There have been many visitors from different parts of the World and students from Nottingham and Manchester Universities, Kesteven and Derby Teacher Training Colleges, Queen's Nurses and Health Visitors. The East Midlands Branch of the Medical Officers of Health Society held a meeting here and we have had a visit from two medical officers from the Ministry of Education.

We feel that the opportunity provided here for deaf children to have their hearing stimulated from an early age, combined with skilful teaching, is the most helpful way to tackle this difficult educational problem. We are hopeful that given the chance with an early start, we shall be able to do more for this generation of deaf children, than we have been able to do with others in the past."



One of Mr. French's staff, Miss A. E. Miller, who is engaged as a peripatetic teacher of the deaf, has submitted the following report :—

"During the year all the Junior Schools in the City were visited in order to acquaint the Head Teachers with the work being done to help the children who may be handicapped by a slight hearing loss.

Just over 70 children were thought by their teachers to be somewhat hard of hearing, the chief reasons given being that the child was inattentive, lacked concentration, was a poor reader or didn't speak clearly. After testing all children reported to me, 14 were placed in classes and given help for one hour each week with general subjects, lip-reading and speech, if necessary.

A surprising feature of the visits has been the difference in the number of children brought forward for testing from school to school. On two visits 10 children were tested, while on others no child was thought to be hard of hearing. The average number of children tested in a school was about 3. Forty children are now attending lip-reading lessons regularly, consisting of 3 infants, 20 juniors and 17 seniors. There are 10 classes, having from 2 to 6 children in each, and held in different districts in the City, as it is thought to be much more satisfactory for the children not to have to travel long distances to a central meeting place.

Of the 40 children attending classes 10 have hearing aids and one other child who was given one has returned it. Another boy is getting real benefit from a hearing aid bought privately by his father. All but one of the children having hearing aids wear them regularly at school and say they sometimes use them at home, usually for television only.

The one boy mentioned has worn his aid regularly for 2 years (he is now 14) but two months ago he said it was broken and couldn't be mended. After he had been without it for a fortnight I myself took it to be mended and returned it to the boy at school. I have since seen the boy's Headmaster who tells me that he still does not wear the aid in school, which rather suggests that he has become self-conscious at being the only one in the school wearing an aid, or that he has been teased about it. (*This is not an uncommon state of affairs R.G.S.*)

Two of the children reported by the School Health Service as needing help have not joined classes owing to parental objection. Apart from these two cases, parents have been co-operative and pleased that their children were receiving help.

Since the last report was made, 9 children have left school and started work, 2 children have left Nottingham and 9 have made satisfactory progress and are no longer attending classes. Three children will be leaving school in July, 1961."

With the continued improvement in hearing aids, it would seem possible for more of our children who attend our School for the Deaf to be returned to ordinary school. This has worked quite well in selected instances where a youngster has gone back to junior school to a teacher who has understood his difficulties, and who has made a point of speaking directly to the child, in a good light, etc. Difficulties arise, however, in the secondary modern school where teachers change for each subject, and where there is less likelihood that any one teacher may take a friendly

and practical interest in an odd youngster. I have discussed this difficulty on several occasions with the Head Teacher of the Ewing School, and I know how easily confused the partially deaf can be when out of their usual routine. It is realised, of course, that these youngsters have to go into the everyday world of employment but their handicap needs special help there and they are, of course, always included in those discussed by the After-Care Committee.

A typical example of a youngster in this category left school recently. His parents were immigrants who always used their own native language in the home so that, with his defective hearing, he was extremely late in using English and indeed it was not until his last two years at school that he was able with the help of a new transistor hearing aid to speak well enough to be understood and to understand what was said to him. He has gone to a technical type of employment and to a thoughtful and understanding employer.

Delicate

Day Special Schools	32
Residential Special Schools	13
Ordinary Day Schools	210

With the steadily improving health of all children, there is a still further decrease in our figures both of those in Day Special and Day Schools. This is something on which we can congratulate ourselves and is a reflection of the general trend throughout the country.

We now no longer put post-rheumatic cases into this group, but make temporary arrangements in schools for restriction of their activities, which rarely lasts as long as twelve months.

Physically handicapped :

Day Special Schools	52
Residential Special Schools	11
Hospital Special Schools	1
Ordinary Day School	12
Home Tuition	2
Awaiting placement	1

Figures have again increased in this group and we are catering for most of these quite adequately in our Day Open Air School.

Those having home tuition are an interesting pair. One, who has had a complete paraplegia due to a transverse myelitis (cause indefinite) and which has been present now unchanged for some years, wishes despite her incontinence to go to school in her push chair. The other, a cerebral palsy with gross athetoid movements, has been tried in Day Open Air School but her movements were so persistent that she almost wore through the skin in contact with her chair.

Those in ordinary schools are noted below and are quite a pathological collection in themselves. They do not find difficulty in taking their places among their fellows or it would be necessary to move them. They are, of course, known well to our department both to the school nurse and annually—or at times more frequently—to the Medical Officer.

Amputation of limb	2
Still's disease	1
Imperforate anus and colostomy	1
Fragilitas ossium	1
Tubercular spine	1
Myositis ossificans	1
Old poliomyelitis	2
Spina bifida	1
Mitral stenosis	1
Hodgkin's disease	1
	<hr/>
	12
	<hr/>

Most of these above conditions involve the bony skeleton in one way or another and youngsters are able to overcome these difficulties so much more easily than adults that one cannot cease to wonder at this facility. A recent memory of mine is of a boy with an artificial leg playing a very good and well balanced game of football.

Educationally sub-normal :

Day Special School	417
Residential Special Schools	3
Awaiting placement in Day Special Schools ..	48*
Awaiting placement in Residential Special Schools	2

*19 of these were admitted to Day Special Schools in January, 1961.

We still have a waiting list but it is being kept within reasonable proportions at the moment, and, continuing our policy of not admitting older children, we are trying to make decisions as early as possible in the child's school life. The waiting list and this policy does on occasion create a problem, e.g. two older boys from an outside authority recently came into the town and as there was no room for them in special schools, they went to ordinary school where they were quite out of place, and, parental interest being absent, it was not long before they came to court where the magistrates were set a problem.

Maladjusted :

Ordinary Day Schools	12
Day Special School	1
Resident Hostels	14
Grammar School (Boarding)	1
Residential Special School	1
Residential Independent Schools	3

This group we tend to keep as small as possible and as I have noted before, we do not include all cases of maladjustment known to us but only those for whom it has been necessary to arrange fairly prolonged child guidance treatment or even make arrangements for residential treatment either in our own hostels or in residential schools. As a rule, residential treatment which can keep close touch with the child's parents is always preferable.

The following two examples of the type of youngster who has done well are of interest.

(1) A bright boy with an I.Q. of 130 who had been noted to have a mild congenital heart condition was, when seen by the psychiatrist "grossly emotionally disturbed, with attainments at variance with his

capacity and with a home background of hysterical neurosis." He would not settle at school, and while attending the Child Guidance Centre for psychotherapy stole a fairly large sum of money from a relative.

He went to a residential school where the emphasis was on hard physical work together with a fairly high standard of educational needs and he did well, and went on to a nautical college for training for the Merchant Navy. It is of interest to note that he developed a duodenal ulcer while there but it "healed" quickly.

(2) A boy of average intelligence who was lying, stealing and quite unreliable in school and home. His home background was very unstable and we could see little hope of helping him while he remained there, and he went to a school similar to that noted above. We encouraged his idea of going into the Royal Navy and this he has done. He was proud of his uniform and his mother, although a little emotional about it, was really proud and a little boastful about her boy, a change of attitude which would never have occurred if he had not had the advantage of efficient and sensible handling in a residential school.

Epileptic :

Day Special Schools	1
Residential Special Schools	9
Ordinary Day Schools	99

There has been an increase in our figures especially of those in residential schools. It is difficult or impossible to give a reason for this. Those who go for residential treatment are always creating anxiety in some way, either in school or at home or, as happened with a recent admission, a child had attacks on a main road which might well have resulted in a serious or even fatal accident not only to herself but to others. It is important to remember that these youngsters (and their parents) are encouraged to lead a normal life.

Most of our children go to Lingfield but it is a long way from our City and the journey is not an easy one to make. It would be an advantage if there was a residential school for this handicap more convenient to Nottingham. Even the Soss Moss school run by the Manchester Authority where we also have children has not a straightforward journey.

Speech Defects :

Ordinary Day Schools	3
Residential Special School	1
Day Special School	1

These figures refer only to youngsters with gross speech difficulties. It will be seen in a note given by our senior speech therapist (see page 23) that we have to deal with large numbers of children suffering from lesser speech defects and that the main job of the speech therapist is to help many, to keep many under observation and to make sure that defects do not persist long enough to become a habit of bad or unsatisfactory speech.

Children with dual or multiple handicaps :

This group is fortunately a small one, but it does create difficulty in making a decision as to which handicap must be considered the most important. The following list gives some idea of the types of mixed handicap we have to deal with, the one noted first being the main one.

Major Handicap	Other Handicap						
	<i>Partially Sighted</i>	<i>Partially Deaf</i>	<i>Delicate</i>	<i>Physically Handicapped</i>	<i>E.S.N.</i>	<i>Mal-adjusted</i>	<i>Epileptic</i>
Partially Deaf ..	1				1	1	
Delicate ..					5		1
Physically Handicapped		1			5		2
E.S.N. ..	2	10	7	1			10
Epileptic ..					3		
Speech ..				1			

I have commented on the difficulties confronting Medical Officers when they have to make a decision on the type of special educational treatment most suitable for a youngster with more than one handicap. I think the above table gives some idea of the miscellaneous handicaps we have to deal with, and therefore the difficulties in coming to a decision. It is surprising how an E.S.N. child finds his additional partially deaf or partially sighted handicap so much more grave a stumbling block than one whose intelligence can help him to overcome his difficulties.

It is necessary for our own special schools to cater for several handicaps, e.g., in the Arboretum Open Air School are children with physical handicaps and speech defects; some of these may also be doubtful educationally sub-normals but the physical handicap being the main difficulty, they remain in our Arboretum School.

It is fortunate that some residential schools will take those with combined handicaps, for example, Exhall Grange which caters mainly for the partially sighted will take those with an additional (e.g. physical) handicap and Bridge House, Yorkshire, the deaf who are also educationally sub-normal.

After-Care of Handicapped Pupils :

The "liaison" Committee consisting of administrative members of the Education Authority and other welfare agencies have continued to meet each term. Every handicapped child leaving school is considered with regard to the type of work possible, and all who have failed to fit into the world of employment since the last meeting of the Committee are reviewed. In a City such as ours in which such a multiplicity of trades function, it is probably easy to place handicapped people in work, and there are few who fail to fit in.

I thought one or two examples of handicapped pupils dealt with by this group would be of interest :—

1. An E.S.N. boy from a home where interest and stimulation was very sketchy—he has been placed in a trainee job with a city firm and has retained this now for some six months.
2. A boy with a spina bifida who has incomplete bladder control has been taken for training by an electrical firm who are making allowances for his difficulty and finding him a likable and useful lad.
3. A cerebral palsied girl, with athetosis and some hearing loss, is working in the kitchen department of a nationally known local firm and has retained her job for six months.

It was not expected that these three would fit into the world of employment easily but events have proved us wrong.

4. A youngster with a multiple arthritis who has great difficulty in getting about but who has fair use of her deformed hands—she has been accepted for training of a vocational type by the local workshops for the disabled. She wants to be independent.
5. A boy whose parents never stimulated him to think of making himself independent and who was quite happy to lean on them at all times—he is still leaning, and the parents seem to be content to let this continue. They have not asked for any help.
6. A girl with longstanding kidney trouble who never seemed to feel she could work and whose parent encouraged this idea—she is unlikely to alter, although most people felt she could do something towards her keep.

We did not expect any of the last three to take any steps to make themselves independent and are glad to find ourselves wrong in one case.

CHILD GUIDANCE :

Reference has already been made earlier in this report to staff changes, and in particular to the shortage of auxiliary staff. (In the complete absence, for a while, of social workers, valuable help was given by School Nurses with home visits, etc.) Nevertheless the work of the department was kept flowing, and the following summary gives an outline of the work done by the various members of the Child Guidance team :

Examinations :

Psychiatrists	..	..	..	..	..	152
Physician	..	..	..	..	..	121
Psychologists	..	..	..	..	..	927
Psychiatric Social Worker	..	..	..	..	..	106

Re-examinations :

Psychiatrists (excluding treatment interviews)	267
Physician (" " ")	15
Psychologists (" " ")	10
Psychiatric Social Worker (" " ")	20

Attendances and Visits :

Attendances for treatment	7,407
Interviews with parents	..	..	..	832
Interviews with others	..	..	..	61
Home visits	..	..	..	11
School visits	..	..	..	695

Cases treated :

Psychiatrists and child psychotherapist	..	64
Educational psychologists	..	124
Educational therapist	..	374
Boarding homes	..	26

During 1960, there were 498 new cases seen at the Centre. Of these, 191 attended for child guidance, 72 had special tests by the educational psychologists in connection with the Annual Selection Procedure, and 235 received educational therapy.

The work of the Child Guidance Centre creates a good deal of interest but many people do not understand the type of work done there, nor have they any idea of the problems which turn up for investigation and, we always hope, for solution. I find Head Teachers on the whole are co-operative and ask for help but every now and again we deal with youngsters who have not created any problem in school because they are quiet, retiring, anything but obtrusive, but who are really unable to take a normal place in a class because of nervousness, fears, timidity and inability to fit socially. This type of child and his family is just as much in need of help as the one who makes a nuisance of himself because he is an undisciplined, noisy extrovert; and, indeed, to see one of the former type blossom, develop self confidence and no longer be a social misfit is a well worthwhile part of Child Guidance.

The following two examples are worth quoting, picked at random from the file :—

1. Referred by her Head Teacher because she was nervous, disinterested, seemed to be losing weight, and bladder control was uncertain.

She was third of six children, often apathetic.

There was little of note physically. Age 8 years and 6 months; I.Q. 85.

Her parents tended to indulge her, but it was felt she was uncertain in her relationships and insecure and that she was pre-occupied with illness and even death, and that her disturbance was more neurotic than impulsive.

She had a mood altering drug for her bed wetting and attended for group therapy.

Her bed wetting settled after three months and she became obedient, liked to help in the house, and her behaviour was now acceptable, and the mother's attitude was improved by this and by the social worker's advice.

It was felt to be a good result and the school reported a more normal attitude to work and better relationships.

2. Referred by family doctor for "thieving practices at school which she denies but claims money, etc. as 'belonging to herself'." Age 6; I.Q. 100. Home good but grand-parents were interfering and tended to go behind the parents' back over gifts, etc. Rebellious and defiant in her own home.

Child inquisitive and acquisitive, quite friendly and made a quick relationship with adults. Good concentration only when interested.

There was little doubt that there were divided loyalties in this case so that parents and grand-parents needed advice which the social worker was able to give, and the youngster came for group therapy where her domineering attitude was most notable; she was not easily snubbed and her play often proved interesting and helpful. She is now much more able to take her place in school and in the home, and is becoming much more acceptable and her "thieving practices" have ceased.

It just happened that both these youngsters are girls and in the younger age groups in which we can expect good results, but it is not so easy with older youngsters.

Educational Therapy :

This has continued as in previous years but it is not possible to cover all the ground necessary. There is, for example, quite a large number of backward youngsters, especially in the secondary modern schools and who may be approaching the educationally sub-normal level, for whom it has been impossible to do anything. It has been more important, we felt, to help those in the junior schools with whom improvement could be more certain. Most of these are seen by the educational psychologists in their visits to schools but some may also have been examined by medical officers as possibly needing special educational treatment.

HOSTELS FOR MALADJUSTED CHILDREN :

Children in hostels :

Hostels of this Authority :

	<i>Orston House</i>			<i>The Gables</i>			<i>West</i>
	<i>City cases</i>	<i>Notts. C.C. cases</i>	<i>Ministry "Pool" case</i>	<i>City cases</i>	<i>Notts. C.C. cases</i>	<i>Grimsby C.B. cases</i>	<i>Riding C.C. case</i>
At beginning of 1960 in residence ..	6	3	-	6	3	1	-
Admitted during year ..	3	3	1	5	-	-	1
Discharged during year ..	1	4	-	5	1	-	-
At end of year in residence	8	2	1	6	2	1	1

City children in hostels of other Authorities :

	<i>The Grove, Notts. C.C.</i>		<i>Staffs. C.C.</i>
At beginning of 1960 in residence	4	1
Admitted during year	1	-
Discharged during year	5	-
At end of year in residence	-	1

The two boys' hostels are now situated in the City, and Orston House is in full occupation. It is a much more compact residence than Silverwood, which had over thirty rooms. We have kept it full since its inception at Easter, and I think the staff consider it a much more workable house and that the boys are more easily kept under observation and control if either is necessary.

SPEECH THERAPY

We had a fairly complete staff for most of the year but unfortunately one of our older members (in time of service only) left us and we had only three to continue the work into 1961. Meantime, as the work was tending to pile up, the Committee have agreed to appoint an extra therapist. This will give us a staff of five: the equivalent of the whole time of one, however, will be given to the hospital service.

It is a pleasure to record that our Speech Therapy service is very well thought of nationally. Not only have the College sent to us visitors from abroad and students, but our staff have been asked from time to time to read papers at conferences.

The following is a summary of the work carried out in 1960 :—

Number of :

Cases treated	313
Cases under supervision	755
Cases discharged*	412
School visits	101
Cases awaiting treatment at end of year ..	200

*Analysis of 412 cases discharged :

Maximum benefit	246
Improved	36
No co-operation	34
Removed from waiting list	27
Mentally retarded (E.S.N.)	6
Left school or district	48
Referred to Child Guidance	2
Referred to Remedial Teacher	3
Treated elsewhere, etc.	10

Miss Grady, Senior Speech Therapist, has given me these notes :—

"There is considerable literature upon the subject of tongue-tie and what effect this condition may have on a child's speech development. Writers are agreed that tongue-tie does not affect speech. In spite of the conclusions reached by Fitzwilliams, Froehels, and Brennemann's dogmatic statement that 'Tongue-tie never interferes with nursing, very little if at all with articulation, never causes delayed speech and, unless very marked, requires no treatment,' tongue-ties are still frequently "snicked."

Surgery could be recommended for two preventative reasons. The first for children whose tongue-tie may so restrict their tongue movements as to make teeth-cleansing actions impossible thus resulting in early dental decay; and the second as a means of preventing delayed or defective speech development. In the case histories of children with tongue-ties it was always the second reason that was given.

The Speech Therapists planned a survey to find out how many children with un-operated tongue-tie had defective speech and how many children operated upon for tongue-tie also had a difficulty with articulating certain consonants. The scope of the survey was widened to include observations on the tongue movements of other speech defectives, particularly those with unintelligible speech, but excluding children with congenital brain damage. While it is realised that isolated cases cannot prove anything significant, it was interesting to note that one child with an immobile tongue due to lymphangioma had clear, articulate speech, a child who had a tongue-tie cut at four years in the hope of improving his speech was found, on subsequent neurological examination, to have a motor-disability giving rise to development dysarthria, and the tongue movements of a group of children with unintelligible speech showed little appreciable difference, when they were asked to perform certain tongue movements, from normal children of the same age.

Spencer and Cade commented, "Infants vary . . . in the degree of development of the tongue at birth, as they do later in teething and talking." It is clear that we need to know a great deal more about the tongue movements used by normal speakers and that we must prove incontrovertibly that children with tongue-tie will not develop certain movements, before surgery is considered. A child who cannot "point" his tongue beyond the margins of his lips may well have sufficient movement for speech since none of us speak with our tongue outside our lips! The reason for cutting may be "because he cannot lick a lollipop," but not because he will not speak properly."

Miss Grady has given me the above notes gleaned from a monograph which she is preparing on the subject of tongue-tie, and for which she has had a great deal of co-operation from the consultants at both the City and the Children's Hospitals. I thought the subject was of sufficient interest to include some of it in this annual report. If it helps to stop an unnecessary and possibly dangerous practice it will have served its purpose.

CLASSES FOR ADULT ILLITERATES.

These classes have continued to be held in the Child Guidance Centre. While, administratively speaking, they have nothing to do with the School Health Service—being a branch of Further Education—they are after all the adult counterpart of our erstwhile remedial classes for schoolchildren. I have been most interested to have reports from the two teachers in charge, Miss J. G. Finch and Mr. J. W. Lowe, and only lack of space prevents me from quoting their reports in full.

At the beginning of the year some 23 adults—their ages ranging from 18 to 50+ enrolled, and although a few soon gave up, the majority maintained their attendance throughout the year. Both teachers speak of the intense feeling of inferiority which the students had on entry to the classes—an inferiority which attacked their self-confidence because illiteracy placed strict limits on their social contacts. In the classes they felt free to be natural among other adults similarly placed, and some made excellent progress. Miss Finch's best pupil was an 18 year old girl who succeeded in raising her reading age from 6 to 14+ during the year and was thereby able to exchange a factory job for that of salesgirl in a high class shoe-shop—becoming, in the process, a much happier and contented person. Mr. Lowe's outstanding case was a young man, also of 18, who had previously attended an Occupation Centre: he was in due course able to read fairly simple books with comparative ease.

I think it is only fair to say that Miss Finch feels strongly that these classes are intended for adults of reasonable intelligence who, for some reason or other, have not been able to learn to read. She feels that to introduce adults who are mentally backward can be an embarrassment to the others.

While I know that the teachers regard themselves as amply rewarded by their successes, the classes continue to fulfil a great need, and I should like sincerely to congratulate them on the work they have done.

EAR, NOSE AND THROAT DISEASES

Arrangements have remained the same. We have the benefit of two consultation sessions weekly, and the consultant has continued to work in our Tonsil and Adenoid Ward in Chaucer Street Clinic also on two sessions. The waiting list has been reduced very substantially, indeed, so much so that the consultant has agreed to transfer to the Chaucer Street T. and A. ward many geographically suitably placed youngsters living in the County from his lengthy waiting list at the Children's Hospital where work had to be curtailed because of shortage of staff. We have been fortunate with staff (most of whom are part-time) on our ward, there having been no changes for some time.

Audiometry :

Mr. Ward, the Audiometrician, tested 320 children, mostly on a single occasion, but some had a second test, making a total of 347 tests.

We have continued to be selective in the cases referred for audiometry, and the following groups, I feel, should be tested as well as those referred by the Medical Officers and consultants :—

1. Children who have had any intracranial damage, whether pathological or (it is important to bear in mind) traumatic, and including cerebral palsy.
2. Those with speech defects or late speech development.
3. Those with recurring Otitis Media or persistent Otitis Media with suppuration.
4. Those who are known to be deaf in order to note improvement or deterioration, and I think this should include those in the School for the Deaf as well as all who are partially deaf in ordinary schools.

ELECTRICAL TREATMENT

Ultra-Violet Ray :

No. of children treated	..	..	..	..	41
No. of attendances ..	..	..	..	..	344

Proetz :

No. of children treated	..	..	..	..	173
No. of attendances ..	..	..	..	..	1,396

Ionisation :

No. of children treated	..	..	..	..	173
No. of attendances ..	..	..	..	..	764

We have continued to use Mag. Sulph. ionisation for warts both plantar and on other areas of the skin. It is particularly effective for the plantar type and has the added advantage that it is painless. There is little doubt that electrical ionisation is the simplest and most effective way of dealing with those on the feet, or a recent crop elsewhere on the body, but old standing warts do not react so readily and one has to resort to the old fashioned but effective use of caustics, which is often slow and patience trying.

It is frequently thought that plantar warts (*verrucae*) are more common in girls than boys but our figures show little difference between the sexes. Warts elsewhere are slightly more common in boys than girls.

If one goes carefully into the histories of youngsters with plantar warts, it is surprising how often one gets the story of other members of the family with, not necessarily plantar, but other warts. One parent complained recently that she had caught her teenage daughter wearing her nylons and that this episode was followed by a plantar wart in exactly the same site as the daughter's.

OPHTHALMIC SERVICE

There was no alteration in the arrangements for the ophthalmic service during 1960 :—

	1955	1956	1957	1958	1959	1960
No. of pupils on rolls on 31st						
December	50,975	51,628	52,115	52,242	52,089	51,691
Pupils refracted	4,719	4,809	4,937	4,773	4,786	4,562
Percentage	9.2	9.3	9.5	9.1	9.2	8.8
Spectacles prescribed (pupils)	1,412	1,604	1,528	1,660	1,603	1,607
Percentage	2.8	3.1	2.9	3.2	3.1	3.1

In addition, our School Nurse held 156 sessions (103 sessions with one nurse in attendance and 53 sessions with two nurses in attendance) at the Chaucer Street and Clifton clinics when they dealt with repairs to children's spectacles.

I asked Dr. Gordon Napier, one of the part-time specialists seconded to us from the Sheffield Regional Hospital Board, for a few notes on testing techniques, and he has kindly supplied me with the following :—

"Refraction work in adults is usually carried out without a mydriatic, as relaxation is easy to gain, but this is impossible as a rule in children. They, when asked to look into the distance in attempting retinoscopy will usually look directly at the examiner and this brings into play the muscles of accommodation so that refraction carried out under these conditions gives a false result. Because of this, nearly all children are refracted under full mydriasis. In very young children, Atropine ointment 1% used three times a day for three days into both eyes gives full mydriasis and full cycloplegia. With the fully dilated pupil and the paralysed accommodation, retinoscopy becomes an easy matter. In somewhat older children, a quick acting mydriatic—the duration of which is short-lasting—is Cyclogil and this is often used, but it is an expensive preparation. In cases where it does not matter if the accommodation is paralysed for 48 hours, Guttae scopolamine hydro-bromide 1/1000 is used. This gives full mydriasis and full cycloplegia (dilatation). After their

objective retinoscopy, a subjective test is undertaken in all children. In the case of the very young, either pictures—different sizes—are shown, or the letter 'E' of different sizes and in various positions, or again, the open hand with the fingers up, down, right or left, (Sjogren) and the child is asked to say which way the fingers are pointing. In older children, the subjective testing is always done on the Snellen's test chart. If, following subjective testing, one eye is found to have defective vision and provided that no diseased condition is found in that eye, occluding the good eye is carried out to make the lazy or amblyopic eye work. Occlusion is nearly always carried out by patching the good eye with either elastic or zinc oxide plaster patches. Unfortunately, in some cases the children are sensitive to either the elastic or the zinc oxide plaster and other methods of occlusion, such as a pad and bandage have to be used. The latter method is quite good in the winter time but is often distressing to the child in the summer. In the past we tried bakelite or plastic patches and even leather patches. These, however, proved unsatisfactory as the children nearly always lifted the patch up and peeped with the good eye, thus undoing all the good of true occlusion."

Orthoptic Treatment at the Eye Hospital :

	1955	1956	1957	1958	1959	1960
New cases treated	84	56	40	58	130	38
Total treated	125	155	125	159	291	164
Awaiting test or treatment at end of year	36	37	11	52	12	11

Operations for Squint at the Eye Hospital :

	1955	1956	1957	1958	1959	1960
Operations	81	106	123	40	69	52
On waiting list at end of year	82	60	10	39	39	33

COLOUR VISION

We have continued to test the colour vision of all youngsters at some convenient age. Some authorities have stopped checking girls' because numbers are so small but I felt it might be worth continuing this, and asking for the co-operation of parents of those girls whose colour vision is abnormal in having their own and any siblings' colour vision also checked. The number this year was only three and none of them had any siblings. (I wondered if there was any significance in this). Our tests told us nothing of interest but I propose continuing this little investigation for a year or two. It might just give us some information and really creates no difficulty or takes any time, and parents are only too happy to feel they are taking part in a little research.

ORTHOPAEDIC TREATMENT

The arrangements have continued along the same lines as in past years. The number of children dealt with does not alter much.

Examinations by orthopaedic surgeons :

At School Clinic	211
------------------------	-----

Children treated as out-patients :

At Nottingham Orthopaedic Clinic	163
At Nottingham Children's Hospital	406

Children treated as in-patients :

At Harlow Wood Hospital	62
At Nottingham Children's Hospital	227

As I, have noted in previous reports, the type of orthopaedic defect dealt with nowadays is of a much more minor type and this I feel is a good thing. The days of long stay bone conditions have now passed and conditions such as hallux valgus (and its accompanying bunion), hallux rigidus, hammer toe and cavus deformities of the feet are now receiving adequate treatment with resultant removal of long term difficulties due to inability to get shoes to fit, limitation of activity as walking was difficult or painful, etc.—a most satisfactory change for the better.

PAEDIATRIC CONSULTATIVE CLINIC

Dr. Page continues to help us in the compilation of our Cardiac Register in which we are noting all children with heart defects whether congenital or rheumatic in origin. He gives us the benefit of his advice not only in the above but in all children who may have a possible heart disability and this includes all who have had heart surgery. The bulk of these latter, of course, can live normal or near normal lives but there are still a few who need careful observation, checking and investigation of their exercise tolerance, and it is this group which we like to feel we have under Dr. Page's keen clinical eye.

He has always taken an active interest in the fat child, and he has recently had in his care a number of youngsters who might be called bad-doers, runts or similar terms, and he has given me a few notes which might be of interest in the case of this small group. Dr. Page says :—

"The "Fat Child" still attends this clinic in undiminished numbers and usually with benefit to the figure.

More recently, attempts have been made in the treatment of the opposite clinical problem, the "Thin Child," the physical state in causative factors ranging from the constitutionally thin and undersized child to the child debilitated from ill health.

The new "anabolising drugs" have been used and Norethandrolone was selected. It is very surprising to find that a 5—8 lbs. weight gain can almost invariably be induced in 6—8 weeks with a dosage of 10—20 mgs. daily given orally.

Slightly higher dosage has been used with pre-pubertal boys of miniature build in order to make use of the mild "virilising" effects of the drug to give them an "endocrine boost."

Some children need two or three courses of 6—8 weeks with 4 weeks rest period between these. The appetite is usually much improved."

The following is a breakdown of the numbers of children who have attended Dr. Page's clinic during the year :—

	<i>No. of cases</i>	<i>No. of attendances</i>
Heart conditions	91	143
Undescended testicles ..	45	69
Obesity, development etc.	88	166



OVERWEIGHT CHILDREN

This year, as noted on the graph (see page 30), we have divided these youngsters into sexes and ages, and we find ourselves with one or two interesting facts.

1. Girls lead the boys generally, in numbers and in weights for equivalent ages.
2. Girls tend to show rather large numbers at age eight whereas there is no peak at this stage in the boys.
3. Both boys and girls show a peak in numbers at eleven years which I find difficult to explain and which may just be due to the onset of puberty.
4. There follows a fall in the actual numbers in the twelve and thirteen age groups, possibly due to a preparation for the physical growth of maturity following puberty.
5. And finally the peak at fourteen—fifteen years associated with the maturation one gets nowadays in the early teens.

The final portions of the graph I think must be ignored as we are dealing with the groups who have elected to remain in school after the age of fifteen and one can well imagine that overweight young teenagers do not wish to continue in school and suffer the embarrassment of their physical attributes.

It will be observed that girls still outnumber the boys. The total figure is lower than last year. Is this a hopeful sign? It will be interesting to see whether next year's figures move up with the year or whether new children step in to take the place of those who have been graphed before.

SCHOOL NURSES

Miss Pinder, our Superintendent School Nurse, has given me the following notes on the work of the nurses.

"The routine work of the school nurses continued throughout the year: preparation for medical inspections, accompanying medical officers at medical inspections and an increasing number of domiciliary visits, have all been efficiently done.

These visits include far too many defaulters from Refraction, Ear, Nose and Throat, Paediatric and Orthopaedic sessions held at the Central Clinic and Minor Ailments Clinics. Unfortunately, most of the absentees are the very children in most need of help and treatment.

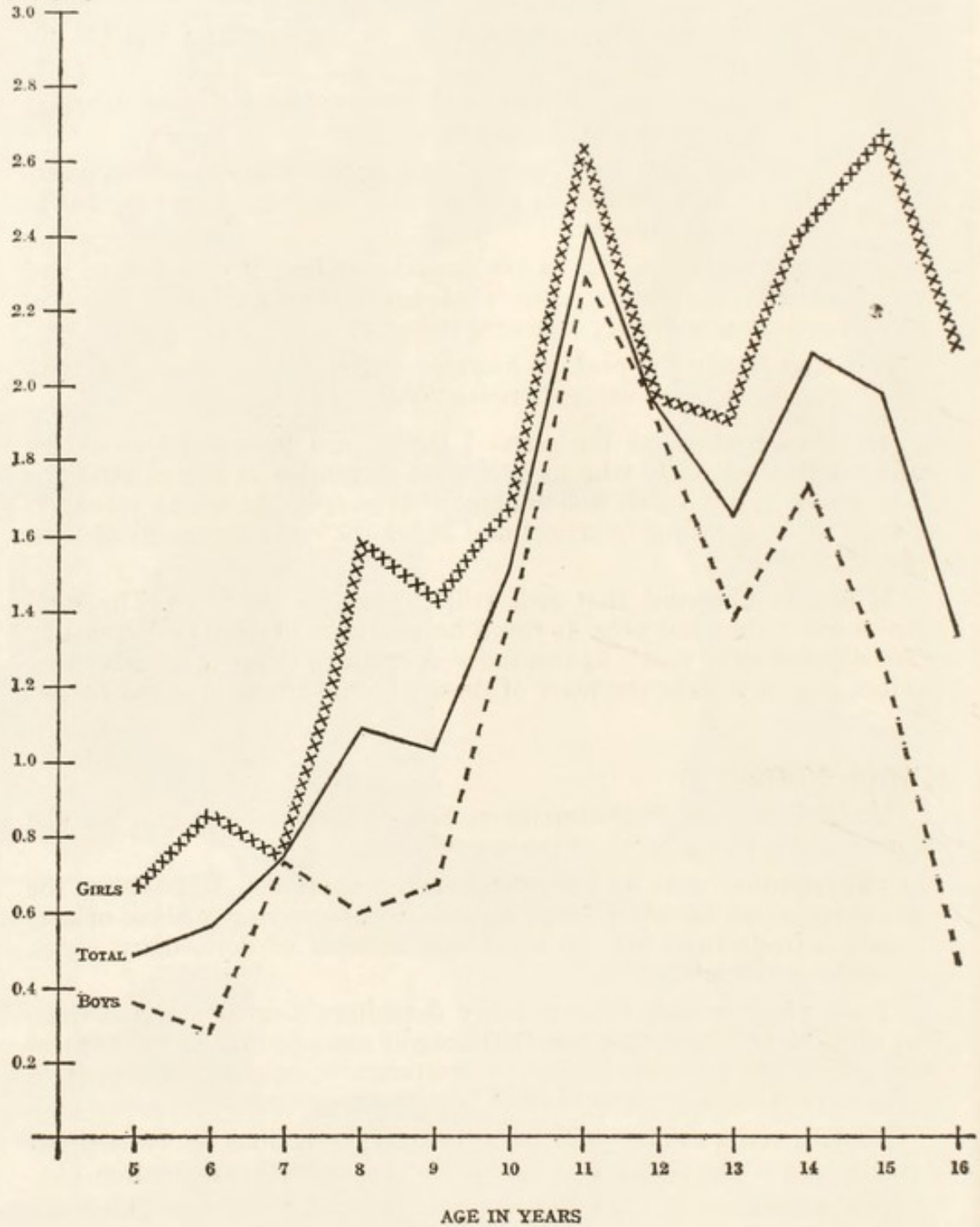
Routine visits to absentees from medical inspections are carried out to ensure this is not a deliberate avoidance of a medical examination.

The nursing staff are still happy to carry out for the Children's Hospital domiciliary visiting of school children who are defaulters from the aural ward and out-patients department. The visiting is time consuming, but the nursing staff are performing a valuable service to the community in persuading the parents of the more difficult families to shoulder their own parental responsibilities.

They have found much of interest in several surveys which are taking place in the School Health Service, e.g. the spinal survey by the Regional Hospital Board Orthopaedic Consultant and the School Medical Officers in the Junior Schools; and the obesity survey in all Schools.

OVERWEIGHT CHILDREN

Number
of Children
expressed
as percentage
of age-group



----- Boys
 xxxxxxxxxxxx Girls
 ————— Total (Boys and Girls)

The experiment being undertaken in the Junior Schools on the Clifton Estate whereby intermediate periodic medical examinations are replaced by termly examinations provides the school nurses in the area with a different approach, that of a much more personal co-operation with parent, Head Teacher and child.

It is interesting to note that members of the nursing staff paid the final visit to the homes of thirty children in this area who were included in the National Survey of the Development of the School Child.

Weekly visits to the Nursery Classes and Nursery Schools were carried out. These give ample opportunity for discussion with teachers on matters affecting the health and well-being of the nursery child. Of course, follow-up visits to homes to ascertain conditions where response to advice and treatment is poor, continue as a regular feature (*and worthwhile, R.G.S.*).

During the year, the staff have again been pleased to show our service to, and help with the training—in so far as our service permits—of, the Health Visitor Students and Queen's Nurses. The Health Visitors not only observe but perform practical work in the clinics and schools. The Queen's Nurses attend for observation visits only."

The following is a summary of the school nurses' work during 1960:

Visits to schools for routine medical inspection	1,629
" " " uncleanliness	298
" " " investigation of infectious disease	10
" " " other purposes	1,531
Visits to homes for uncleanliness	884
" " " deafness and other ear conditions	84
" " " absentees from ophthalmic clinic	588
" " " absentees from T. and A. clinic	140
" " " follow-up after T. and A. operation	8
" " " miscellaneous reasons	1,348
Clinic sessions	6,465

CLEANLINESS

	1955	1956	1957	1958	1959	1960
On school rolls	50,975	51,628	52,115	52,242	52,089	51,691
Examinations	185,525	187,112	182,949	161,622	160,796	165,719
Number found unclean	6,403	5,975	5,615	5,326	4,848	4,424
Percentage of the number on rolls	12.5	11.5	10.8	10.2	9.3	8.5
Statutory notices to parents	41	26	29	51	73	78
Children cleansed	34	24	22	37	54	61

There is not a great deal I can say about this other than what has been said on many previous occasions. It is gratifying to see that each year seems to bring a slight improvement in the position, but it is not a very pleasant reflection on modern society that over four thousand children in this City alone had dirty heads. The sad part of it is that very often as quickly as we get a child clean, re-infestation occurs from other members of the family.

I would, I think, be remiss if at this stage I did not pay tribute to the work of our team of nurses' assistants whose job it is to carry out most of the examinations and treatment. It is with pleasure that I record my thanks to them for the quietly efficient way in which they go about their job.

ACCIDENTS TO PUPILS

Report by Dr. E. J. More, School Medical Officer.

For the sixth year I have analysed the figures of accidents to school children, figures which have come from various sources.

The School Health Service is notified of accidents involving children in school and, with the help of the School Nurses, I have followed up those which appeared serious.

The City Police Traffic Department supplied details of road accidents involving city children aged 5 to 15 years.

The Casualty Department at the General Hospital again co-operated, and from their register I have extracted the figures for accidents to city children aged 12 to 15 years.

The Casualty Department at the Children's Hospital were also very helpful, and from their register I extracted the figures for accidents to city children aged 5 to 11 years. This is the second complete year for which we have obtained these figures.

I should like to thank the Chief Constable, the Secretaries of the Nottingham No. 1 and 2 Hospital Management Committees, Sister Migley of the Casualty Department of the General Hospital, and Mr. Town, Records Officer at the Children's Hospital, for the help they have given in extracting the necessary figures from their records.

1.—School Accidents : Total number on rolls of maintained schools on 31st December, 1960 : 51,691.

(a) Compare the past six years :

	1955	1956	1957	1958	1959	1960
Total no. of accidents reported to School Health Service	372	384	261	227	286	216
Percentage of nos. on rolls	0.73	0.74	0.5	0.43	0.55	0.42
Percentage (boys)	62.3	65.4	65.5	64.8	65.7	71.3
Percentage (girls)	37.7	34.6	34.5	35.2	34.3	28.7

(b) **Serious accidents,** mainly fractures and dislocations, were followed-up. The diagnosis was confirmed and the number of school days lost was checked.

	1955	1956	1957	1958	1959	1960
No. confirmed serious	Not available	120	101	91	86	77
Percentage of all accidents		31.2	38.7	40	30.1	35.6
Percentage (boys)		74	73.3	69.2	73.2	72.7
Percentage (girls)		26	26.7	30.8	26.8	27.3
Total school days lost		888	903	756	700.5	799
Average loss per accident in school days		7.4	9.0	8.3	8.1	10.4

(c) **Accidents occurring during Physical Education or Games :**

	Percentage of all accidents					
	1955	1956	1957	1958	1959	1960
Physical education	Not avail- able	23.7	18.0	18.5	15.4	21.3
Games		16.6	19.9	21.6	25.5	19.9

(d) **Total Accidents :**

- (i) *Primary Schools :* number on rolls on 31st December 1960 : 29,610.

	1955	1956	1957	1958	1959	1960
Total accidents	141	121	96	89	96	87
Percentage of no. on rolls	0.42	0.37	0.30	0.28	0.32	0.29

- (ii) *Secondary Modern Schools :* number on rolls on 31st December, 1960 : 17,182.

	1955	1956	1957	1958	1959	1960
Total accidents	173	193	131	99	139	101
Percentage of no. on rolls	1.32	1.24	0.82	0.59	0.80	0.59

- (iii) *Secondary Grammar and Technical Schools :* number on rolls on 31st December, 1960 : 4,899.

	1955	1956	1957	1958	1959	1960
Total accidents	58	70	34	39	51	28
Percentage of no. on rolls	1.81	1.84	0.83	0.89	1.13	0.57

(e) **Serious Accidents :**

- (i) *Primary Schools :*

	1956	1957	1958	1959	1960
Number confirmed serious ..	41	39	30	25	36
Place of occurrence or agent : Play	25	25	15	7	18
Physical education or games	13	11	10	10	13
Ice	—	—	4	1	—
Other	3	3	1	7	5

(ii) *Secondary Modern Schools :*

	1956	1957	1958	1959	1960
Number confirmed serious ..	56	45	43	44	31
Place of occurrence or agent : Play	14	5	7	7	5
Physical education or games	34	31	30	27	23
Ice	—	—	1	—	—
Other	8	9	5	10	3

(iii) *Secondary Grammar and Technical Schools :*

	1956	1957	1958	1959	1960
Number confirmed serious ..	23	17	18	17	10
Place of occurrence or agent : Play	9	4	—	1	—
Physical education or games	14	9	14	11	9
Ice	—	—	—	—	—
Other	—	4	4	5	1

Prevention and Disability :

As in previous years, the majority of serious accidents were not foreseeable. The number occurring at play in primary schools has gone up this year, but fortunately there were no cases of disability in those followed up.

In secondary modern schools, one pupil was still not taking part in physical education nine months after a fracture of tibia, and another still required transport to school four months after having fractured an ankle.

In grammar schools, one pupil was still attending the Orthopaedic Out-Patient Department at intervals fourteen months after having fractured an arm, and was unable to straighten the arm fully.

2. Road Transport Accidents in Nottingham to children aged 5 to 15 years : Details obtained from City Police :

(a) Number of pupils aged 5 to 15 years inclusive, 49,000 approx.

	1957	1958	1959	1960
Total No. of accidents	197	243	225	275
Percentage of Nos. on rolls ..	0.39	0.48	0.45	0.56
Percentage (Boys)	68.5	65.4	68.9	73.1
Percentage (Girls)	31.5	34.6	31.1	26.9

Group (i): 5 to 11 years. No. on rolls=31,000 approx.

	1957	1958	1959	1960
No. of accidents	135	172	141	154
Percentage of Nos. on rolls ..	0.37	0.49	0.41	0.5

Group (ii): 12 to 15 years. No. on rolls=18,000 approx.

	1957	1958	1959	1960
No. of accidents	62	71	84	121
Percentage of Nos. on rolls ..	0.41	0.44	0.53	0.67

(b) By Month :

		Jan.	Feb.	Mar.	Apr.	May	June
No. of accidents	1957 ..	9	19	24	13	20	15
	1958 ..	15	17	18	26	27	33
	1959 ..	15	9	17	20	20	26
	1960 ..	11	18	15	26	36	26
School holidays	1960 ..	11th April to 26th April					
		July	Aug.	Sept.	Oct.	Nov.	Dec.
No. of accidents	1957 ..	17	20	14	13	14	19
	1958 ..	26	17	16	19	18	11
	1959 ..	15	17	27	25	20	14
	1960 ..	30	22	26	23	25	17
School holidays	1960 ..	25th July to 2nd Sept.		23rd to 31st Dec.			

(c) Week-days and week-end days :

		1957	1958	1959	1960
Accidents on week-days :	Number	131	188	167	203
	Percentage	66.5	77.4	74.2	73.8
	Average accidents/day	0.5	0.7	0.6	0.8
Accidents on Saturdays and Sundays :	Number	66	55	58	72
	Percentage	33.5	22.6	25.8	26.2
	Average accidents/day	0.6	0.5	0.6	0.7

<i>Analysis of Accidents</i>						<i>Percentage of Total</i>			
						1957	1958	1959	1966
Slight accidents	..	..	..	..	..	71.0	71.2	73.4	78.2
Serious accidents	..	..	..	..	..	26.9	27.2	24.4	20.0
Fatal accidents	..	..	..	..	..	2.1	1.6	2.2	1.8
Accidents to pedestrians	..	..	..	..	..	55.3	59.3	59.6	58.9
Accidents to cyclists	..	..	..	..	..	40.6	35.4	37.3	37.1
Accidents to passengers in or on vehicles	..	..	..	..	..	—	5.3	3.1	4.0
Unspecified	..	..	..	..	..	4.1	—	—	—

3. Children aged 12 to 15 years treated at the Casualty Department, General Hospital :

		1957	1958	1959	1960
(a) Approximate number of children aged 12 to 15 years on rolls ..	..	15,000	16,000	16,000	18,000
Total number treated .. ..	..	1,094	1,329	1,515	1,721
Percentage of pupils .. ..	..	7.3	8.3	9.5	9.5
(b) Boys treated .. ..	..	739 or 67.5%	892 or 67.1%	1,014 or 66.9%	1,168 or 67.9%
Girls treated .. ..	..	355 or 32.5%	437 or 32.9%	501 or 33.1%	553 or 32.1%
(c) Treated during school hours ..	..	50.6%	65.8%	66.3%	65.5%
Treated outside school hours ..	..	49.4%	34.2%	33.7%	34.5%

(d) Injuries treated which were serious, e.g., fractures, or needing in-patient treatment, etc. ..							
	22.0%	23.2%	14.5%	29.9%			
(e) Holidays compared with school terms :							
(i) Easter Holiday :	1957	1958	1959	1960			
Number of days (including weekends)	18	18	18	16			
Number of accidents	53	61	52	59			
Average per day	2.9	3.4	2.9	3.7			
(ii) Summer Holiday :							
Number of days (including weekends)	37	40	49	40			
Number of accidents	103	133	146	161			
Average per day	2.8	3.3	2.9	4			
(iii) Spring term :							
Number of days (including weekends and mid-term holidays)	101	86	79	96			
Number of accidents	304	300	253	405			
Average per day	3.2	3.5	3.2	4.2			
(iv) Summer term :							
Number of days (including weekends and Whitsuntide holiday)	82	95	103	89			
Number of accidents	264	375	521	510			
Average per day	3.2	3.9	5.1	5.7			

4. Children aged 5 to 11 years treated at the Casualty Department of the Children's Hospital :

	1959	1960
(a) Approx. number of children aged 5 to 11 years on rolls	34,000	31,000
Total number treated	3,249	3,120
Percentage of pupils	9.6	10%
(b) Boys treated	2,134 or 65.7%	2,099 or 67.3%
Girls treated	1,115 or 34.3%	1,021 or 32.7%
(c) Treated during school hours	2,063 or 63.5%	2,004 or 64.2%
Treated outside school hours	1,186 or 36.5%	1,116 or 35.8%
(d) Place of accident (where specified) :		
(i) School	517 or 15.9%	624 or 20%
(ii) Home	1,127 or 34.7%	1,235 or 39.6%
(iii) Outside school or home (road, yard, garden, swimming bath, park, etc.)	1,345 or 41.4%	1,044 or 33.5%
(iv) Unspecified	260 or 8.0%	217 or 6.9%
(e) Cause of accident (where specified) :		
(i) Fall	982 or 30.2%	980 or 31.4%
(ii) Dog Bite	107 or 3.3%	126 or 4.0%
(iii) Foreign body	159 or 4.9%	192 or 6.2%
(iv) Road transport	108 or 3.3%	104 or 3.3%
(v) Burn or scald	59 or 1.8%	59 or 1.9%
(vi) Blows, traps, sharp implements ..	109 or 3.3%	961 or 30.8%
(vii) Other	1,725 or 53.2%	698 or 22.4%
(f) No. requiring in-patient treatment ..	84 or 2.6%	103 or 3.3%

5. Fatal Accidents : From Registrar General's Returns :

Total number	10
Accidents to Boys	7
Accidents to Girls	3
Road Transport	5
Drowning	1
Murder	1
Burns	3
(Ages ranged from 5 to 14 years)	

It is interesting to note that the number of accidents reported to the School Health Service has gone down in the past year, and is 156 less than the number in 1955. Is the increased interest in accident prevention bearing fruit?

The number of serious accidents in secondary modern and grammar schools decreased last year, and has fallen considerably since the 1955 figure.

Road transport accidents are up on last year, with the bigger increase in the 12 to 15 year group. Again there is little difference between the average number of accidents on weekdays and Saturdays and Sundays.

There is little variation in the percentage attendances at the Casualty Departments.

I am grateful to Dr. More for her complete collection and analysis of the figures, and am pleased to note a general tendency to a reduction in the figures for school accidents, probably due to the continued interest being taken in them. I am sorry to note increased figures for road transport accidents, fortunately largely amongst the less serious (is this inevitable with increase in volume of traffic?) and two more accident fatalities than last year.

HAEMOLYTIC INFECTION OF REMOVED TONSILS

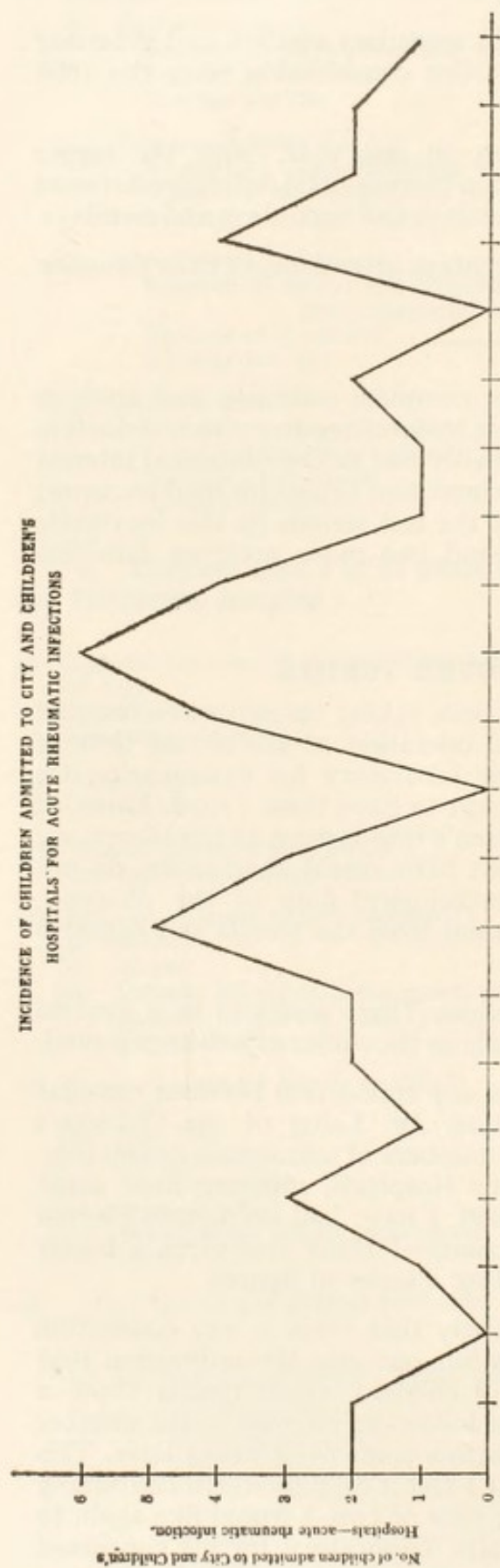
For the past two years, we have been taking throat swabs from all children noted for tonsil and adenoid operation at the actual time of consultation and sending these to the laboratory for examination for streptococci without making any attempt to have these typed. Later, at the time of operation, these same children's tonsils went to the laboratory for the same examination. There seems little doubt that swabs do not give a very exact reflection of the pathological flora of the pharynx, positive swabs not giving a positive result from the tonsils and negative ones being quite unreliable.

Tonsillar infections are plotted below. There seems to be a general tendency for a rise in the spring and again in the winter as is to be expected.

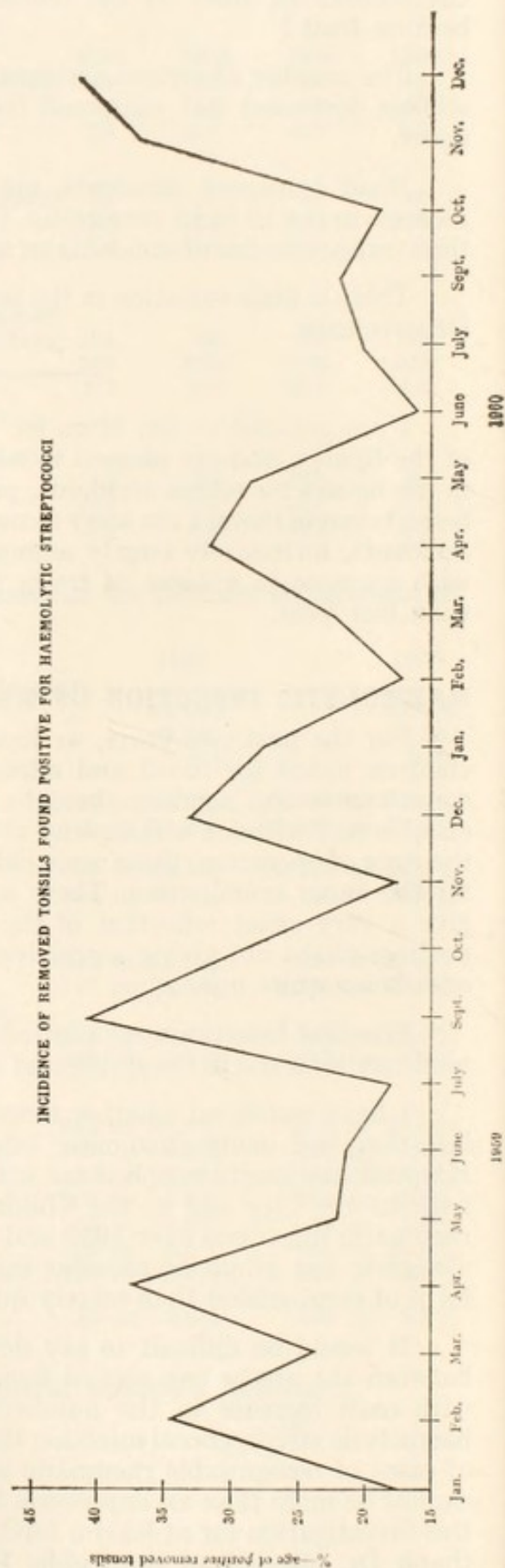
I have wondered whether there is any connection between tonsillar infection and acute rheumatic infection. Dr. Laing of the Children's Hospital has kindly supplied me with numbers of admissions of children, both to the City and to the Children's Hospitals, suffering from acute rheumatic infections over 1959 and 1960. I have had her figures plotted alongside our graph of tonsillar infections—I think this gives a better form of comparison than merely quoting a series of figures.

It would be difficult to say definitely that there is any connection between the above two sets of figures but one gets the impression that with each increase in the numbers of children whose tonsils show a haemolytic streptococcal infection there follows an increase in the number of cases of recognisable rheumatic infection some 4—8 weeks later. This cannot be more than an impression but I feel it may be worth continuing this investigation for at least a further year or two. I would like again to thank Dr. Mitchell of the Public Health Laboratory for his continued help and interest.

INCIDENCE OF CHILDREN ADMITTED TO CITY AND CHILDREN'S HOSPITALS FOR ACUTE RHEUMATIC INFECTIONS



INCIDENCE OF REMOVED TONSILS FOUND POSITIVE FOR HAEMOLYTIC STREPTOCOCCI



SEX DISTRIBUTION

Figures can be interesting on occasion. For example, Ministry of Education Form 7 Returns collected by the Education Department look like a mass of figures which might be of interest to teachers and the School Attendance Departments, and, as a whole, to the Authority who have to find places for the children these figures represent.

There have been notes in these Annual Reports about the excess of boys over girls on previous occasions. This situation still remains and there are in all schools at the moment 1,340 more boys than girls. This figure can be reduced slightly as there are about 200 more boys than girls having some form of higher education, for example, in Sixth Forms of Grammar Schools.

This slight but definite discrepancy, however, is tending to correct itself in the infant departments where there are only 220 (1.7%) more boys than girls, whereas in junior departments, the figure is 650 (4.4%). It is actually 352 (1.6%) in secondary schools.

There are some schools in the City where girls are actually in the majority and it is almost possible to predict which they are, and in the same way it is easy to predict which schools would have a preponderance of boys, e.g. Player Junior School have 54% boys and 46% girls and others 57% boys and 43% girls, whereas the infant schools in these same areas have almost identical numbers of boys and girls.

It would seem that the fact that we have "never had it so good" tends to produce a more even sex distribution whereas days of hardship tended to produce a higher ratio of boy babies, who with our improved facilities for infant care have survived in greater numbers than used to be the case.

In checking with the Health Department on the figures for under fives which are given below, it is worth noting that the next group to come into schools actually has a few more girls than boys but that the gap between the sexes is again tending to widen, and that this year (1960) there is some 4% difference between the sexes again.

This is probably of no practical significance but it is of interest that there should be this rhythmic change in the proportion of the sexes.

One cannot help but wonder if manipulation of the environment, or of the feeding habits at the time of conception would alter the sex ratios of offspring but I have no doubt the academic veterinary experts have this problem very much in mind.

Estimated under-5 population compiled from live birth figures, less children under 5 who have died (no account taken of transfers in/out of the City).

Year	Males			Females		
	<i>Births</i>	<i>Deaths</i>	<i>Total</i>	<i>Births</i>	<i>Deaths</i>	<i>Total</i>
1957 ..	2,752	89	2,663	2,726	53	2,673
1958 ..	2,863	84	2,779	2,714	62	2,652
1959 ..	2,865	91	2,774	2,733	64	2,669
1960 ..	3,006	94	2,912	2,721	60	2,661

SEX EDUCATION

It seems to be popular at the moment to comment on the need or otherwise for this in schools, on lack of respect for the opposite sex, on teenage morals and similar subjects. Now that much pornographic literature is allowed on our bookstalls, and a novel by a local author has been given excellent advertisement by being dragged through the courts before being put on the stalls in astronomic numbers, it is inevitable and understandable that there is a much more blatant attitude to sex, and much less emotionalism attached to it. This reaction to our Victorian attitude to sex is difficult to understand by those of us who have grown up in a world in which sex was not allowed to rear its ugly head too obviously.

We are now living in an age when young people are not only maturing earlier but are, in the world of employment, much more independent and indeed are the group who have money to spend, almost to burn. This, of course, creates a very new situation. Gone are the days of prolonged dependence on parents by both sexes and what, therefore, could be more natural than a general relaxation of the attitude to sex? The young of all groups of animals have always been sexually the most virile and considered by the experts the most desirable and the same can surely be said of the human species if they have full independence. This kind of thing has applied to the poor for many years but is now becoming accepted by the middle income groups since they too are becoming much less dependent on parents because of grants, etc., to those continuing education, and because of the high scale of salaries given to those still learning trades and other skills.

I am not advocating sexual promiscuity but feel that we must consider our youngsters of both sexes to be about three years in advance physically and physiologically of the pre-war youngster, e.g. the fifteen year old now is at the stage of those who were eighteen at that time, and that his knowledge and feelings have in all probability also advanced if not to the same extent, at least to some extent. His more intimate knowledge of sex, and of contraceptives even, can also influence his actions.

My feelings on this subject have been stimulated by the fact that several youngsters recently have been pregnant before they have left school and this has created the problem of what to do with them until they reach school leaving age. One cannot help wondering if a little more knowledge (or a little less) might have helped these youngsters at the time of conception. I might add that this problem is more likely to confront the duller girls in any school, possibly not just because they are dull but because of the unsatisfactory example in the home.

If one enquires into the number of girls who may have had sexual experience before leaving school, it cannot be noted as an exact figure but is only an impression gained in discussion groups, etc. The figure, however, is a small one, of that there is little doubt. If it is as high as 20% in the dullest groups, it is probably less than 1% in the whole of any leaver group, and one cannot help but wonder if this is a figure any different from the less mature days of the pre-war period.

As for the older boys, the impression is that, apart from an odd boy, they are not so interested as the girls in affairs of sex. It is generally accepted that they reach maturity somewhat later than the girls and so their interest may not be stimulated until they have left the secondary modern school.

As I write, there has been a series of articles entitled "Teenage Morals" in Education and the Times Educational Supplement reports on a discussion in Croydon on "Boy and girl relationships," and an Inter-School Conference on the Christian view of sex in Northampton. The fact that these meetings are taking place and that there is discussion of a subject which is usually dealt with in a vague and biological way only is, I think, evidence of the way the wind is blowing. It will act as a contradiction to the "What does it matter—everybody does it" and "Have it now—you can pay later" attitude which is common not only in business but in sexual relationships.

Don't let us, however, get lost in the welter of indefinite information gleaned from sources many of which are inaccurate, misleading and hazy. I am assured by Head Teachers of girls' schools, who I feel still have their feet on the ground, that the proportion of girls in their schools who have had sexual experience is still a very small one and that the fact that sex is a popular subject is bringing it into a quite unwarranted limelight.

AGE OF MATURITY

As a corollary to the foregoing remarks, I felt it would be worthwhile to find how many mature girls there are in our junior schools (age 7-11 years). I knew there were odd ones but a quick survey gives a figure of 140 girls known to teaching staffs as mature and already menstruating. (It is not easy to check on the maturity of boys, even a deep bass voice may be misleading, and there is not time to arrange medical examinations in a survey such as this).

This is an extraordinary figure—something which can scarcely be credited by generations who hardly had their maturity before the age of 15—17. It also creates a difficulty in that there are no facilities (except those provided by the staff) for the disposal of soiled linen, and its replacement.

HEIGHTS AND WEIGHTS : 1910 and 1960 Comparison

While on the subject of earlier maturity which, of course, goes hand in hand with physical development, I thought the following figures would be of interest. I give the figures for five year olds to show that there has been improvement in this group, and also the percentage improvement so that one can have an accurate comparison of the two sets of figures. It will be noted that the girls in the leaver groups, both to-day and fifty years ago, were taller and heavier than their male contemporaries, suggesting the likelihood of earlier maturity in the female sex. Incidentally they were weighed in those days with only their shoes removed, so that the 1910 figures shown below might well be a little on the high side.

The School Medical Officer in his report at the time also noted that the Nottingham figures were above the "average"—I presume for England and Wales.

Comparison Between Average Heights and Weights in 1910 and 1960

AGE/YEAR	BOYS			GIRLS		
	<i>Number examined</i>	<i>Average height in inches</i>	<i>Average weight in lbs.</i>	<i>Number examined</i>	<i>Average height in inches</i>	<i>Average weight in lbs.</i>
5 YEARS OLD						
1910	971	40.68	38.82	1,056	40.54	38.05
1960	250	42.55	41.61	250	42.25	40.34
Average increase						
1910/1960 ..	—	1.87	2.79	—	1.71	2.29
% increase						
1910/1960 ..	—	4.60%	7.19%	—	4.22%	6.02%
*13 YEARS OLD						
1910	1,977	55.94	76.38	1,622	56.58	78.55
1960	222	61.73	102.68	245	62.36	108.02
Average increase						
1910/1960 ..	—	5.79	26.30	—	5.78	29.47
% increase						
1910/1960 ..	—	10.35%	34.43%	—	10.22%	37.52%

*It should be noted that the average age of the children examined in 1960 was approximately 13½ years, while the children examined in 1910 were probably only just 13 years old.

ASTHMA AND INTELLIGENCE

I had always had the impression that asthma was a condition which tended to occur in the more intelligent youngster. In attempts to find whether there was any relationship, I persuaded Mr. Gorton, our Junior Educational Psychologist, to check on the probable capabilities of as many asthmatics as possible by taking their I.Qs. I append some notes and a graph he has given me. It does seem that my impression was wrong and also that these youngsters are not working up to their potential. I agree with Mr. Gorton that a study of the domestic situation and relationships would be enlightening if we had time.

Mr. Gorton writes :—

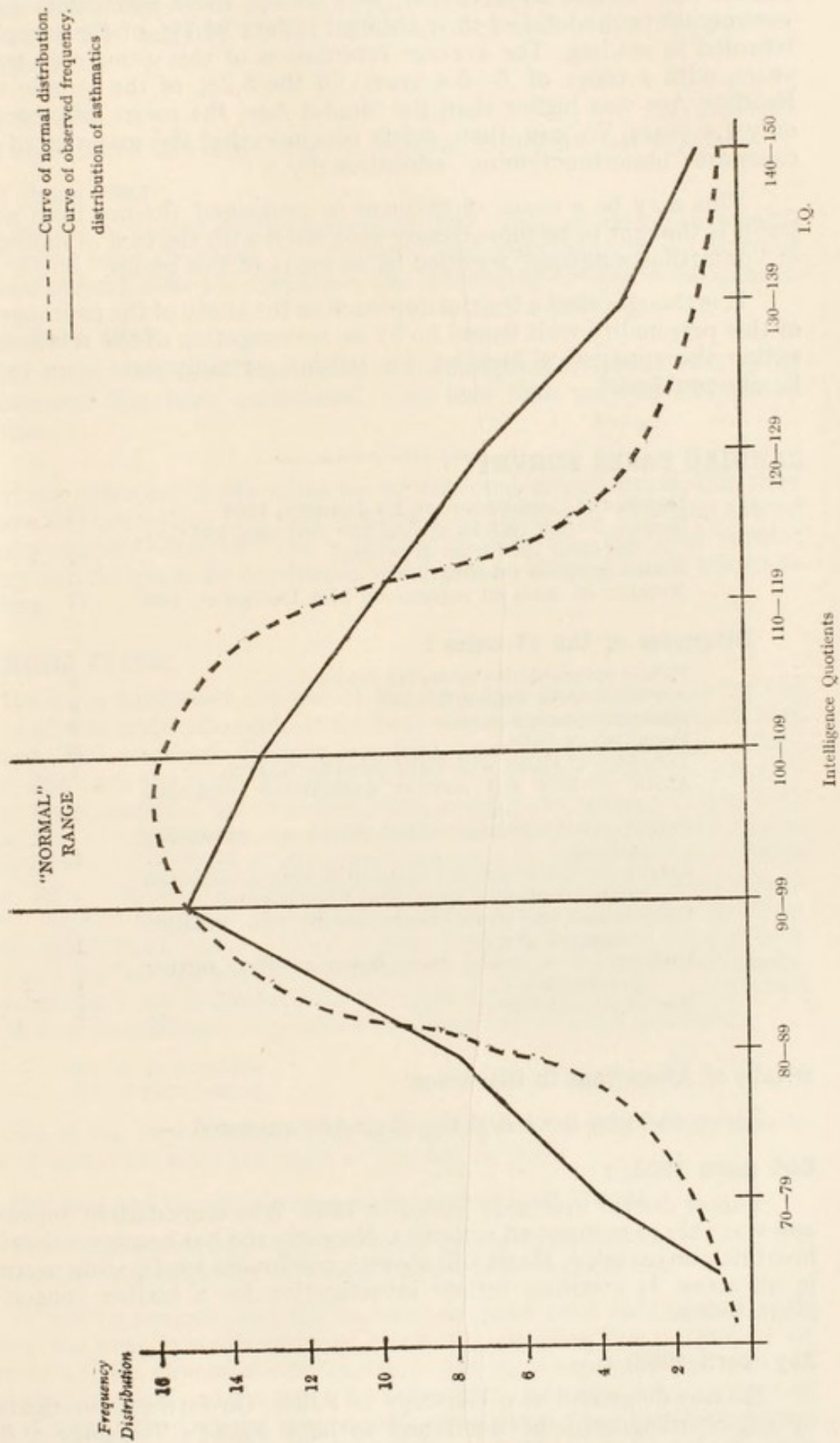
“The mean chronological age of the sample was 11 years 8 months, with a range of 5 years 3 months to 17 years 5 months, and the mean I.Q. was 104.9, range 58—148, i.e. from very limited to very superior. 54.8% had I.Qs. greater than 100.

An interesting picture is revealed when the spread of I.Qs. is depicted in tabular form :—

I.Q.	No. in sample (frequency)
Under 70	1
70—79	4
80—89	8
90—99	15
100—109	13
110—119	10
120—129	7
130—139	3
140—150	1

In graphical form this would show a curve roughly equivalent to that of the curve of normal distribution, with a frequency concentration around the “norm,” for, although the mean I.Q. is slightly above the average of 100, 45.16% fall into the “normal” range of 90-110.

ASTHMATIC CHILDREN AND INTELLIGENCE QUOTIENTS



From a consideration of the figures of Reading Age compared with Mental Age, it can be seen that, as a group, these youngsters are not working up to the level of their ability : in fact 94.7% of the sample are retarded in reading. The average retardation of this group was by 2.24 years, with a range of .3—5.4 years. Of the 5.3% of the sample whose Reading Age was higher than the Mental Age, the mean difference was only 1.4 years. We can, then, safely conclude that the majority of these cases are "underfunctioning" educationally.

This may be a result of frequent or prolonged absence from school, but it is thought to be more closely associated with the lack of motivation or "unforthcomingness" revealed by so many of this group.

It is thought that a fruitful approach to the study of the psychogenesis of this personality trait would be by an investigation of the relationships within the youngsters' families, for asthma certainly does seem to be a family problem."

CARDIAC CASES SURVEY

Number of cases known on 1st January, 1960 ..	12
Removed from register during the year (one left City, the other died from drowning)	2
Added to register during year	7
Number of cases on register on 31st December, 1960	17

Diagnoses of the 17 cases :

Patent interventricular septal defect	5
Aortic stenosis, uncomplicated	1
Mild pulmonary stenosis	1
Tetralogy of Fallot	3
Tetralogy of Fallot with right-sided aortic arch ..	1
Aortic stenosis and another unidentified congenital defect	1
Patent interventricular septal defect +? pulmonary stenosis	1
Patent Ductus arteriosus (ligated) having a suspected further congenital heart defect investigated ..	1
Unidentified acyanotic heart lesion with multiple congenital defects	1
Unidentified acyanotic heart lesion awaiting further investigation	1
Rheumatic carditis	1

Details of Alterations in Diagnoses:

Three children have had the diagnosis amended :—

Girl (born 1953) :

Patent ductus arteriosus ligated in 1957. Was immediately improved and was able to manage all activities. Recently she has become somewhat breathless on exertion. Heart still shows a continuous loud systolic murmur in all areas. Is awaiting further investigation for a further congenital heart lesion.

Boy (born 1953) :

He was diagnosed as a Tetralogy of Fallot. On further investigation by angiocardiology he was found to have Fallot's Tetralogy and a right sided aortic arch. He is now awaiting surgery.

Girl (born 1953) :

She was thought to have a mild pulmonary stenosis. She is now more limited in activity by her breathlessness and is awaiting further investigation.

Heart Surgery

Two children had heart surgery, but not within the last year :—

Girl (born 1953)

Ligation of patent ductus arteriosus 1957. Immediate improvement. Now having some dyspnoea on exertion. Loud continuous systolic murmur has been present since the operation. She is awaiting further investigation.

Boy (born 1954)

Tetralogy of Fallot—operation in Birmingham in 1956. Very great improvement has been maintained. Can now take part in all normal activities.

These notes are really more for professional consumption, but they do show the interesting fact that of these youngsters—all of whom attend ordinary schools—only one has a rheumatic infection, and that cardiac surgery can do much for conditions which not so long ago were felt to be hopeless.

ENURESIS CLINIC

We have continued the use of the Pad and Bell apparatus for the year, and this unquestionably is the best way of treating youngsters with enuresis (bed wetting). Results are good but one cannot claim 100% cures; there are too many variable factors which may upset the effective use of the apparatus, for example unless co-operation is good from both parent and child, failure may result, and one cannot expect good results where parents are afraid of the apparatus as they are at times, or where father says "The b—— bell wakens me as well as the next door neighbours," before the child comes round sufficiently to press the bellstop. On the other hand, one has homes where the mere fact that the pad is in place and the bell set to ring is sufficient to result in no further wet beds, and indeed it is not uncommon for the mere suggestion of the use of a Pad and Bell to be sufficient to produce the longed for change of habits.

No. of boys treated	..	..	..	..	..	31
No. of girls treated	..	..	..	..	..	6

Six of the boys treated did not improve very much, mostly due to poor co-operation from the boys, or parents, or both.

One boy and two girls were sent for and did not attend.

From home visiting, eight boys and two girls had improved and did not require the equipment and were taken off the waiting list.

It will be noticed that the number we have been able to deal with during the year is comparatively small. Our waiting list is tending to increase a little. One of our difficulties is getting a supply of pads, and it has been impossible to use these for more than one case. Wastage among pads is high as they are not very sturdy, must not be bent and connections are easily broken unless handled carefully.

INFECTIOUS DISEASES

The figures over the past seven years for the more common conditions are given below :—

	1954	1955	1956	1957	1958	1959	1960
Chicken Pox ..	1,589	1,966	1,257	1,617	1,412	2,560	2,662
Measles ..	300	2,723	123	2,005	1,401	1,388	2,128
Mumps ..	2,114	584	796	2,080	266	879	3,965
Scarlet Fever ..	319	85	147	244	216	304	167
Whooping Cough ..	427	326	711	169	194	339	329

The three main conditions in which it is not possible to provide any active immunisation still show large numbers.

A low figure (1) for polio is especially worthy of note and also the fact that there has again been no case of diphtheria. This speaks well for the immunisation state of the City, but does not give reason for complacency, and I would like to stress the continued need for as high a percentage polio immunisation rate as possible. At present the rate in schools is considered satisfactory (75.8%). (Dr. Dodd, the Medical Officer of Health, has given me some statistics about the school population and they appear in the next paragraph). There are many at risk in the 28—39 age group who have not taken advantage of this form of protection but if, as has happened in Liverpool, there happened to be a few cases, there would be an embarrassing rush which would stretch the facilities of the Health Department to breaking point with resultant delays and disappointments. It is all very well refusing this protection with an air of bravado, but this is a disease which creates very considerable concern; the fear of paralysis is worse than that of death, and it is so easy to get rid of the former.

IMMUNISATION AND VACCINATION

I am indebted to the Medical Officer of Health for the following statistics. Dr. Dodd points out that the figures for poliomyelitis and diphtheria refer to the whole child population of school age in the City, whereas the figures for B.C.G. vaccination apply only to those schools maintained by the Education Authority.

Poliomyelitis Vaccination

The following table shows the number of children aged 5—14 years who have received 3 injections at 31st December, 1960.

<i>Year</i>	<i>No. of Children</i>	<i>Estimated Population</i>	<i>%</i>
1958	693	49,200	1.4
1959	32,166	49,300	65.2
1960	37,140	49,000	75.8

Diphtheria Immunisation

The table shows the number of children aged 5—14 years who have been immunised against diphtheria at 31st December, 1960.

<i>Year</i>	<i>No. of Children</i>	<i>Estimated Population</i>	<i>%</i>
1958	42,840	49,200	87.0
1959	40,658	49,300	82.4
1960	41,398	49,000	84.8

B.C.G. Vaccination

	1956	1957	1958	1959	1960
Maintained Schools visited ..	45	47	44	50	43
No. of 13 year olds	4,359	5,284	4,165	5,197	6,149
No. of acceptances	3,052	3,925	2,791	3,455	4,235
No. of refusals	1,173	1,243	1,294	1,595	1,804
No. of others	134	114	80	147	110
No. tested	3,058	3,912	2,592	3,265	3,957
Negative reactors vaccinated ..	2,339	3,154	2,155	2,814	3,388
Positive reactors	660	658	371	372	498

CHEST RADIOGRAPHY

I am grateful for this summary kindly sent by Dr. A. E. Beynon, Medical Director of the Chest Radiography Centre.

1. Pupils submitted to Chest Radiography

	<i>Males</i>	<i>Females</i>	<i>Totals</i>
(a) Senior Students (exceeding 15 years)	860	438	1,298
(b) Mantoux Positive Reactors (13/14 years) ..	—	—	—
(c) Contacts	45	—	45

2. Number of Significant Chest Conditions Discovered

For the first time since these school groups have been x-rayed, i.e. since 1945, no cases of active pulmonary tuberculosis were discovered during 1960. However, one must bear in mind the fact that we now only x-ray your senior students or contacts following the recommendation of the Adrian Committee report on Radiation Hazards, and the number of schoolchildren examined during the year was, therefore, considerably reduced by comparison with previous years. Moreover, the positive Mantoux reactors from the B.C.G. groups are now dealt with at the Forest Dene Chest Clinic.

One boy of seventeen was found to have a spontaneous pneumothorax and is still under observation and treatment. Six cases (3 boys and 3 girls) were found to have chest conditions of sufficient importance to bring to your attention.

3. General Observations

Although the above results are excellent, it must be borne in mind that it is not a true picture of the situation throughout the school population in view of the fact that the numbers who attend for x-ray are considerably reduced, and that the Mantoux Positive Reactors are now x-rayed at the Forest Dene Chest Clinic who also follow up the contacts in which an active case may be discovered.

Finally, I would mention that occasional cases of active tuberculosis in schoolchildren are still found in those who are referred to this Centre by their General Practitioner."

Dr. W. H. Roderick Smith of the Nottingham and District Chest Centre has let me have these notes about Mantoux Positive School Leavers :—

"We started x-raying this group in March, 1960, until December, 1960, and I find that a total of 341 attended.

Two children are being kept under clinical and radiological observation whilst small primary lesions are healing.

Fifty-three children showed definite radiological evidence of healed lesions.

Two hundred and eighty-six children showed no radiological evidence of Pulmonary Tuberculosis.

No case of active Pulmonary Tuberculosis requiring treatment has been detected amongst this group."

DEATHS OF CHILDREN OF SCHOOL AGE DURING 1960

Analysis of causes :

Road accidents	..	..	..	..	..	5
Burns ..	..	..	..	..	..	3
Drowning ..	..	..	..	..	..	1
Murder ..	..	..	..	..	..	1
Malignant growths	..	..	..	..	..	5
Leukaemia ..	..	..	..	..	..	3
Pneumonia (mongol)	..	..	..	..	..	1
Cholaemia ..	..	..	..	..	..	2
Meningitis ..	..	..	..	..	..	1
Acute nephritis	..	..	..	..	..	1
Heart operation	..	..	..	..	..	2
Cerebral haemorrhage (non-accidental)	..	..	..	..	..	1
Pleural effusion ..	..	..	..	..	..	1

It is unfortunate again that preventable conditions are still so high. This is, of course, creating considerable concern throughout the country, and I regret that this year we have to report a figure higher than last year on all counts, a most distressing state of affairs.

CONVALESCENT HOME TREATMENT

During the year 41 children were sent to the following convalescent homes, compared with 60 in 1959 :

Charnwood Forest Convalescent Home, Woodhouse Eaves ..	24 children
Roecliffe Manor Convalescent Home, Woodhouse Eaves ..	17 children

I am grateful to the matrons and staffs of the convalescent homes for the kindly attention they gave to the children in their care and on occasion for helpful notes about behaviour and other difficulties.

I feel some comment is called for on the much lower number of children sent to convalescent homes compared with the previous year, and I find it difficult to offer any explanation. Our policy has not been

changed in any way, it being left largely to the School Medical Officers to put forward cases they see or have brought to their notice. Neither can one look to the weather, because I recall that the Summer of 1960 was not one of our best. It would appear to be "just one of those things!"

SCHOOL DENTAL SERVICE

The Principal School Dental Officer reports:

Premises and Equipment

Although no new premises were completed during the year, some minor improvements were made to the old ones. A start was made to replace the old child chairs with full size ones and the purchase of other new equipment is slowly bringing our clinics up to date.

Staff

On 31st December, 1960, the staff consisted of:—

	<i>Full-time</i>	<i>Part-time</i>
Principal School Dental Officer	1	—
Orthodontist	NIL	.6
Dental Officers	NIL	1.4
Medical Anaesthetists	NIL	1.3

Policy

Because of the worsened staff situation, not as many Infant and Junior Schools could be inspected during 1960 as we had hoped at the end of 1959. Nevertheless, the policy in last year's Annual Report was followed as far as it could be, with a noticeable falling off in patient inspired casualties as the result.

Dental Inspections

During the year 7,389 children (or 14.3% of our school population) received a routine dental inspection and 34 dental officer sessions were devoted to this work. Of the children thus inspected, 6,798 (or 92%) were found to require treatment and treatment was offered to 5,198. 3,703 (or 71.2%) consented to treatment which is a very much better response than last year's 53%.

A further D.M.F. ("Decayed, Missing and Filled") survey of 5+ schoolchildren was carried out. Owing to the staff shortage, it had to be somewhat hurried. 840 children were examined, showing 14.5% NIL D.M.F. and an average number of D.M.F. teeth of 5.1.

The figures published in the Report of the Chief Medical Officer to the Ministry of Education for the years 1958 and 1959, published since our last report, are interesting in that the figures given for the 1958 national survey quoted below are fairly similar to those published in our last year's Annual Report. The Nottingham 1959 figures are shown in brackets.

	<i>Percentage of children showing no D.M.F. teeth</i>	<i>Average number of D.M.F. teeth per child examined</i>
5+ age group ..	12.8 (11.3)	5.7 (5.7)
12+ age group ..	5.0 (3.7)	5.5 (5.5)

One wonders if the 1960 Nottingham figures for the 5+ age group have any significance. We shall have to wait another five years to compare them with the next national survey.

Dental Treatment

During 1960, some 1,433 dental sessions were devoted to treatment (including orthodontics) and of those sessions 474 were reserved exclusively for extractions under general anaesthesia. 16,533 attendances were made by schoolchildren and the following treatment was carried out :—

Fillings :	Permanent teeth	5,151
	Temporary teeth	4
		<hr/> 5,155
Extractions :	Permanent teeth	6,983
	Temporary teeth	22,144
		<hr/> 29,127

A general anaesthetic was given for extractions on 9,694 occasions and a local anaesthetic on only 170 occasions.

In contrast, a local anaesthetic was given for fillings on 1,235 occasions.

Other operations :	Permanent teeth	421
	Temporary teeth	2
		<hr/> 423

Number of diagnostic X-ray films taken :	334
--	-------	-----

In the prosthetic and orthodontic department, 293 sessions were devoted to this work and 1,941 attendances were registered (included in 16,533 above).

222 new dentures were supplied to our children and 30 dentures were repaired.

63 orthodontic cases were completed during the year and 78 appliances (all removable) were fitted.

Fluoridation of Water Supply

The annual report of the Chief Medical Officer to the Ministry of Health Part II of 1959, published since our last report, is worth reading on this subject. It states in concluding the section :

"Despite the careful scrutiny to which fluoridation has been subjected in various parts of the world by special commissions and professional bodies of standing, no evidence has been found of any hazard to

health at a concentration as low as 1 p.p.m. Nevertheless, fluoridation is still the subject of controversy, albeit confined to a comparatively small section of the population, and follows a pattern familiar to public health workers who remember the opposition to the introduction of chlorination of water, pasteurization of milk and vaccination against smallpox."

Is this then the reason for our not being allowed to adopt this obviously needed public health measure? Is a small minority determined not to allow us to try to reduce the incidence of dental caries in this way? One part per million is all that we require in Nottingham. The .02—.06 parts per million which we already have, are not enough.

Summary of dental treatment carried out, under the Local Health Authority Maternal and Child Health Scheme, by the School Dental Service Staff.

During 1960, arrangements continued to be supervised by the Principal School Dental Officer. Treatment for children of pre-school age was made available at most of the school dental clinics, thereby reducing delay in the treatment of urgent cases. Dental treatment of mothers continued to be available at the General Dispensary and at the Central School Clinic in Chaucer Street, where dental x-ray examinations were also carried out.

No dental inspections were attempted at welfare centres or nurseries owing to lack of dental officer staff. Patients continue to be referred by medical officers of welfare centres and by general medical practitioners.

<i>Dental Inspection and Treatment</i>	<i>Mothers</i>	<i>Children</i>
No. examined	463	422
No. needing treatment	461	410
No. treated	451	406
No. made dentally fit	398	149
Number of sessions	101	19.5
No. of attendances for inspection and treatment	1,366	475
Scalings and gum treatment	44	—
No. of fillings	76	4
Silver nitrate treatment only	2	—
No. of crown and inlays	—	—
No. of teeth extracted under general anaesthetic	2,589	1,125
No. of teeth extracted under local anaesthetic	285	—
No. of general anaesthetics	533	453
Dentures provided :		
full upper or lower	200	—
partial upper or lower	44	—
Radiographs	13	—
Other operations	484	—

We have to express once more our gratitude to Head Teachers and teaching staffs, the staffs of the Education and Health Departments and to the Hospital services, for their invaluable co-operation and support. The Chairman and members of the Committee may rest assured that this further depleted staff is doing its best to cope with a difficult situation and that their encouragement, and understanding of the problems involved, are very much appreciated.

W. McKAY, L.D.S., R.C.S. (Edin.),

Principal School Dental Officer.

PHYSICAL EDUCATION

The Committee's Physical Education Inspector, Mr. S. L. Goldthorpe has kindly supplied me with the following notes :—

"As I was wondering what to say for the Principal School Medical Officer's Annual Report, there appeared in an edition of 'Education' an account of 'The Vauves Experiment.' This supports what has been stated in this country for many years, i.e. 'that the growing body needs about two hours of vigorous muscular activity per day.' It goes further in claiming that such an amount of activity does not jeopardise academic attainments—rather the reverse.

Of recent years in Nottingham, this fact has influenced physical education in two ways—firstly, in replacing formal Swedish Gymnastics by training which has recreative aims, and secondly, in increasing the opportunities for recreation through the expansion of school clubs and societies. If the fourteen school sports associations were to make known the extent of their activities with particular reference to the expenditure of time in teacher-hours it would make impressive reading. Even so it would not account for the very considerable time spent outside school hours on inter-house activities and school expeditions.

The parent body of the school associations for sport (now known as the City of Nottingham Schools' Council for Sport) in reviewing the over-all activities of its members points out that at best they provide recreational opportunities for about a quarter of a school's population. They also point out that while further expansion of the school sports association is desirable, such expansion is never likely to meet the needs of the majority of school children.

This parent body suggests that before the needs of the many can be considered, it is necessary to discover their recreational interests. The difficulty, of course, is to find a convenient method for obtaining the information. Trials have been made and if the samples are representative, the information to be gained is amusing, startling and highly informative.

Potentially this is a very important step for the information could well affect not only the provision for physical education in schools but also the provision for recreation in the City generally."

Miss B. Brown goes on to say :—

"In junior schools where large fixed apparatus is installed, the development of spine and shoulders is marked, mobility and strength being achieved despite the fact that there are few specialised teachers of physical education to give the desirable guidance.

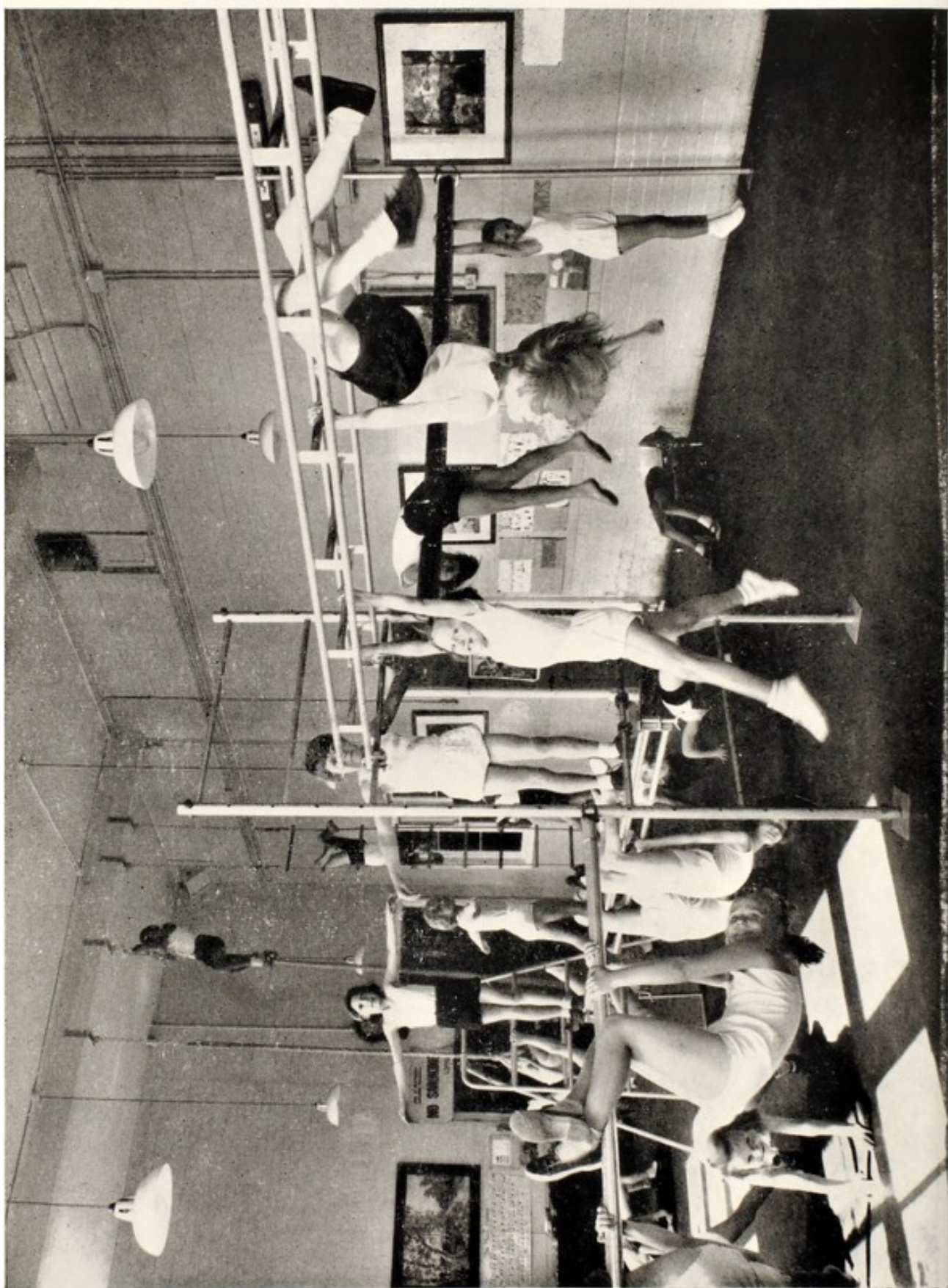
The Committee's policy of equipping infant schools with the large apparatus continues slowly. This apparatus, when the weight strength ratio is favourable to the child, gives most satisfactory results.

Plantar warts in some of the girls' secondary schools has given concern and barefoot work where necessary has been stopped. With regular foot inspection by the gymnast and shoes worn whenever there is any foot complaint, this problem will settle. (Why is it worst in the new housing estates?).

All the floors are still not fit for barefoot work but with new schools and extensions to the older schools, progress is being made.

Showering is still not as popular as it ought to be."





Mr. Goldthorpe suggests in his note that there is much of interest in the samples, and one cannot help but hope that on the next possible occasion, he will be able to give us some suitable examples of this "amusing, startling and highly informative" material. In a brief talk with Mr. Goldthorpe, I think there is little doubt "he has got something."

SCHOOL MEALS SERVICE

Miss E. N. Beard, School Meals Organiser, has supplied me with these notes :—

"There is little to be said with reference to the school meal that has not been said already. Of all the sections dealing with the welfare of school children the School Meals Service excites the most criticism. From the beginning of time children have complained about the fare offered to them and, therefore, one does not attach a great deal of importance to that; it may be due to lack of experience in eating different types of food. Parents nowadays tend to listen to their children and expect greater variety. Members of the teaching staff would prefer a different menu and also have not accepted the fact that the school meal is an important addition to their already arduous school day. Tax payers will also criticize the expenditure wondering whether the country can afford this service.

It is not really appreciated how much thought goes into the compilation of the menus to give the required nutriment for a growing child, keeping within a very limited cost laid down by officials in London. The food available is of good quality and the quantity is adequate. It requires skill on the part of the workers to produce an attractive meal which will satisfy all appetites. In Nottingham some 18,000 meals a day are provided from 47 kitchens.

Because providing meals for school children is virtually a part-time job it appeals mainly to mothers and widows to undertake it and this may mean that sometimes we are not able to employ the most able people. These women work hard for very little reward. They do, however, appreciate the interest taken in them by members of Committee who visit at regular intervals and by members of the Medical Staff who include the visit to the canteen as part of their general inspection. These visitors all express appreciation of the work done bearing in mind the problems which have to be overcome."

Miss Beard feels that there is much criticism, often of an adverse nature, of her efforts but we are all critical of our food and of those who cook it. But as one who has sampled many school meals I can congratulate her on making the best of material which is economical and tasty. I feel sure she is right in her policy of trying as much variety as possible even when "it does not go down very well" with some of her customers.

NOTTINGHAM CHILDREN'S HOMES, SKEGNESS

During the year, 677 boys and 632 girls were recommended as likely to benefit from a holiday at the seaside and of these, 404 boys and 405 girls went to the Skegness Homes for a stay of three weeks. We are privileged in Nottingham to have the continued use of these two Homes in Skegness, and for those fortunate enough to know and to see the children before and after their stay there, the improvement and general glow of health is something to be seen before it can be believed.

PIPEWOOD SCHOOL

763 youngsters were examined by the School Medical Officers before their departure to Pipewood.

The Committee found it necessary, as an economy measure, to discontinue the use of this school in July, 1960. From this department's angle, we were sorry to see the school close because we no longer have the chance to arrange from time to time for older boys and girls to be got away from home when domestic circumstances cried out for some relief—for example, when a mother was very seriously ill and children were perforce being neglected to some extent.

I should like to place on record my personal appreciation of the work of Dr. F. G. A. Armson, who acted so ably as medical officer to the school.

CONCLUSION

In conclusion I should again like to take this opportunity of thanking all members of the Committee for their encouragement during the year and for their continued collaboration in the welfare of the children. I hope you will find something of interest in a report which deals largely with routine matters. It is a pleasure to refer to the continued loyalty and co-operation of the School Health staff, both professional and administrative, and to acknowledge the assistance received from Head Teachers and others, without which our work would be much more difficult. My thanks are also extended to the Director of Education and his staff for their continued support.

I am, Ladies and Gentlemen,

Your obedient Servant,

R. G. SPRENGER,

Principal School Medical Officer.

MEDICAL INSPECTION AND TREATMENT RETURN

Year ended 31st December, 1960

Part I—Medical Inspection of Pupils attending Maintained Primary and Secondary Schools (including Nursery and Special Schools)

TABLE A.—PERIODIC MEDICAL INSPECTIONS

Age Groups Inspected (By Year of Birth)	Number of Pupils Inspected	Physical Condition of Pupils Inspected			
		Satisfactory		Unsatisfactory	
		No.	% of Col. 2	No.	% of Col. 2
(1)	(2)	(3)	(4)	(5)	(6)
1956 and later	558	558	100	—	—
1955	1,405	1,405	100	—	—
1954	1,796	1,795	99.94	1	0.06
1953	240	239	99.58	1	0.42
1952	104	104	100	—	—
1951	120	120	100	—	—
1950	2,655	2,655	100	—	—
1949	3,899	3,899	100	—	—
1948	1,413	1,412	99.93	1	0.07
1947	135	133	98.52	2	1.48
1946	2,508	2,508	100	—	—
1945 and earlier	1,319	1,318	99.92	1	0.08
Total	16,152	16,146	99.96	6	0.04

TABLE B.—PUPILS FOUND TO REQUIRE TREATMENT AT PERIODIC
MEDICAL INSPECTION (excluding Dental Disease and
Infestation with Vermin)

Age Groups Inspected (By Year of Birth)	For defective vision (excluding squint)	For any of the other conditions recorded in Part II	Total individual pupils
(1)	(2)	(3)	(4)
1956 and later	5	60	65
1955	23	187	206
1954	51	264	306
1953	12	17	28
1952	4	7	11
1951	9	11	20
1950	285	229	490
1949	386	408	755
1948	171	145	297
1947	91	60	144
1946	387	216	581
1945 and earlier	181	63	237
Total	1,605	1,667	3,140

TABLE C.—OTHER INSPECTIONS.

Number of Special Inspections	..	..	..	..	..	..	..	15,446
Number of Re-inspections	..	..	..	..	..	..	..	10,470
Total								25,916

TABLE D.—INFESTATION WITH VERMIN.

(a)	Total number of individual examinations of pupils in schools by school nurses or other authorised persons	..	..	..	..	..	165,719
(b)	Total number of individual pupils found to be infested	..	..	..	..	..	4,424
(c)	Number of individual pupils in respect of whom cleansing notices were issued (Section 54 (2), Education Act, 1944)	..	..	..	..	..	78
(d)	Number of individual pupils in respect of whom cleansing orders were issued (Section 54 (3), Education Act, 1944)	..	..	..	..	..	61

Part II—Defects found by Medical Inspection during the year

TABLE A.—PERIODIC INSPECTIONS

Defect Code No. (1)	Defect or Disease (2)	Periodic Inspections							
		Entrants		Leavers		Others		Total	
		(T) (3)	(O) (4)	(T) (5)	(O) (6)	(T) (7)	(O) (8)	(T) (9)	(O) (10)
4	Skin	34	6	61	3	160	15	255	24
5	Eyes—								
	(a) Vision ..	83	191	502	29	1,020	249	1,605	469
	(b) Squint ..	94	14	58	2	259	16	411	32
	(c) Other ..	13	—	9	—	24	6	46	6
6	Ears—								
	(a) Hearing ..	10	17	5	5	17	39	32	61
	(b) Otitis Media	19	8	13	1	40	16	72	25
	(c) Other ..	8	5	2	—	23	2	33	7
7	Nose or Throat ..	237	138	28	3	160	66	425	207
8	Speech	10	24	3	1	4	7	17	32
9	Lymphatic Glands	—	9	1	—	5	4	6	13
10	Heart	6	23	5	5	16	65	27	93
11	Lungs	18	31	10	12	43	78	71	121
12	Developmental—								
	(a) Hernia ..	10	12	—	—	6	5	16	17
	(b) Other ..	9	44	10	6	39	126	58	176
13	Orthopaedic—								
	(a) Posture ..	3	1	13	1	8	16	24	18
	(b) Feet ..	21	20	4	2	38	23	63	45
	(c) Other ..	13	20	26	5	57	50	96	75
14	Nervous System—								
	(a) Epilepsy ..	1	7	4	2	6	22	11	31
	(b) Other ..	3	4	1	1	9	68	13	73
15	Psychological—								
	(a) Development	2	11	—	1	13	13	15	25
	(b) Stability ..	1	10	3	3	23	15	27	28
16	Abdomen	6	4	—	—	4	1	10	5
17	Other	1	29	1	7	4	83	6	119

TABLE B.—SPECIAL INSPECTIONS

Defect Code No. (1)	Defect or Disease (2)	Special Inspections	
		Requiring Treatment (3)	Requiring Observation (4)
Skin		209	41
Eyes— (a) Vision		1,042	2,339
(b) Squint		254	473
(c) Other		63	12
Ears— (a) Hearing		34	245
(b) Otitis Media		28	28
(c) Other		210	17
Nose or Throat		692	491
Speech		19	54
Lymphatic Glands		2	11
Heart		2	162
Lungs		5	190
Developmental—			
(a) Hernia		3	16
(b) Other		18	176
Orthopaedic—			
(a) Posture		3	12
(b) Feet		44	66
(c) Other		28	111
Nervous System—			
(a) Epilepsy		5	77
(b) Other		7	57
Psychological—			
(a) Development		64	127
(b) Stability		100	176
Abdomen		1	11
Other		739	786

Part III—Treatment of Pupils attending Maintained Primary and Secondary Schools (including Nursery and Special Schools)

TABLE A.—EYE DISEASES, DEFECTIVE VISION AND SQUINT

	Number of cases known to have been dealt with
External and other, excluding errors of refraction and squint	821
Errors of refraction (including squint)	5,354
Total	6,175
Number of pupils for whom spectacles were prescribed	2,221

TABLE B.—DISEASES AND DEFECTS OF EAR, NOSE AND THROAT

	Number of cases known to have been dealt with
Received operative treatment	
(a) for diseases of the ear	142
(b) for adenoids and chronic tonsillitis	1,167
(c) for other nose and throat conditions	114
Received other forms of treatment	1,519
Total	2,942
Total number of pupils in school who are known to have been provided with hearing aids	
(a) in 1960	23*
(b) in previous years	57†

* Includes four pupils living in the Nottinghamshire County Council Area.

† { Includes eight pupils living in the Nottinghamshire County Council Area.

{ Includes five pupils living in the Derbyshire County Council Area.

TABLE C.—ORTHOPAEDIC AND POSTURAL DEFECTS

	Number of cases known to have been treated
(a) Pupils treated at clinics or out-patients departments	569
(b) Pupils treated at school for postural defects	—
Total	569

TABLE D.—DISEASES OF THE SKIN (excluding uncleanliness for which see TABLE D of Part I).

	Number of cases known to have been treated
Ringworm— (a) Scalp	3
(b) Body	18
Scabies	55
Impetigo	162
Other Skin Diseases	2,584
Total	2,822

TABLE E.—CHILD GUIDANCE TREATMENT.

	Number of cases known to have been treated
Number of pupils treated at Child Guidance Clinics	588*

*By Psychiatrists 64 By Educational Therapist .. 374
By Educational Psychologists 124 In Boarding Homes 26

APPENDIX

TREATMENT ARRANGEMENTS

<i>Clinic</i>	<i>Address</i>	<i>Treatment Carried out</i>	<i>Doctor attended</i>	<i>Children's attendances during 1960 for minor ailments</i>
Central	28 Chaucer Street	Minor Ailments, Refractions, Dental, Electrical, Ear Nose and Throat	Tuesday and Friday a.m.	11,440‡
Well	Main Street, Bulwell and Springfield School	Minor Ailments, Refractions, Dental, Speech Therapy	Monday and Thursday a.m.	7,696
Don	Southchurch Drive, Clifton	Minor Ailments, Refractions, Dental, Speech Therapy	Wednesday p.m.	7,192
West Purser	Wilford Road	Minor Ailments, Speech Therapy	—	1,155
Side	Canal Street	Minor Ailments, Dental	Thursday p.m.	7,100
Stow	Henry Whipple Infant School, Padstow Road & Burford School	Minor Ailments	Monday a.m.	14,061
Wood School*†	Blithbury, Staffs.	Minor Ailments, and in-patient treatment of acute conditions	Daily, as required	1,518 (part year only)
er	Beechdale Road	Minor Ailments, Refractions, Dental, Speech Therapy	Monday and Thursday a.m.	15,287
land	Portland Junior School Westwick Road	Minor Ailments	—	3 095
hill	St. Matthias' Road	Minor Ailments, Refractions, Dental, Speech Therapy	Tuesday p.m.	11,692
holme	Beaconsfield Street	Minor Ailments	Tuesday a.m.	5,580
am Crane	Aspley Estate	Minor Ailments, Speech Therapy	Wednesday a.m.	5,751
oretum	Arboretum Day Open-Air School	Speech Therapy	—	—
Guidance	34 Clarendon Street	Speech Therapy	—	—
odontic Clinic	36 Clarendon Street	Orthodontia	—	—

for children attending this School only. ‡Including U.V.R., Ionisation and Proetz cases. posed down in July.

	Number of cases known to have been treated
Pupils treated by speech therapists	313

TABLE G.—OTHER TREATMENT GIVEN.

	Number of cases known to have been dealt with
(a) Pupils with minor ailments	7,292
(b) Pupils who received convalescent treatment under School Health Service arrangements ..	41
(c) Pupils who received B.C.G. Vaccination ..	3,388
(d) Other than (a), (b) and (c) above :	
1. by the Authority: U.V.R.	41
2. at hospital: general medicine	513
3. at hospital: general surgery	530
4. at hospital: paediatrics	101
Total (a) — (d)	11,906

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

(1)	Number of pupils inspected by the Authority's Dental Officers:							
(a)	At Periodic Inspections							7,389
(b)	As Specials							6,054
	Total (1)							13,443
(2)	Number found to require treatment							12,490
(3)	Number offered treatment							10,866
(4)	Number actually treated							9,891
(5)	Number of attendances made by pupils for treatment (including orthodontics)							16,533
(6)	Half days devoted to: Periodic School Inspection							34
	Treatment							1,907
	Total (6)							1,941
(7)	Fillings: Permanent Teeth							5,151
	Temporary Teeth							4
	Total (7)							5,155
(8)	Number of teeth filled: Permanent Teeth							4,611
	Temporary Teeth							4
	Total (8)							4,615
(9)	Extractions: Permanent Teeth							6,983
	Temporary Teeth							22,144
	Total (9)							29,127
(10)	Administration of general anaesthetics for extractions							9,694
(11)	Orthodontics:							
(a)	Cases commenced during the year							50
(b)	Cases carried forward from previous years							37
(c)	Cases completed during the year							63
(d)	Cases discontinued during the year							1
(e)	Pupils treated with appliances							70
(f)	Removable appliances fitted							78
(g)	Fixed appliances fitted							—
(h)	Total attendances							845
(12)	Number of pupils supplied with artificial teeth							222
(13)	Other operations: Permanent Teeth							421
	Temporary Teeth							2
	Total (13)							423

	Blind (1)	Partially Sighted (2)	Deaf (3)	Partially Deaf (4)	Delicate (5)	Handi- capped (6)	tionally Sub- normal (7)	Mal- adjusted (8)	Epileptic (9)	Speech Defects (10)	Total (1)-(10) (11)
During the calendar year ended 31st December, 1960, number of handicapped pupils :—											
A. newly placed in special schools or boarding homes	1	1	4	4	19	11	73	11	3	1	128
B. newly assessed as needing special educational treatment at special schools or in boarding homes	1	3	4	4	22	15	53	14	5	—	121
On 20th January, 1961, number of handicapped pupils from the area :											
C. (i) on the registers of maintained special schools as :—	—	—	26	11	31	51	417	1	1	1	539
(a) day pupils	—	—	—	—	1	6	1	1	4	—	15
(b) boarding pupils	5	2	—	—	14	5	4	1	6	1	42
(c) ditto, (Non-maintained special schools)	—	1	3	2	—	—	—	—	—	—	—
(ii) on the registers of independent schools under arrangements made by the Authority	—	—	1	—	—	—	—	3	—	—	4
(iii) boarded in homes and not already included under (i) or (ii) above	—	—	—	—	—	—	—	15	—	—	15
Total (C)	5	3	30	13	46	62	422	21	11	2	615
D. being educated under arrangements made under Section 56 of the Education Act, 1944 :	—	—	—	—	—	—	—	8	—	—	8
(i) in hospitals	—	—	—	—	—	—	—	—	—	—	—
(ii) at home	—	—	—	—	—	2	—	—	—	—	2
E. requiring places in special schools :	—	—	—	—	—	—	29	—	—	—	29
(i) day	—	2	—	—	1	1	1	1	2	—	8
(ii) boarding	—	—	—	—	—	—	—	—	—	—	—

F. Number of children on registers of hospital special schools on 20th January, 1961 45

G. Number of children reported to the Local Health Authority during the calendar year ended 31st December, 1960

(i) under Section 57(3) of the Education Act, 1944 26

(ii) under Section 57(5) of the Education Act, 1944 (prior to 1st November, 1960) 12

iii) how many decisions that a child is unsuitable for education at school have been cancelled under Section 57A(2) of the Education Act, 1944 ? 2

