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CITY OF
NOTTINGHAM



EDUCATION
COMMITTEE



PRINCIPAL SCHOOL MEDICAL OFFICER'S

ANNUAL REPORT

ON THE WORK OF THE

SCHOOL HEALTH SERVICE

FOR THE

YEAR 1962



Adopted by the Education Committee at
its meeting held on 25th September, 1963



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

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



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CITY OF NOTTINGHAM

GENERAL INFORMATION AS AT 31ST DECEMBER, 1962

Population	314,360	No. of Schools	169
Area acres	18,364	No. on Rolls	50,846
Density of Population: 17.12 persons per acre		Average attendance	90.0%

CENTRAL SCHOOL CLINIC,
28 CHAUCER STREET,
NOTTINGHAM.

Telephone: Nottingham 43064.

SCHOOL HEALTH SERVICE

SPECIAL SERVICES SUB-COMMITTEE (Municipal Year 1962-63)

Chairman: Councillor H. WILSON

Vice-Chairman: Councillor B. MORLEY

Alderman W. DERBYSHIRE

(Chairman of the Education Committee)

Councillor R. E. GREEN

(Vice-Chairman of the Education Committee)

Alderman Mrs. K. BARSBY

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Councillor Mrs. M. WHITTAKER

Councillor Mrs. O. MOSS

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

Councillor C. M. REED, J.P.

H. J. PEAKE, Esq., M.A., M.Sc., Ph.D.

STAFF (31st DECEMBER, 1962)

Principal School Medical Officer:

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

Deputy Principal School Medical Officer:

ELEANOR J. MORE, M.B., Ch.B., D.P.H.

School Medical Officers:

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

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

MARJORIE A. WROUGHTON, M.B., Ch.B.

W. D. SINCLAIR, M.B., Ch.B., D.P.H. (from 3.9.1962)

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., J.P. (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)

ELIZABETH ARKLE, M.D., D.P.M. (Psychiatrist)

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

Part-time Medical Officers:

HELMMA M. PHELPS, M.B., B.S.

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

J. K. S. MOORE, M.A., M.B.,

L.R.C.P.

B. Chir. (M.O., Boots' College)

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

Principal School Dental Officer

W. McKAY, L.D.S.

Dental Officers:

LINDA E. POOLEY, B.D.S.	ERIKA MELLAKAULS, L.D.S.
MARGARET C. ROE, L.D.S.	(from 1.4.1962)
(from 1.12.1962)	*E. A. MEADOWS, L.D.S.
*V. C. CARRINGTON, L.D.S.	*D. M. SNAPPER, B.D.S.
*N. E. CHETTLE, L.D.S.	*W. TORZ, B.D.S.
JENNIFER M. SHARMAN (Dental Auxiliary—from 10.9.1962)	

Child Guidance Centre:

Mrs. J. FRY, M.A., Ed.B. (Senior Educational Psychologist)	Miss P. A. E. GRADY, L.C.S.T. (Senior Speech Therapist)
Miss N. M. GATELY (Psychiatric Social Worker—from 10.9.1962)	Miss J. S. MYNALL, L.C.S.T. (Speech Therapist—from 10.9.1962)
Miss M. M. BEESON (Remedial Teacher)	Miss R. SHONE, L.C.S.T. (Speech Therapist)
Mrs. E. WILL (Social Worker)	Miss A. STEWART, L.C.S.T. (Speech Therapist)

Administrative Assistant: D. R. FREER, D.P.A.*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.*Ward Orderly:* One. *Dental Surgery Assistants:* Seven.*Clerical Staff:* Chief Clerk (G. E. D. HANCOCK, D.M.A.) and twenty-four Clerks.*Hostels for Maladjusted Pupils:*

ORSTON HOUSE—Superintendent and Matron: Mr. and Mrs. C. A. FITCH.

THE GABLES—Warden and Matron: Mr. and Mrs. C. COLUMBINE
(from 1.5.1962)

*Part-time Staff.

CITY OF NOTTINGHAM EDUCATION COMMITTEE

SCHOOL HEALTH SERVICE

REPORT FOR THE YEAR ENDED 31st DECEMBER, 1962

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 to you the 54th Annual Report on the work of your School Health Service.

As in many previous years there have been no striking happenings, no alteration in the incidence of the common infectious diseases which seem to be always with us but which are now so much less virulent than they used to be and yet despite this, there seems little change in the school attendance rates compared with, for example, pre-war days or my own school days when, if our class completed 95% attendance for the week, we were allowed to leave an hour earlier on Friday. Whether this was a good thing or not I cannot be sure. It certainly bade ill for any truant caught in the act by the more enthusiastic and earnest members of the class.

We have been fortunate this year by having a full staff of medical officers so that it has been possible to bring most inspection work up to date.

At Clifton we have continued the selective examinations of all age groups in Primary Schools after the "Entrant" examination, and the school nurses have checked on the vision at regular intervals. (There are further notes about inspections at Clifton on page 11).

The defects found at medical inspection continue in about the same proportion as previously in all age groups, and are given on page 51.

Treatment arrangements have remained unchanged, and are shown on page 58. The periods of attendance of consultants are now shown in the same table.

Following last year's report, one never ceases to wonder why a simple factual statement with a possible explanation can arouse national, indeed international, interest. The mere fact that more girls than boys are born to the aristocracy is interesting, but why this should create interest to our American cousins I cannot see unless, being the best fed nation in the world, this is producing a form of petticoat rule which they are secretly afraid of. Certainly from what one hears, the wealth of the United States is gradually passing into the hands of their distaff side, as they so ungallantly refer to female descendants.

It is interesting to note that the Births Column in the "Telegraph" if taken over a period at random shows a slightly higher proportion of girls than boys, the figures being for two separate weeks at different times of the year—Girls 291; Boys 284. This just about reverses the usual tendency—but is the difference enough to be significant? And to which of the Registrar General's classes does the subscriber to the *Daily Telegraph* belong—would it be mainly to Classes I and II? The figures taken from *The Times* for two successive weeks in June show that notices of births were inserted for 73 boys and 80 girls in the first period and in the second period 80 boys and 76 girls.

It is gratifying to report an improvement in the staffing of the School Dental Service. We have had during the year almost the equivalent of five full-time officers together with one dental auxiliary from September, certainly not enough to cater for the requirements of a school population of 50-odd thousand, but a decidedly better situation than in 1961. It looks as though school dentistry is going to be run almost entirely by the female side of the profession. Our recent part-time male dentists only stay until they have built up sufficient private work to make themselves no longer dependent on part-time local authority work. This is only natural as earnings in private practice can be much greater than is possible in a local authority.

One incident which I feel worthy of note occurred in the Autumn. Youngsters attending one of the clinics on returning to school one day collected a number of laburnum pods, and removing the pea-like seeds distributed these amongst their colleagues, who were noticed by their teacher to be looking pale and one or two to be sick. Fortunately, none had swallowed many of the seeds, which contain one of the most potent poisons among plants in this country (cytisine). Its action is normally similar to nicotine. All the children settled without need for any urgent measures, but this incident serves to remind us that dangerous drugs exist in other than the home and that it is necessary to keep children warned of these dangers especially in the Autumn, and here teachers can be, of course, the main means of imparting information, particularly to children too young to heed one's first warning.

INVESTIGATIONS :

The policy of undertaking as many investigations as possible without prejudice to the main inspection work of the department has continued. With the facilities for statistical and other surveys so ready to hand, it would seem remiss not to make every use of these, and I have continued to encourage both medical officers and nurses to do so.

Some of the conditions in which we have interested ourselves demand longterm follow-up and so are continued from year to year. Others can be completed in a single survey but may need comparison with figures of previous years so that we can note increase or decrease of the defects we have reviewed and whether any epidemic tendency needs to be considered and investigated further.

We have continued to take an active interest in the following:—

Foot infections and plantar warts : We have not gone into this from the angle of all schools and especially, of course, secondary schools but more from the point of view of the individual school with a higher than normal figure of infection.

Age of onset of sexual maturity in boys and girls : There is little to add to what was noted last year except to say that all girls who had reached school leaving age were fully mature but that boys lagged behind and fully a quarter of them had not yet reached the age when voices break, and the other evidences of maturity are present.

Spinal and other movements : This has been continued and Mr. Waugh's interim conclusions are on page 42. Drs. More and Ward have continued to follow-up the original youngsters they surveyed in 1958, and to note especially whether their spinal movements had improved or otherwise as they grow and possibly lead more active lives.

Infective organisms in removed tonsils : We have continued to have these examined at the Public Health laboratory, thanks to the kindness of Dr. Mitchell. It has proved difficult to find exactly how many cases of rheumatic infections there were in the two hospitals which take children, so that we have had to drop this part of our survey. It can be noted, however, that there is an excessively increased number of tonsils with streptococcal infections during the summer months and this seems to be a fairly regular thing, see figures on page 27.

Undescended testicles : Dr. Ward and Dr. Hunter have continued with their survey of undescended testicles and a complete analysis of the figures appears on page 38.

Acne : We have now made a start with this survey. It will probably have to be continued over a number of years. Dr. Wroughton is particularly interested in skin abnormalities and her full report will appear next year. One of the striking things about this condition seems to be that it is much less common than first impressions would lead us to believe.

Hernia : The school medical officers have continued to collect data on hernias, details of which appear on pages 38 and 39.

Muscular dystrophy : Last year I mentioned that I thought there might be some association between pseudo-hypertrophic muscular dystrophy, a fatal condition, and limited intelligence, especially since on two occasions the delayed intellectual maturity was the symptom for which I was asked to see the children and the muscular dystrophy was noted during this examination.

In an endeavour to arrive at more complete figures for a large number I have been in touch with many of my colleagues in the School Health Service Group of the Medical Officers of Health Society and they have given me figures which I have condensed and noted on pages 46-48.

Clothing : There can be no doubt that the clothing worn by school children has improved very considerably during the last thirty years or so, and that it, outwardly, has obviously changed for the better in quality and protective needs, but I could not help but wonder whether underclothing had kept pace, and so, while inspections were being done, it was simple to check on this and there are some notes about our findings on page 31.

Families at risk : There are a certain number of families in the City, in which there are hereditary defects which constitute handicaps and I have always felt we do not know enough about these. We are making a

start with a roll of these families and it becomes increasingly difficult not to know which to note, but which to leave out. As the Health Department keep a Register of Families at risk, it may be that we shall get considerable help from them as their Register is built up.

Speech Survey : There has never been an accurate survey of the numbers of children with speech defects and so with the help of Dr. Daniels of the Institute of Education of the University of Nottingham and with the added stimulation of the interest of Dr. Simpson of the Ministry of Education, the whole speech therapy department undertook a survey of a 10% cross-section of the primary school population during the months of March to May.

Glycosuria Survey : Dr. Macfie, Consultant Physician of the City Hospital, who takes a special interest in Diabetics, asked us if we could do a survey of the school population for possible early discovery of cases of diabetics, and so with Dr. Macfie's help we obtained a large initial supply of "Clinistix" free of charge. We have been able to check on the urines of some 10,000 children. As we could check on possible kidney involvement at the same time without difficulty, advantage was taken of this urine testing and the same children were checked for this condition also. The results are shown on page 42.

STAFF :

There has been one change in the medical staff. Dr. Garden left to take up an appointment as a civilian doctor to the Army in Germany and Dr. Sinclair came to us from Hull, and as he is no stranger to Local Authority work, he has settled into the work quickly and easily. We are very pleased to welcome him to our service.

There were two full-time dentists also appointed—Mrs. Mellakauls who started after Easter and who commenced her professional career in Latvia, and Miss Roe who came to us in December. Mr. Snapper who belongs to a local family has also been able to give us some sessions.

Mrs. Durance who had been with us in a part-time capacity for ten years, unfortunately had to give up her appointment.

We have had a dental auxiliary on the staff from September. This is an innovation and it is impossible to comment on the usefulness of this type of officer as yet. Dental Auxiliaries must be supervised by a fully qualified dentist in their work.

Child Guidance Centre: We were fortunate to get the services of a psychiatric social worker, Miss Gately, from September, so that we feel quite well staffed, after a long period of difficulty, with now having two social workers.

The post of junior education psychologist remained unfilled for the whole year and we cannot be grateful enough to Mrs. Fry for the way in which she has accepted, always so willingly, the burden of keeping the school psychological service and the psychologists' work in the Child Guidance Centre running so smoothly. Fortunately, as I write, and as a result of the upgrading of the post to Soulbury II scale, we are expecting Mr. Ridley to take up the work after Easter 1963.

In the Speech Therapy Department, Miss Hartley resigned at the end of January and Miss Simms left us at the end of June to get married. Miss Mynall came to us in September but up to the time of writing it has not been possible to fill the other vacancy.

Nurses : Two nurses retired during the year, two more left to start a family and only one other resigned during the year. I am pleased to say that we were able to obtain five excellent nurses to take their places.

Office Staff : Five members of the office staff resigned during the year, two senior and three junior clerks. Replacements for the senior clerks were obtained from another department of the Committee and we had no difficulty in obtaining suitable junior staff.

MEDICAL INSPECTION :

The Ministry require returns of medical inspection work in the form given on pages 50 to 58. These sets of figures can give us a great deal of information but interpretation is not always easy and comparisons with previous years are sometimes difficult as figures may not refer exactly to the same conditions or the same groups.

The first note on Medical Record cards refers to the presence of the parent at the examination. It is interesting to note in these days of high employment ratios amongst married women that they turn out in the following proportions for their youngsters' examinations. I think it does show that mothers (and occasionally fathers) take a very active interest in the welfare and fitness of their offspring.

<i>Group</i>	<i>Percentage of Inspections at which a parent attended</i>
Entrant	88
Intermediate (1) — (aged 7 to 8 years) ..	79
Intermediate (2) — (aged 10 to 11 years) ..	77
Leaver	33

These proportions have varied little from year to year. They are not quoted annually but in 1957 and 1958, for example, the figures were:—

<i>Group</i>	<i>Percentage of Inspections at which a parent attended</i>	
	1957	1958
Entrant	92	92
Intermediate (1)	87	87
Intermediate (2)	85	84
Leaver	42	40

—indicating only a very little reduction of interest now on the part of parents in the condition of their children.

Heights and weights are measurements which do not give us much information about the actual physical condition of children but one can get from them some little indication of any considerable difference from the norm which one carries in one's mind constantly, when dealing with young people, e.g. if it be noted that a five year old's record shows him as being 42 ins. tall but only 30 lbs. in weight—instead of between 40 and 45 lbs.—one can have in one's mind's eye a rough picture of the child. Or, if his weight is 50 lbs. or over, the picture then becomes naturally more rotund.

It is not quite so simple at the other end of the ten years at school because of the differences of the age of maturity (often genetically determined) but nevertheless one can also in these youngsters spot any considerable variation from the normal.

Some years ago we were inclined to think that heights and weights were useless pieces of information but we have been able to compare those taken at present with those at the commencement of your service, just prior to the First World War, such a marked improvement is shown in these two fixed statistical figures making it evident that these measurements have been well worthwhile.

CLEANLINESS

	1957	1958	1959	1960	1961	1962
On school rolls	52,115	52,242	52,089	51,691	51,694	50,846
Examinations	182,949	161,622	160,796	165,719	162,576	152,551
Number found unclean ..	5,615	5,326	4,848	4,424	4,458	3,745
Percentage of the number on rolls	10.8	10.2	9.3	8.5	8.6	7.4
Statutory notices to parents ..	29	51	73	79	61	69
Children cleansed	22	37	54	61	53	56

It is rare indeed nowadays for our staff to complain of the unsatisfactory state of either the clothing or the person of youngsters in school. The odd youngster may have forgotten to wash his feet for the medical officer's visit but one usually realises it is an oversight by the look of shame on the child's face, making it probable that he will not offend again. There can be little doubt that force of example exerts a considerable effect. I can remember having occasionally to send a child to get himself washed before I could examine him and on an odd occasion finding a child sewn into his clothing for the winter. It is heartening now to see a class at physical education, often with only shorts on, all with a certain amount of pride in the fact that they will finish their lesson and go into the showers with all the enthusiasm in the world and a sense of the need for personal cleanliness.

Infestation of the body is a thing of the past in school and I doubt if medical officers nowadays would recognise the parasite which Burns so ably wrote about after his visit to church.

TO A LOUSE

On seeing one on a lady's bonnet at church

(Verses 1, 7 and 8)

"HA! whare ye gaun, ye crowlin' ferlie!
Your impudence protects you sairly:
I canna say but ye strunt rarely,
Owre gauze and lace;
Though, faith, I fear ye dine but sparely
On sic a place.

"O Jenny, dinna toss your head,
And set your beauties a' abroad!
Ye little ken what cursed speed
The blastie's makin'!
Thae winks and finger-ends, I dread,
Are notice takin'!

"Oh wad some power the giftie gie us
 To see oursel's as others see us!
 It wad frae mony a blunder free us,
 And foolish notion:
 What airs in dress and gait wad lea's us,
 And even devotion!"

The *Pediculus capitis* (head louse) is, however, still with us, and so children's heads need constant care and attention. There is no doubt that spread in schools does happen but most of the persistent infestation occurs in families where home care and interest are limited or absent and it is this chronic pool which needs the attention of cleanliness staff.

I am pleased to note a downward trend, if only very slowly, as the following "Infestation with Vermin" figures will show:—

	1946	1955	1957	1959	1960	1961	1962
No. of individual examinations of pupils ..	143,379	185,525	182,949	160,796	165,719	162,576	152,551
No. of individual pupils found to be infested ..	6,162	6,403	5,615	4,848	4,424	4,458	3,745

While on the subject of head infestation and as an example of present day ignorance of the condition, we were asked to see a child who attended a private school and whose mother wanted advice on:—

1. whether her child was affected, and
2. what to do if this were so.

It was surprising how very ignorant of the situation this parent really was and how it had never occurred to her that there was any need for watchfulness. We were able to help, of course, especially when another child in the same school turned up similarly affected. We felt that the staff at that school should warn parents to be on the look-out for further similar incidents.

Once again, I would like to thank our cleanliness staff for their quiet efficiency and also for the diplomatic way in which they constantly bear in mind that it is not the fault of the child if affected but that they—and possibly the parents—need help.

The Clifton Experiment : This has continued along the same lines. It has not been possible to report fully on the results but our latest figures are given below. There cannot be any check on whether we are doing a good job or not until those children who have been the guinea pigs in this experiment have had their "leaver" medical examinations at the age of 14 or 15 years. That will be between the third year for the Intermediate (2) group and the sixth year for the Intermediate (1) group, after the start of this change in our inspection arrangements.

Meantime we are checking vision in the first year at the junior school and also continuing to arrange for a check of height, weight and vision by the school nurse, of all Clifton children in their final year in junior school. She knows many who have needed treatment or care during their junior school lives, and can satisfy herself that they seem well, clothing is adequate and sensible, and footwear good. She also does a quick check on hearing, to pick up those who were satisfactory at earlier inspections, but now may have become defective, as a result of acquired loss or a variable defect associated with upper respiratory tract infections or enlarged tonsils and adenoids or even actual otitis media.

The latest figures are given below:—

<i>School</i>			<i>Spring 1961</i>	<i>Summer 1961</i>	<i>Autumn 1961</i>	<i>Spring 1962</i>	<i>Summer 1962</i>	<i>Autumn 1962</i>
A								
Follow-ups .. ..	..	..	37	34	22	24	5	26
Supt. Nurse's list ..	..	..	10	10	9	3	5	7
Handicapped Pupils ..	..	..	3	2	1	1	1	—
H.T.'s requests .. ..	..	..	13	29	16	23	5	11
			<u>63</u>	<u>75</u>	<u>48</u>	<u>51</u>	<u>16</u>	<u>44</u>
B								
Follow-ups .. ..	..	..	32	34	17	17	5	23
Supt. Nurse's list ..	..	..	9	10	5	11	—	10
Handicapped Pupils ..	..	..	5	5	1	5	—	2
H.T.'s requests .. ..	..	..	6	7	10	7	7	10
			<u>52</u>	<u>56</u>	<u>33</u>	<u>40</u>	<u>12</u>	<u>45</u>
C								
Follow-ups .. ..	..	..	31	35	17	27	4	29
Supt. Nurse's list ..	..	..	9	8	6	6	5	7
Handicapped Pupils ..	..	..	1	4	1	1	—	—
H.T.'s requests .. ..	..	..	15	14	17	15	7	8
			<u>56</u>	<u>61</u>	<u>41</u>	<u>49</u>	<u>16</u>	<u>44</u>
D								
Follow-ups .. ..	..	..	12	23	14	10	4	17
Supt. Nurse's list ..	..	..	4	6	—	4	—	6
Handicapped Pupils ..	..	..	5	4	1	3	—	5
H.T.'s requests .. ..	..	..	8	3	6	4	6	7
			<u>29</u>	<u>36</u>	<u>21</u>	<u>21</u>	<u>10</u>	<u>35</u>
E								
Follow-ups .. ..	..	..	32	21	14	15	3	21
Supt. Nurse's list ..	..	..	3	4	2	1	—	2
Handicapped Pupils ..	..	..	2	2	—	1	1	1
H.T.'s requests .. ..	..	..	11	—	10	10	3	11
			<u>48</u>	<u>27</u>	<u>26</u>	<u>27</u>	<u>7</u>	<u>35</u>
F								
Follow-ups .. ..	..	..	25	19	8	9	4	12
Supt. Nurse's list ..	..	..	1	2	—	1	—	1
Handicapped Pupils ..	..	..	—	—	1	—	—	—
H.T.'s requests .. ..	..	..	—	—	8	—	1	6
			<u>26</u>	<u>21</u>	<u>17</u>	<u>10</u>	<u>5</u>	<u>19</u>

G

Follow-ups	15	19	5	12	5	25
Supt. Nurse's list	2	3	1	1	1	3
Handicapped Pupils	1	2	2	2	2	1
H.T.'s requests	1	9	8	17	10	13
	<hr/> 19	<hr/> 33	<hr/> 16	<hr/> 32	<hr/> 18	<hr/> 42

H

Follow-ups	24	23	3	14	1	2
Supt. Nurse's list	6	10	—	5	—	1
Handicapped Pupils	3	4	1	2	—	2
H.T.'s requests	1	—	2	—	11	2
	<hr/> 34	<hr/> 37	<hr/> 6	<hr/> 21	<hr/> 12	<hr/> 7

ANALYSIS OF DEFECTS

<i>Defect Code Number</i>	<i>Referred for Treatment</i>	<i>Referred for Observation</i>
4	—	3
5a	17	22
5b	—	—
5c	—	2
6a	3	24
6b	—	2
6c	—	1
7	12	17
8	7	14
9	—	1
10	—	6
11	—	25
12a	—	—
12b	1	20
13a	—	3
13b	1	1
13c	1	10
14a	1	4
14b	3	8
15a	7	34
15b	8	12
16	—	3
17	1	121

I am a little concerned about one point in these arrangements, namely that it is possible for a child to come into one of the Clifton Schools having missed the normal medical inspections elsewhere and never be seen at all until the Leaver examination. This is an administrative loophole which we have to fill and which does not concern us when children are seen as Intermediates as a routine inspection arrangement.

HANDICAPPED PUPILS :

These pupils include all who may in any way need some, even minor, alteration in the school curriculum to allow them to fit into ordinary schools, even although this alteration need only be on occasion, e.g. our asthmatics can usually do everything most of the time but may on occasion be unable to take part in certain activities or lessons because of their difficulty. Included also are all who are in our day special schools for the Deaf, Delicate and Physically Handicapped and Educationally Sub-normal, as are, of course, all children in Residential Special and Hospital Schools.

Blind :

Residential Special Schools	6
-----------------------------	----	----	----	---

This figure includes one new pupil who had previously spent a good deal of his time in the Nottingham City Hospital School having, as well as his gross defect of vision, a marked arthritis of his legs, rheumatoid in type, and only helped by a continuous dose of steroids, the effect of which is not very reliable but which seems the only form of treatment in our present knowledge which controls his joint disease as well as the recurring attacks of eye inflammation. This boy was bright enough to gain a place at Worcester College but unfortunately as I write he has been readmitted to hospital with a further exacerbation of his eye condition.

Partially sighted :

Residential Special Schools	..	..	..	4
Day Special Schools	..	..	..	3
Ordinary Schools	..	..	..	16

The total figure in this category is lower than last year but there are two more now in residential schools, who previously had been struggling along in ordinary school awaiting residential placement.

Most parents are only too pleased to accept the need for their child going to a Residential School when they realise how great a handicap defective vision is to him and that he is falling behind with his school work. Some parents, however, are not so co-operative and refuse the advantages of education in a school which can cater for the children and whose staff understands fully their difficulties.

As I have noted before, if children in this category are also dull, the one difficulty seems inversely to affect the other and exaggerates its effect.

Deaf :

Residential Special Schools	..	..	..	4
Independent Residential Special School	..	..	..	1
Day Special Schools	..	..	..	26

The numbers are a little reduced compared with 1961, due I believe to fewer children being considered as deaf; more are being placed in the category following (partially hearing). Modern policy considers it essential to stimulate hearing as early as possible and so retain whatever rudiments of hearing there are.

I am afraid the speech of children in this group never becomes easy to follow. Many of our deaf pupils become efficient lip readers and it is almost as essential that they also learn to write so that they can make brief but reliable communication with others.

Partially hearing :

Residential Special Schools	..	..	..	2
Day Special Schools	..	..	..	18
Ordinary Schools	..	..	..	67

This category has been renamed to keep pace with modern thought, and to make the treatment and teaching required for this handicap more realistic.

The numbers in this group are much the same as last year. The effect of the up-to-date equipment in the Ewing School for the Deaf and Partially Hearing is now beginning to show results—speech is more toneful although not always improved otherwise. Children with some hearing are being enabled to make full use of what hearing they have.

There still remains, amongst those in this group, a certain amount of diffidence about wearing their aids, and it often becomes necessary for teachers both in ordinary schools and at the Ewing School to insist that these aids are working, worn and used. Young people have changed little from my own young days when they would often stubbornly refuse to put up with or wear anything which suggested they were different from their colleagues. We become less sensitive about this kind of thing as we become older and are merely labelled as harmless eccentrics.

Our peripatetic teacher continues to keep all in this group under supervision. She tells me that there are still some children whose parents refuse to allow them to attend her classes for lip reading and who continue to lack the help which facility at this can give them in communication. It is surprising on the other hand how adept some children become without any help. Intelligence seems to have something to do with it but it does not always follow that all partially hearing and intelligent children become good lip readers nor that all good lip readers have a superior intelligence.

We have continued to bear in mind the need for all partially hearing children to have the benefit of education in ordinary schools, not overlooking the fact that they have to find employment in a world of the hearing where communication takes place by means of speech, and so, from time to time, some pupils are tried part-time in ordinary schools.

Delicate :

Residential Special Schools	..	..	..	8
Hostel for Diabetics..	..	..	..	1
Day Special Schools	..	..	..	26
Ordinary Day Schools	..	..	..	162

Many in this group have chest conditions such as bronchitis, asthma, etc., which may entail minor alterations in their school curricula. I feel, however, that chest conditions are much reduced in number especially since infants with "chests" could have antibiotics. In support of this feeling, I find that of the 92 children in this category who are handicapped on account of their chest condition, only 9 of them are under 10 years of age.

Physically handicapped :

Residential Special Schools	..	..	..	10
Hospital Special Schools	..	..	..	3
Day Special Schools	..	..	..	59
Ordinary Day Schools	..	..	..	21
Home Tuition	..	..	..	1
Awaiting placement	..	..	..	1

There is a slight increase in numbers in this group and it is good to report that it is almost entirely amongst those who are in ordinary schools. I feel that school staffs and their own colleagues are accepting them and their handicap. I am certain this means that these youngsters are largely making themselves independent, which augurs well for their attitude to the world of employment.

The same cannot always be said for those in special schools. There is, I am afraid, at times a too dependent attitude both on the part of parents and children, an attitude which means they are unlikely to accept the incentive which work and its rewards can give them to get out of the rut and rely on their own capabilities. It is too easy for them to feel that the world owes them a living especially in these days of the Welfare State. I cannot help but feel at times that all our solicitude is not really kindness after all.

I would like to express my thanks to the British Red Cross Society again for the very effective arrangements they made for a holiday for eight of our physically handicapped children at Hopwell Hall. I think I can say that a good time was had by all.

Educationally sub-normal :

Residential Special Schools	..	..	..	3
Day Special Schools	..	..	..	371
Awaiting placement in Day Special Schools	..	..	..	70*

* 16 of these were admitted to Day Special Schools in January, 1963.

The figures on the waiting list suggest that we are not catering very well for this group of youngsters. However, I am pleased to say that as I write a new school at Clifton is in process of completion and it is hoped that it will be ready for occupation after Easter, 1963. This will cater for the Clifton area and it will also be able to accept children from the Meadows area of the City who can make use of public transport to and from school at off-peak periods when travelling is easy. The new school will have 80 places and we shall be in the fortunate position of having no (almost) waiting list.

As I write this report, I am very pleased to learn that of the 23 educationally sub-normal girls who left the Westbury Day Special School during 1962, only one girl has never had a job, and this was because she is keeping house for her father (a widower). There are at present 3 girls unemployed.

Similarly of the 31 educationally sub-normal boys who left the Rosehill Day Special School during 1962, there is none who has never had a job and only 2 boys at present are unemployed.

Maladjusted :

Hospital Special Schools	..	..	..	..	3
Residential Independent Schools	..	..	..	..	3
Residential Hostels	..	..	..	..	14
Day Special Schools	..	..	..	..	1
Ordinary Day Schools	..	..	..	..	21

Our figures reflect the general tendency throughout the country and although we only attach this label to the smallest possible number, nevertheless, there is a slight increase in our figures due to children in the Hospital School in St. Ann's.

During the year the Warden and Matron of our Gables Hostel left to work for a County Authority. As there was a limited field of applicants, we reduced our numbers in that hostel as low as possible so that if necessary

we could accommodate all our boys in the other hostel. Fortunately this was unnecessary but staffing difficulties at the hostel have continued and as a result we have had to keep our numbers low, a not undesirable position while the Warden and Matron were new and getting into their stride.

There is often doubt about what is really meant by maladjustment and it so difficult to give a definition which is readily understood. Maladjustment can cover many deviations from the normal and I give below an example of a child who is at present in one of our hostels.

An eleven year old boy who was referred by the family doctor on account of refusal to attend school—he had always been a shy, sensitive child with very little self-confidence, not able to mix freely with his peers or separate from his mother. After observation, we gained the impression of a rather inadequate, somewhat passive, dependent boy who regressed to an infantile state when he found himself in a competitive situation. The move to a large Secondary School had precipitated a great deal of anxiety and he found himself unable to adapt to any situation which required a certain amount of self-reliance. It was felt that he would benefit from a period in one of our Hostels for Maladjusted Boys and a smaller school environment. He has been in Hostel for a few months now, has settled in well and is attending school regularly.

Epileptic :

Residential Special Schools	..	..	..	8
Day Special Schools	..	..	..	10
Ordinary Day Schools	..	..	..	84

The above figures are interesting from several angles:—

1. The number in our Day Special Schools, for example (these schools include all our educationally sub-normal and open air schools), is proportionally higher than the figure for the whole school population. I think this can be explained by the fact that many of our youngsters in the special schools are brain damaged, and while this may be producing a handicap in addition to the epilepsy, nevertheless this latter remains the major difficulty.

2. Those in Residential Schools are children who often have an added difficulty which makes residential care and education essential. It is not uncommon for social conditions in the home to be unstable or unreliable so that a child is not only ill-cared for, or even neglected, but also does not receive consistent medication and handling.

As an example of the type of situation found on occasion, the following case might be of interest:—

An immigrant youngster started having major attacks in school. He was taken home where it was found that no-one was in on one or two occasions. Later visits to check on the regularity of his medication were unsatisfactory and as he continued to have attacks of a severe type in school and neighbours were complaining about the apparent lack of home care, admission was arranged to a Residential Special School. We would have liked the N.S.P.C.C. to take action against the parents but in the child's interest, we felt that the sooner he was in residential care, the better.

3. We have been accused on occasion of fussing too much about our epileptics but I think the large number who are in ordinary schools and who create there only a very minimal problem, is evidence to the contrary. I would like to thank all our teachers who have epileptics in their classes, who accept them without fuss and deal with them sensibly and considerately if on occasion they do have an attack. One realises that alterations in the frequency of attacks, especially for example, as may occur at puberty, can create an excessive amount of upset in a school and may mean that changes in medication, or possibly even residential education, must be arranged.

While on the subject of epilepsy, I would like to thank Dr. Fabisch and his staff in the E.E.G. Department at both the St. Ann's and the Children's Hospital for their continued helpfulness in making arrangements for and carrying out these examinations. I am afraid appointments at times are not kept, or patients are not as co-operative as they might be—for these difficulties we apologise and would like them to know that we find these electro-encephalograms extremely valuable. Negative results, while not conclusive, can be extremely reassuring to parents and we are very grateful for the continued use of this facility.

Speech Defects:

Residential Special School	1
Day Special School	1
Ordinary Day Schools	2

Children with gross defects only are included in these figures, but there are many children who have speech difficulties not severe enough to be included. These are reported on separately on page 25.

Children with dual or multiple handicaps:

<i>Major Handicap</i>	<i>Other Handicap</i>						
	<i>Partially Sighted</i>	<i>Partially Hearing</i>	<i>Delicate</i>	<i>Physically Handicapped</i>	<i>E.S.N.</i>	<i>Mal-adjusted</i>	<i>Epileptic</i>
Blind ..				1			
Partially Sighted ..					3		
Partially Hearing ..	2		1		10	1	
Delicate ..		2			4		
Physically Handicapped	1	3			7		4
E.S.N. ..			1				
Epileptic ..			1		11		

This table is especially interesting in that it shows what a large number of children have more than one handicap. It also notes the combination of handicaps which create some interplay of difficulties, e.g. it can be noted that there are 10 partially hearing youngsters who have

the added handicap of dullness severe enough to classify them as also E.S.N. You may remember that I noted this earlier when discussing partial loss of hearing.

The physically handicapped group also contains a rather large proportion of children who mostly, due to brain damage, have this concomitant difficulty of dullness which incidentally limits their ability to overcome their physical handicap. Also, rather in a similar category, is the group of epileptic children who are also dull possibly because of brain damage. I should hasten to point out that it does not necessarily follow that all epileptic children are likely to be dull, but the proportion is higher than amongst ordinary children.

There are indeed nine children in Grammar Schools and with one possible exception, they are not creating any problem from the epileptic angle.

SCHOOL DENTAL SERVICE

The Principal School Dental Officer reports:—

Premises and Equipment:

The highlight of the year was the building of a new dental clinic at Bestwood. This consists of two well-equipped surgeries, recovery room and darkroom. Due to be opened in October, 1962, delays in the building programme postponed opening until after the end of the year.

Further improvements and additions to existing equipment continue to be made, though no minor improvements in existing premises were accomplished during 1962.

Staff

On 31st December, 1962, the staff consisted of:—

		<i>Full-time</i>	<i>Part-time</i>
Principal Dental Officer	..	1	—
Orthodontist .. ..	..	—	.2
Dental Officers .. ..	..	3	.6
Medical Officers .. ..	..	—	1.1
		<hr/>	<hr/>
		4	1.9
Dental Auxiliary .. ..	..	1	—
Dental Surgery Assistants	..	7	.4

I have much pleasure in welcoming both Mrs. Erika Mellakauls and Miss Margaret Roe to the full-time dental officer staff and I hope they will continue to be happy in their new appointments.

Welcome also to Miss Sharman who has come to us from the New Cross Dental Auxiliaries Training School.

There has been a marked improvement in the dental staffing position during the year and it is to be hoped that this will continue. I was particularly sorry to see Mrs. Enid Durance leave our part-time service after being with the Authority for ten years and I hope that she may find it possible to re-join our ranks at some time in the future. Welcome to Mr. D. M. Snapper who was with us full-time for a short period until he started in general dental practice. This practice now takes up most of his time. The same reason took Mr. W. Torz from us during 1962.

Policy:

With our expanding dental officer staff, we are now in a slightly better position insofar as conservation treatment is concerned and it is hoped that the effects of this will be shown in 1963. A further slight drop in the patient-inspired casual rate is noted.

Dental Inspections:

During the year 7,388 children (or 14.5% of our school population) had a routine dental inspection and 23 dental officer sessions were devoted to this work. An additional 5,371 children (or 10.5%) were seen as casual or special inspections (mainly because of pain or sepsis). A total of 12,759 children (or 25%) therefore, were inspected.

Some comparative figures for the past seven years are of interest:—

	<i>Percentage of school population who received routine dental inspection</i>	<i>No. of casual or special inspections</i>	<i>Average effective number of dental officers</i>
1956 ..	21.4	6,136	3.9
1957 ..	20.7	5,901	3.7
1958 ..	22.0	5,822	4.4
1959 ..	18.5	6,221	4.1
1960 ..	14.3	6,054	3.2
1961 ..	17.7	5,542	2.8
1962 ..	14.5	5,371	4.3

Of the 7,388 children routinely inspected during 1962, 7,040 (or 95.3%) were found to require some form of treatment and treatment was offered to 6,419. 3,124 (or 48.7%) consented to treatment.

In view of our still very low ratio of dental officers to establishment, no special measures are taken to encourage a higher acceptance rate.

Dental Treatment:

During 1962 some 2,100 dental sessions were devoted to treatment (including orthodontics) and of those sessions, 385 were reserved exclusively for extractions under general anaesthesia. 19,304 attendances were made by school children and the following treatment was carried out:—

Fillings:	Permanent teeth	9,840
	Temporary teeth	66
		<hr/> 9,906
Extractions:	Permanent teeth	5,928
	Temporary teeth	11,978
		<hr/> 17,906

A general anaesthetic was given for extractions on 7,035 occasions and a local anaesthetic on 91 occasions. In contrast, a local anaesthetic was given for fillings on 796 occasions.

Other operations:	Permanent teeth	1,239
	Temporary teeth	16
		<hr/> 1,255
Number of diagnostic X-ray films taken		906

In the prosthetic and orthodontic section, 324 sessions were devoted to this work and 2,340 attendances were registered (included in the 19,304 above). 139 new dentures were supplied to our children and 22 dentures were repaired.

Fifty-six cases (orthodontic) were completed during the year and 143 appliances (all removable) were fitted.

Some further comparative figures for the past seven years will be of interest:—

	<i>Average effective number of dental officers</i>	<i>Teeth extracted</i>	<i>Administration of general anaesthetics</i>	<i>Teeth filled</i>
1956 ..	3.9	19,499	8,783	6,126
1957 ..	3.7	14,549	7,587	5,635
1958 ..	4.4	16,341	8,917	7,997
1959 ..	4.1	25,606	8,968	7,457
1960 ..	3.2	29,127	9,694	4,615
1961 ..	2.8	23,711	8,349	3,585
1962 ..	4.3	17,906	7,035	8,862

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

During 1962, arrangements continued to be supervised by the Principal School Dental Officer. Treatment for children of pre-school age was still made available at all of the school dental clinics. 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.

Again, no dental inspections were attempted at welfare centres or nurseries owing to the shortage of dental officers. 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>
Number examined	419	344
Number needing treatment	418	326
Number treated	400	324
Number made dentally fit	351	76
Number of sessions	94	15
Number of attendances for inspection and treatment	1,307	382
Scalings and gum treatment	36	—
Number of fillings	39	—
Silver nitrate treatment only	9	—
Number of crowns and inlays	—	—
Number of teeth extracted under general anaesthetic	2,200	866
Number of teeth extracted under local anaesthetic	364	—
Number of general anaesthetics	488	355
Dentures provided:		
full upper or lower	171	—
partial upper or lower	66	—
Radiographs	12	—
Other operations	445	7
		(Temp. teeth)

Dental care for the mentally sub-normal

A dental inspection of the children on the register and some on the waiting list of the City Occupation Centre was carried out during the year. 102 children were inspected and 64 were found to require dental treatment. Only 2 so far have been treated, these being emergency extractions.

We have to express our gratitude to Head Teachers and teaching staffs, the staffs of the Education and Health Departments and to the Hospital service, for their invaluable co-operation and support. The continued interest and encouragement of the Chairman and members of the Committee, with their desire that the service should continue to improve its premises and equipment and attract much needed dental officer re-inforcement, is a constant inspiration to all members of this still very small dental service staff.

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

Principal School Dental Officer.

CHILD GUIDANCE :

Staffing arrangements have continued as in recent years. Dr. Arkle, the Child Psychiatrist seconded to us by the Sheffield Regional Hospital Board, continues to give us four sessions weekly and as she is in charge of the Children's Unit (Harper Villa) in St. Ann's Hospital, Nottingham—this unit is now recognised as a hospital special school—we have very close liaison with the hospital and this personal contact is an advantage to the clinic and, I hope, the hospital.

Dr. Rogers has continued with us as Senior Registrar and we have had help from other members of the medical staff of this hospital both for treatment, review and observation sessions. As I write I learn that Dr. Rogers has been appointed Consultant Child Psychiatrist at Blackpool, Preston and Lancaster. He will leave us in May, 1963.

We are hoping to make an arrangement with the Nottingham Hospital Management Committee No. 3 to share with them the services of a child psychotherapist.

Examinations :

Psychiatrists	..	..	..	..	..	177
Physician	..	..	..	..	..	164
Educational Psychologists	..	..	..	..	..	896
Social Workers	..	..	..	..	..	160

Re-examinations :

Psychiatrists (excluding treatment interviews)						147
Physician	..	..	..	..	..	16
Education Psychologists	..	..	..	..	..	13
Social Workers	..	..	..	..	..	108

Attendances and Visits :

Attendances for treatment	6,330
Interviews with parents	..	..	..	1,209
Interviews with others	..	..	..	125
Home visits	..	..	..	147
School visits	..	..	..	570
Hostel visits	..	..	..	80

Cases treated :

By Psychiatrists	..	..	..	111
By Educational Psychologists	..	..	..	46
By Educational Therapist	..	..	..	312
By Psychiatric Social Worker	..	..	..	17
In Boarding Homes	..	..	..	22

During 1962, there were 398 new cases seen at the Centre. Of these, 213 attended for child guidance, 41 had tests by the educational psychologist in connection with the Annual Selection Procedure and 144 received educational therapy.

I quote the following successful example to illustrate the type of work performed in our Child Guidance Centre.

A twelve year old boy was referred by his mother as he was creating difficulties in the home, mainly because of his temper outbursts. We found him to be a boy of superior intelligence who was suffering from mood changes of a manic-depressive type. This was complicated by the fact that he was in the early stages of adolescence. There was also strong rivalry with his older sister and relationships were difficult in the home.

The boy attended regularly for treatment for three months, he settled down quite well and a satisfactory adjustment was achieved. His mother attended, too, at the same time for help from the Social Worker. When last seen the mother reported that her son was well and happy. He only needs to be seen occasionally now.

As I write, a group of Nottingham Infant Head Teachers were invited to the Child Guidance Centre on 21st January to see examples of clinical work. Mock case conferences were held and in addition, the Speech Therapists played recordings of typical speech disorders—general discussion followed. The Head Teachers showed great interest and were delighted to have the opportunity of seeing the Centre “at work.”

I have always felt that we did not know enough of the social background of many of our children, especially our handicapped ones including the educationally sub-normal. The opportunities which school medical officers have to explore this side of youngsters' lives is very limited and it is not easy for a parent to relax sufficiently in the time available when dealing with a professional individual to give a complete and relaxed picture of their home situation, their fears and their hopes. And so our Social Worker in the Child Guidance Centre, who prior to coming to us had known many of the homes of our educationally sub-normal pupils, has been visiting their homes again and bringing back a history not only useful to us as medical officers but also to teachers to whom a knowledge of a home background can be helpful and interesting. I am sure that it is always valuable to teachers to know whether or not a youngster gets any stimulation, encouragement and help from his home and parents.

Educational Therapy :

Special help to backward children has continued to be given this year, mainly in Junior Schools and at the Child Guidance Centre for special cases recommended by the Child Guidance team.

The following notes about the work done during the first four weeks of the Midsummer holidays have been taken from a report given to me by Miss Beeson, the Remedial Teacher—

“Following the success of the venture in 1961, reading groups again continued to meet at the Child Guidance Centre and at Clifton Clinic during the first four weeks of the summer holidays.

Fourteen sessions were arranged and 43 children accepted the appointments offered. Of these, only 2 failed to co-operate as promised and 2 other were unavoidably prevented from attending. 39 children were seen regularly and a total of 140 attendances were made.

Among those who gained particular benefit from the extra tuition this year were six children due for transfer to Secondary Modern Schools in September. Their progress was such that attendance at the groups will no longer be necessary. Altogether, 12 vacancies were created in readiness for the new term.

In view of the fact that the scheme has been successfully operated for the second successive year, one wonders whether it could not profitably be included as a permanent feature of the Remedial Teaching programme. It is possible, of course, that other suitable teachers might have to be introduced in helping with this remedial work during the holiday. Though there are obvious drawbacks in breaking the continuity of work by introducing the children to newcomers for these short periods, it should be possible to reduce such disadvantages to a minimum.”

HOSTELS FOR MALADJUSTED CHILDREN :

Children in hostels :

Hostels of this Authority :

	<i>Orston House</i>		<i>The Gables</i>	
	<i>City</i>	<i>Notts. C.C.</i>	<i>City</i>	<i>Notts. C.C.</i>
	<i>cases</i>	<i>cases</i>	<i>cases</i>	<i>cases</i>
At beginning of 1962 in residence ..	5	3	4	2
Admitted during year	4	—	7	1
Discharged during year	3	2	4	2
At end of year in residence.. ..	6	1	7	1

City children in Hostels of other Authorities :

	<i>The Grove</i> <i>(Notts. C.C.)</i>		
At beginning of 1962 in residence	2
Admitted during year	—
Discharged during year	1
At end of year in residence..	1

I have already made brief comments about our hostels on page 16.

I add here a note about some of the difficulties experienced, chief of which has been the problem of how to allow the new Warden and Matron of the "Gables" to have sufficient "off duty" time. The assistant matron left in November and up to the time of writing, we have been unable to obtain a replacement. This has, of course, placed a heavy burden on the remaining staff.

SPEECH THERAPY

The following is a summary of the work carried out in 1962 :—

Number of:

Cases treated	..	..	..	..	294
Cases under supervision	..	..	..	..	892
Cases discharged	..	..	..	..	511*
School visits	..	..	..	..	57
Cases awaiting treatment at end of year	..	..	..	..	194

*Analysis of 511 cases discharged :

Maximum benefit	..	..	..	..	303
Improved	..	..	..	..	106
No co-operation	..	..	..	..	19
Removed from waiting list	..	..	..	..	28
Left school or district	..	..	..	..	51
Referred to Child Guidance	..	..	..	..	1
Treated elsewhere	..	..	..	..	3

Commenting on these figures:—

1. The number of children treated was rather smaller than last year, owing to the Speech Therapy section working below strength for the whole year. One member of the staff left the district at the end of January and another member resigned on marriage at the end of June. We were fortunate in obtaining the services of Miss Mynall in September, but it has not been possible to fill the other vacancy.
2. The number of children under observation has remained substantially the same, but the number discharged is higher this year—50 more than last year having obtained maximum benefit and some 90 more than last year have improved sufficiently for them to be discharged from further attendance.
3. The majority of the 28 children removed from the waiting list had, it was found on first interview, improved as to make speech therapy unnecessary.

I was pleased that Miss Grady was able to make time to accept visitors from training colleges:—

4 students from Leicester School of Speech Therapy.

2 students from Nottingham Teachers' Training College.

1 student from the Institute of Education Diploma Course.

5 prospective students of Speech Therapy.

I am certain that the acceptance of students is an essential part of any speech therapy department.

Miss Grady has let me have the following report:—

"There is a wide range of disorders of speech and language. Included in this range are speech difficulties owing to cleft palate, to dental irregularities, to mental defect or retarded mental development, as well as speech difficulty secondary to brain damage. In addition to the more obvious speech defects, there are minor defects of articulation such as lisps, which are not hard to note. There are also some children who are just slow in learning to talk. Unfortunately, not all children with speech difficulties are able to benefit from speech therapy but the majority who are referred for treatment are helped to achieve either near-normal, or normal, speech.

Speech therapists make allowances for both dialectal and individual preferences of pronunciation of words but it is not always easy to decide what degree of variation of articulation can be allowed from the accepted norm. Each child must then be considered as an individual against his socio-educational background and with older children it may be necessary to take into account their choice of career. Speech therapists know that what may be thought an attractive lisp in a child of five, loses all its charm in a public speaker, a teacher, or in anyone who has to address groups of people. The defect can render a speaker subject to ridicule and this can often be the case with not-so-bright children and every effort is made to help them overcome their defect. There is, however, a general tendency for minor defects to be dismissed as unimportant or as too insignificant to merit correction. Recently a girl who could not say the consonant 's' was refused admission to a Teachers' Training College until she had made an attempt to correct it. When mild defects impede communication, then treatment must be considered. What may be thought in later life to be an idiosyncrasy in manner of speech may stem from earlier and unresolved disorders of speech and language.

A highly intelligent youth presented himself at the speech clinic recently with the demand for more treatment. His original defect was the result of poorly co-ordinated movements of his tongue and lips and although he had made excellent progress in the Junior School, his speech would probably never allow him to speak easily in public. He had even applied for admission to a Teachers' Training College, but was subsequently rejected and was then faced with finding another career. There are some who will not "grow out of it," however hard they try and however much they are helped. There are others who may require a lot of encouragement to develop and retain what speech therapy has helped them to acquire.

Just recently a twelve year old child who had received residential treatment for her speech defect was followed up to see how she was progressing in school. Her speech was clearly, if somewhat carefully, articulated but she was very shy about talking, blushed when spoken to, found it very difficult to describe events in her own words and whenever possible avoided making a verbal response in class. There are several such children in whom speech therapy has achieved its aim, but who would be certain to benefit from oral English work in school to help them fix their hard-won ability to speak clearly so that they become fluent, unself-conscious, pleasant-toned talkers."

EAR, NOSE AND THROAT DEPARTMENT

Arrangements for the Tonsil and Adenoid Ward in the Central School Clinic have continued as in previous years. It has been necessary on occasion to send children to one of the hospitals if bleeding after operation has been excessive or prolonged and I include some figures of the numbers involved.

I should like to add my appreciation of the extra duties undertaken by Miss Pinder during the unfortunate illness of Mrs. Barnfather, the senior part-time Ward nurse. By remaining in the building for over 30 hours at a time she allowed us—

(a) to keep the ward running,
and (b) to continue to employ our part-time staff who otherwise would have been "stood off."

Thus our waiting list has been kept within reasonable proportions and we cannot be too grateful to Miss Pinder for the unselfish way in which she kept things running smoothly—acting as an unpaid stand-in.

Number of Operations for Tonsils and Adenoids . .	584
Number of Operations for Tonsils only	105
Number of Operations for Adenoids only	93

There were 29 cases which required care after operation to control bleeding. Of those, it was necessary to send 7 to the Nottingham General Hospital for further treatment, and 2 more had other complications requiring further hospital care. There were no really serious troubles but those mentioned did create some concern to the Consultant and to our staff.

The figures for the number of tonsils which need operation continue to fall but with 149 names from the conurbation being added to our list during 1962, it remains much as before, namely 336 at the end of the year.

We find that most of our candidates for tonsillectomy come from children in the Infant Departments of our schools and as we see these at medical inspections in the summer, our waiting list tends to ebb and flow as a result.

EXAMINATION OF REMOVED TONSILS FOR HAEMOLYTIC STREPTOCOCCAE

We have sent to Dr. Mitchell at the Public Health Laboratory for some time now removed tonsils for a straight check on whether they were infected with haemolytic streptococcae. I had hoped to demonstrate an association between the numbers found to be positive and the occurrence of such conditions as rheumatic fever, carditis, etc. This, however, has proved difficult as our local hospitals draw their cases from a much larger area than is the catchment area for tonsil operations here so that one gets an apparently exaggerated picture from our hospitals.

Haemolytic Streptococcal Check on Tonsils

1961

	<i>Positive</i>		<i>Negative</i>		<i>Total</i>
	<i>Number</i>	<i>Proportion of total</i>	<i>Number</i>	<i>Proportion of total</i>	
January ..	6	13%	39	87%	45
February ..	9	32%	19	68%	28
March ..	4	25%	12	75%	16
April ..	23	37%	39	63%	62
May ..	8	16%	42	84%	50
June ..	9	21%	32	78%	41
July ..	No operations		No operations		—
August ..	No operations		No operations		—
September ..	18	21%	64	79%	82
October ..	9	18%	40	82%	49
November ..	2	17%	10	83%	12
December ..	No operations		No operations		—
Totals ..	88	22.9%	297	77.1%	385 (100%)

1962

	<i>Positive</i>		<i>Negative</i>		<i>Total</i>
	<i>Number</i>	<i>Proportion of total</i>	<i>Number</i>	<i>Proportion of total</i>	
January ..	Nil	—	12	100%	12
February ..	12	25%	36	75%	48
March ..	7	16%	37	84%	44
April ..	4	9%	40	91%	44
May ..	15	29%	36	71%	51
June ..	10	28%	26	72%	36
July ..	22	34%	43	66%	65
August ..	No operations		No operations		—
September ..	49	53%	43	47%	92
October ..	47	51%	45	49%	92
November ..	41	44%	51	56%	92
December ..	19	40%	28	60%	47
Totals ..	226	36.3%	397	63.7%	623 (100%)

There is a much higher percentage of positives for the latter part of 1962. What is the significance? Does it point to a likely increase in haemolytic streptococcal infections? Only a longterm check can reflect any trend, but there seems little doubt that there is a higher proportion of infected tonsils in the summer months than at other times of the year. This may be an explanation for the usually increased severity of the summer colds from which many individuals suffer.

Audiometry :

Mr. Ward, the Audiometrician, attended for 31 sessions during the year. He tested 290 selected children who made 321 attendances.

ORTHOPAEDIC TREATMENT**Examinations by orthopaedic surgeons :**

At the Central School Clinic	202
Number of new cases	86

Children treated as out-patients :

At Nottingham Orthopaedic Clinic	118
At Nottingham Children's Hospital	311

Children treated as in-patients:

At Harlow Wood Orthopaedic Hospital	74
At Nottingham Children's Hospital	242

We are grateful to Mr. Waugh for his continued interest in our children.

Details of the interim report of Mr. Waugh's survey on "spinal and other movements" is given on pages 42 and 43.

ELECTRICAL AND OTHER TREATMENT**Ultra-Violet Ray :**

Number of children treated	24
Number of attendances	246

This has continued mostly at the request of general practitioners and I often think some of the most grateful parents are those who have brought their children for this form of treatment, but there is little doubt that it is now out-moded and dependent for effect on its psychological stimulation except for youngsters suffering from psoriasis who react well to ultra-violet treatment.

Ionisation :

Number of children treated	101
Number of attendances	869

We have continued to use this form of treatment for warts and on the whole we have met with considerable success. Other forms of wart treatment are often painful and not always successful.

Proetz :

Number of children treated	104
Number of attendances	958

This treatment is found useful in all cases of sinus involvement and catarrhal noses which children cannot clear for themselves. Ability to blow the nose seems to have some relationship to intelligence but just what is difficult to say. It is also observed that deaf children find great difficulty in learning to blow the nose effectively.

OPHTHALMIC SERVICE

The arrangements for the ophthalmic service continued unchanged.

	1957	1958	1959	1960	1961	1962
No. of pupils on rolls on 31st December	52,115	52,242	52,089	51,691	51,694	50,846
Pupils refracted	4,937	4,773	4,786	4,562	4,536	4,477
Percentage	9.5	9.1	9.2	8.8	8.8	8.8
Spectacles prescribed (pupils)	1,528	1,660	1,603	1,607	1,504	1,525
Percentage	2.9	3.2	3.1	3.1	2.9	3.0

The school nurses held sessions twice a week, at the Central and the Clifton School Clinics, when the repair and replacement of spectacles were dealt with. In all 200 sessions were held.

The absentee rate for ophthalmic examinations remains the highest of any of our services. I wonder why parents will not spare an hour once or twice a year for this most important service for their offspring?

Orthoptic Treatment at the Nottingham Eye Hospital :

	1957	1958	1959	1960	1961	1962
New cases treated	40	58	130	38	72	75
Total treated	125	159	291	164	165	153
Awaiting test or treatment at end of year	11	52	12	11	5	6

Operations for Squint at the Nottingham Eye Hospital :

	1957	1958	1959	1960	1961	1962
Number of operations ..	123	40	69	52	41	38
On waiting list at end of year	10	39	39	33	22	18

COLOUR VISION

<i>Leaver Group</i>	<i>Children with defective colour vision</i>		
	<i>Boys</i>	<i>Girls</i>	<i>Total</i>
Secondary Modern Schools ..	106	6	112
Grammar Schools	14	1	15

Normally we check colour vision at the age of eleven so that children and parents know of the defect before they start to consider their youngsters' life's work. When I think of colour vision, I am always reminded of an incident some years ago when a friend asked my advice about his boy's employment. I knew this boy to be a quick, intelligent lad with some little ability in drawing and I suggested he might go into the printing trade. This he duly did and for some reason or other his usual medical examination was overlooked until he had been at work for some time and then I was asked to see him. He was physically very fit but much to my chagrin he was completely colour blind. You can imagine that the interview I had later with his parent was not a very happy one and served only to remind me that in future all children would have their colour vision checked before the question of future employment was under discussion, and certainly before any decision could be final.

PAEDIATRIC CONSULTATIVE CLINIC

Dr. Page has continued to hold a weekly Paediatric Out-Patient clinic here during 1962, and we are very grateful to him for his interest and advice.

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	57	88
Undescended testicles ..	38	69
Obesity, development, etc. ..	65	115

SCHOOL NURSES

The following is a summary of the work of the school nurses during 1962:—

Visits to schools for routine medical inspection	1,956
“ “ “ uncleanliness	310
“ “ “ investigation of infectious disease	2
“ “ “ other purposes	1,675
Visits to homes for uncleanliness	926
“ “ “ deafness and other ear conditions	63
“ “ “ absentees from ophthalmic clinic	552
“ “ “ absentees from T. and A. clinic	108
“ “ “ follow-up after T. and A. operation	91
“ “ “ miscellaneous reasons	1,594
Clinic sessions	5,346

CLEANLINESS OF UNDERCLOTHES

As a School Health Department, I feel we should take an interest in hygiene from all angles and surely the personal one is that which affects all of us most closely. And so, when our “Leaver” groups were being examined, I thought a survey of underclothes would give us some interesting facts. The impression I had was that probably a little more than half our leaver boys wore underpants and the following figures go to show how wrong one’s impressions can be. I was pleasantly surprised to find that underpants are almost universally worn, that their cleanliness rarely calls for any adverse comment, and was amused at some of the reasons given for their not being worn. The figures surely provide one reason for the prosperity of the hosiery trade, not only in Nottingham, but in the country generally.

Cleanliness of underclothes in boys :

Number of boys inspected for individual hygiene	1,282
Number of boys wearing underpants ..	1,232 or 96·1%
Number of boys not wearing underpants	50 or 3·9%

<i>Condition of underpants</i>	<i>Number</i>	<i>Percentage of boys wearing underpants</i>
Outwardly clean	1,209	98·13
“ indifferent	18	1·46
“ dirty	5	0·14
Inwardly clean	1,225	99·43
“ slightly soiled	6	0·49
“ badly soiled	1	0·08
Smell	Nil	—

Condition of trousers (boys not wearing underpants) :

The trousers of all 50 boys were clean with no smell.

Reason for not wearing underpants :

Expense	4
Too warm	21
Too cissy	12
No room under jeans	8
Being washed	1
Don't know	4

Cleanliness of underclothes in girls :

Number of girls inspected for individual hygiene 1,199

Underpants :

<i>Material</i>	<i>Number</i>	<i>Percentage</i>
Cotton	1,129	94.16
Wool	4	0.33
Nylon	41	3.42
(2 prs.) Cotton/Nylon	25	2.09

Condition :

Outwardly clean	1,192	99.41
„ indifferent	7	0.59
Inwardly clean	1,178	98.24
„ slightly soiled (faeces)	7	0.59
„ soiled (mens.)	14	1.17
Smell—Nil	1,189	99.15
„ Urine	10	0.85

It is interesting to note that most boys seem to realise that the wearing of pants is a cleanliness measure and that even in the cases of those who were without, cleanliness was not unsatisfactory.

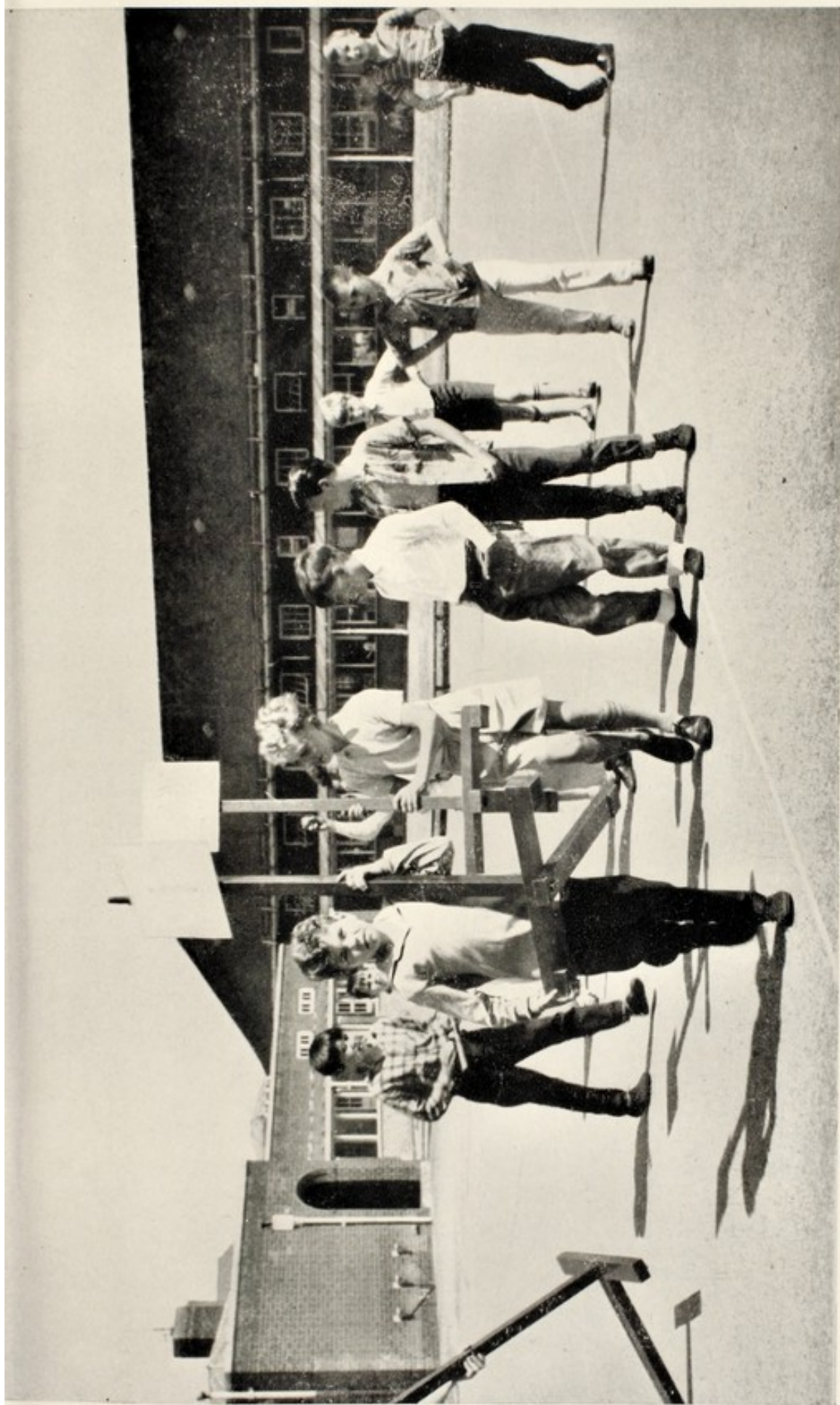
It is also noted that two per cent of the girls feel it necessary to protect their nylon underclothes from being soiled by wearing cotton panties underneath, or is it that they do not like the feel of nylon next to their skin?

I cannot help but feel that these figures speak well for the present day standard of cleanliness in both boys and girls, and also I think it calls for a word of congratulation to parents on their attitude to personal hygiene and to teachers who spread the gospel, not only by teaching but by example and insistence on a reasonable standard of cleanliness in the classroom.

One may argue that youngsters seen at medical inspections have been especially “got up” for the occasion but the mere fact that this is so is surely evidence of pride in their appearance and cleanliness and something well worth encouraging.

While on the subject of clothing, one cannot help but mention (a) the number of boys in junior school wearing long trousers or jeans (see photograph opposite), a far cry from the pre-1939 days when shorts were worn until a boy of fourteen left school. Is this the result of watching television “Westerns” or merely a good excuse for not having to wash knees so often; and (b) the flamboyant and almost bizarre wear of some of our older pupils especially, I note, those from Secondary Modern Schools. I presume the Secondary Grammar pupils are more under the thumb of their parents so that this attempt at self expression, if such it can be called, is less evident amongst them. Most of the clothing referred to is worn after school or at the week-ends. It would, I feel, not be a very helpful influence in maintaining discipline otherwise.

I wonder whether this indicates some kind of feminisation of our males. The fancy kind of footwear also points in a similar direction. The unusual and, I believe, expensive hair styles are further evidence of a shift in this direction. I am told by the owner of riding stables that horse riding now seems too dangerous for boys as he rarely has a male customer. These observations make one reflect whether our youths are losing their manhood.



"YOUNG MEN OF TODAY" IN A JUNIOR SCHOOL

There is one item of decoration, however, where I feel the boys have it all their own way. This is the fairly recently introduced craze to school boys, tattooing. I have seen in the last few months some very extensive examples of the tattooer's art, which I am sure, apart from anything else, must have been quite costly but also, after the newness had worn off, *not* something to be proud of.

Discussing this with a Head Teacher, I pointed out that the boys involved are usually those who are delinquency-prone, and that these identity marks might be very useful on some future occasion. I am not sure that inflicting these permanent markings on school boys is not a technical assault.

SEX DISTRIBUTION

The gradual increase in the birth rate is apparently continuing, according to both national and local statistics. There seems each year in Nottingham to be approximately 120 to 150 more boys born than girls, and it is interesting to note that in Primary Schools there are approximately 400 and in the Secondary and Special Schools some 750 more boys than girls. The total, according to the Form 7 returns, shows almost 1,200 more boys than girls in our school population; the figure for boys being higher than expected because of the proportional increased number of boys who remain at Secondary Grammar and Modern Schools after the age of 15—figures often seized upon by the feminists to prove that girls do not get the same opportunities as boys for further education.

I observed last year that certain areas housing families belonging to the Registrar General's Classes 1 and 2 tended to have more girls than boys. Much the same distribution is noticeable again this year. If the conclusion one can draw from these figures is that good living begets girls, then things must be good on our Clifton Estate as almost without exception all Infant departments there have more girls than boys—a state of affairs which speaks well for this smokeless suburb. I do not mean to suggest that smokeless conditions have any influence on the sex ratio but it might give us some interesting fireside reflexions.

A further point of interest in this sex ratio concerns Roman Catholic Schools, the majority of which have more girls than boys on their rolls. In fact, there is a 4% excess of females in these schools. Is there a religious reason for this or is it a physical one?

GIRLS ABOVE AVERAGE HEIGHT

Noticing some remarks recently in the medical press which suggested that girls of above average height might be affected:—

(a) physically because of their need to stoop to listen to what their colleagues had to say to them, or to stoop to hide their height which was creating an embarrassment, or

(b) emotionally because of their obtrusiveness

—I arranged for our nurses to find out in the schools, first how many girls were 5 ft. 7 ins. and over in height and secondly, whether in their teachers' estimation this was creating any emotional disturbance.

Below are the results :—

There were 18 schools included in the Survey with a total girl population of 5,790. A total of 111 girls were found to be 5 ft. 7 ins. or over in height, this being 1.9% of the girl population in the sample.

4 girls being 5.33% of the sample population's 1946 age group							
36	"	"	7.0%	"	"	"	1947 " "
33	"	"	2.24%	"	"	"	1948 " "
31	"	"	2.0%	"	"	"	1949 " "
7	"	"	0.5%	"	"	"	1950 " "
<hr/>							
Total 111 " being 1.9% of the sample population							
<hr/>							

There was only one girl whose height was creating some emotional imbalance.

These figures are interesting in that they show what a large number of tall girls we have in our Secondary Modern Schools (the figures do not include those in Grammar Schools), and while we have not gone accurately into the actual heights of these youngsters, it is noted that some are as tall as 5 ft. 10½ ins. The size of shoes required will also be appropriate to their height so that the days when five was the popular size have now gone and demands must be for sizes 7 and 8 for our tall Amazons. I believe there is no popular demand for women's size 9 as yet and this size is not made on a mass production scale. One parent I know of has to buy them in London.

CARDIAC REGISTER

Details of our cardiac register as at 31st December, 1962, are as follows:—

1. Total number of children on the register :

Total number of children on the register 1.1.62	..	..	20
Added to the register during the year	..	..	13
Removed from the register during the year	..	..	1
Total number of children on the register 31.12.62	..	..	32

2. Diagnoses :

(a) Acyanotic heart defects :

1. Patent interventricular septal defect	..	..	..	12
2. Aortic stenosis uncomplicated	..	..	..	1
3. Mild pulmonary stenosis	..	..	..	1
4. Mild aortic stenosis+another lesion	..	..	..	1
5. Patent interventricular septal defect+pulmonary stenosis	..	..	..	1
6. Patent interventricular septal defect with mild infundibular pulmonary stenosis and small L. to R. shunt	..	..	..	1
7. Patent ductus arteriosus, successfully ligated	..	..	..	1
8. Patent ductus arteriosus, ligated, subsequently developed ductus aneurysm—this now having been successfully ligated	..	..	..	1
9. Persistent patent ductus arteriosus with congenital pulmonary stenosis	..	..	..	1
10. Unidentified acyanotic heart lesion	..	..	..	2
11. Unidentified acyanotic heart lesion with multiple congenital defects	..	..	..	1

(b) Cyanotic heart defects :

1. Tetralogy of Fallot	5
2. Tetralogy of Fallot with R. sided aortic arch	1
3. Tetralogy of Fallot+another unidentified lesion	1
4. Severe cyanotic heart lesion—persistent tunicus arteriosus	1
(c) Rheumatic carditis	1

3. No alterations have been made in diagnosis

4. Changes in condition :

1. **Girl born 14.8.54 :** Diagnosed as having a patent inter-ventricular septal defect and pulmonary stenosis. During the last year she has become increasingly tired, unable to do any physical activity without exhaustion. She is now awaiting urgent surgical treatment at Sheffield.
 2. **Boy born 26.7.53 :** Diagnosed as having Fallot's Tetralogy+R. sided aortic arch. During the last few months he has become increasingly tired and dyspnoeic. He is awaiting further investigation at Sheffield.
 3. **Girl born 29.4.54 :** Diagnosed as having Fallot's Tetralogy. During the last year she has become increasingly dyspnoeic and cyanosed. Is awaiting further investigation at Sheffield—attends special day school for delicate children but has had to spend long periods at home because of her poor condition. In August, 1962, she was thought to have a bacterial endocarditis and spent some time in hospital. This diagnosis was not proved—she improved and returned home.
 4. **Girl born 11.9.55 :** Diagnosed as having Fallot's Tetralogy. During the past few months she has become more tired and cyanosed and is awaiting further investigation at Sheffield. Attends special day school for delicate children.
 5. **Boy born 31.8.56 :** Diagnosed as having Fallot's Tetralogy, and another unidentified lesion. During last few months he has become much more tired and dyspnoeic. He has also developed a mild L. facial palsy which may be related to his heart condition. He is awaiting urgent surgical treatment at Sheffield and attends special day school for delicate children.
5. **Of the 32 children on the register, 28 attend ordinary schools and 4 attend Day Special Schools for delicate children as follows :—**
1. **Boy born 31.8.56 :** Fallot's Tetralogy and another unidentified lesion.
 2. **Girl born 29.4.54 :** Fallot's Tetralogy.
 3. **Girl born 16.3.57 :** Severe cyanotic congenital lesion—tunicus arteriosus.
 4. **Girl born 11.9.55 :** Fallot's Tetralogy—first attended an ordinary school, but became too exhausted to maintain this. She was transferred to special day school for delicate children in January, 1962.

6 No child in the age group covered has developed a rheumatic heart lesion during the last year.

7. Heart surgery :

5 children have been subjected to heart surgery—only 1, however, in the past year:—

1. **Girl born 14.9.53 :** Ligation of patent ductus arteriosus 1957, subsequently developed a ductus aneurysm. This was successfully operated on in February, 1962. She is now very well, with an apparently normal heart and no disability.
2. **Boy born 20.5.54 :** Tetralogy of Fallot—Pott's operation performed 1956 in Birmingham. A very great improvement maintained and he takes part in all activities. He is, however, awaiting further surgical attention at Birmingham.
3. **Girl born 6.7.56 :** A patent ductus arteriosus was ligated in August, 1960, with excellent results, and the ability to take part in all physical activities.

These 3 children appeared in last year's cardiac register.

Boys—twins both born 1.7.54 :

4. **Twin I—Nigel :** Fallot's Tetralogy diagnosed and a Blalock's operation performed by Mr. Holmes Sellors at Middlesex Hospital 1959 with considerable improvement in condition. He is, however, still a little cyanosed and has an exercise tolerance limited to about 300 yards. Apparently there is a remaining pulmonary stenosis and narrowing of the pulmonary artery. He is awaiting further treatment at the Middlesex Hospital.
5. **Twin II—Charles :** Fallot's Tetralogy diagnosed but he remained in better condition than his twin brother, Nigel. Had Blalock's operation performed by Mr. Holmes Sellors in 1961 with considerable improvement. He has some minimal cyanosis and some restriction of activity, but is in better condition than his twin. Attends Middlesex Hospital and may need further surgical treatment. Both twins attend ordinary schools but can manage very little physical activity.

Further comments :

Only 1 child has a history of maternal virus disease in early pregnancy:—

Girl born 31.1.57 : Persistent ductus arteriosus and congenital pulmonary stenosis. Mother had rubella at 7/52 of pregnancy.

INFECTIOUS DISEASES

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

		1956	1957	1958	1959	1960	1961	1962
Chicken Pox	..	1,257	1,617	1,412	2,560	2,662	784	2,286
Measles	..	123	2,005	1,401	1,388	2,128	1,589	855
German Measles	..	3,182	215	188	214	222	577	1,177
Mumps	..	796	2,080	266	879	3,965	318	416
Scarlet Fever	..	147	244	216	304	167	74	38
Whooping Cough	..	711	169	194	339	329	88	45

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 school children who have received 3 injections at 31st December, 1962. In addition 16,497 of these children were given their fourth dose against poliomyelitis.

<i>Year</i>	<i>No. of Children</i>	<i>Estimated Population Ages 5 to 15 years</i>	<i>Percentage</i>
1958	693	49,200	1.4
1959	32,166	49,300	65.2
1960	37,140	49,000	75.8
1961	38,028	48,400	78.6
1962	39,782	47,700	83.4

Diphtheria Immunisation :

The table shows the number of children who have been immunised against diphtheria at 31st December, 1962.

<i>Year</i>	<i>No. of Children</i>	<i>Estimated Population Ages 5 to 15 years</i>	<i>Percentage</i>
1958	42,840	49,200	87.0
1959	40,658	49,300	82.4
1960	41,398	49,000	84.5
1961	40,724	48,400	84.1
1962	38,855	47,700	81.4

B.C.G. Vaccination :

	1957	1958	1959	1960	1961	1962
Maintained Schools visited ..	47	44	50	43	45	47
No. of 13 year olds	5,284	4,165	5,197	6,149	4,938	4,768
No. of acceptances	3,925	2,791	3,455	4,235	3,606	3,631
No. of refusals	1,243	1,294	1,595	1,804	1,224	1,032
No. of others	114	80	147	110	108	105
No. tested	3,912	2,592	3,265	3,957	3,394	3,396
Negative reactors vaccinated ..	3,154	2,155	2,814	3,388	3,050	2,863
Positive reactors	658	371	372	498	285	454

CONVALESCENT HOME TREATMENT

During the year, 26 children were sent to the following convalescent homes, compared with 66 in 1961 :—

Charnwood Forest Convalescent Home, Woodhouse	
Eaves	13 children
Roecliffe Manor Convalescent Home, Woodhouse	
Eaves	12 children
Arclid Hall Camp	1 child

UNDESCENDED TESTICLES SURVEY

It may be remembered that we have been taking an active interest for some years past in undescended testicles. Figures have come in from all of our School Medical Officers but Dr. Ward has very kindly collated and analysed the following results. It will be noted that no case has had any treatment for this condition during the year so that it is necessary to add to the total those seen by Dr. Page—they number 38. Treatment usually consists of hormones either by mouth or injection or both.

<i>Age of Boys</i>	<i>No. of Boys examined</i>	<i>Unilateral undescended testicles</i>		<i>Bilateral undescended testicles</i>	<i>Total</i>	
		<i>Right</i>	<i>Left</i>		<i>No. of cases</i>	<i>Percentage of age group</i>
Up to 5 years	404	—	1	1	2	0.49
5 years ..	733	2	4	7	13	1.77
6 years ..	994	4	2	10	16	1.61
7 years ..	187	2	1	2	5	2.67
8 years ..	1,145	2	5	4	11	0.96
9 years ..	636	4	2	8	14	2.20
10 years ..	959	13	7	5	25	2.60
11 years ..	1,586	6	9	16	31	1.95
12 years ..	674	5	3	2	10	1.48
13 years ..	274	2	2	—	4	1.46
14 years + ..	2,417	2	1	—	3	0.12
Totals ..	10,009	42	37	55	134	1.22

Dr. Ward's comments are:—

1. A slightly higher incidence of this defect has been found during the year—1.22% (1.06% in the years 1959—1961).
2. The right testicle was more frequently undescended than the left.
3. The peak continues to occur at 9 to 10 years with a high incidence also at 7 years. By 14 to 15 years the incidence has fallen to a very low level.

These findings would seem to support the theory that the testicle frequently descends naturally in the years immediately preceding puberty. None of the boys included in this survey had had any treatment for the condition.

HERNIA SURVEY

Hernias of the inguinal type are not uncommon and can only be cured by operation. We have been collecting the figures for those found at ordinary medical inspection. Dr. Ward has very kindly analysed these for me, and they are given below.

From impressions gained during my army service, I feel that these figures can be misleading as it will be seen that no children leave school with an actual hernia present and yet hernias were one of the common causes of invalidism out of the army. It may be that, between the ages of 15 to 25, the physical strain of heavy manual employment brings to light an inherent weakness so that figures then go up in this decade. I cannot see any way in which this weakness can be predicted.

One is often inclined to think of inguinal hernia as being the prerogative of the male sex but there are still a few girls who have this condition although the ratio is as low as 7 to 1.

Girls :

Number having had successful operation..	..	5
Number already awaiting operation	.. ..	3
Number under observation..	.. ..	1
Number unaware of the condition	.. ..	—
		—
Total	..	9
		—

Boys :

Number having had one successful operation	..	30
Number awaiting operation	.. ..	6
Number having had an unsuccessful operation	..	1
Number who had had more than one operation before being successful	.. ..	1
Number of cases already under observation by General Practitioner	.. ..	3
Number of cases where treatment was refused	..	—
Number unaware of defect and referred for treat- ment	.. ..	18
		—
Total	..	59
		—

HERNIA SURVEY 1962

Age Group	Total No. of Pupils Inspected	Cases of Hernia—Boys						Cases of Hernia—Girls					
		No of Boys Inspected	Right	Left	Both	Total	Percentage of Boys Inspected	No. of Girls Inspected	Right	Left	Both	Total	Percentage of Girls Inspected
Up to 5 years	807	404	2	2	—	4	0.99	403	—	—	—	—	—
5 years	1,465	733	3	2	2	7	0.95	732	1	1	—	2	0.27
6 years	1,988	994	7	8	1	16	1.61	994	—	—	—	—	—
7 years	373	187	1	1	—	2	1.07	186	—	—	1	1	0.54
8 years	2,290	1,145	1	3	1	5	0.44	1,145	2	1	—	3	0.26
9 years	1,272	636	3	3	1	7	1.16	636	—	1	—	1	0.16
10 years	1,917	959	3	—	1	4	0.42	958	—	—	—	—	—
11 years	3,171	1,586	4	5	—	9	0.57	1,585	1	—	—	1	0.06
12 years	1,347	674	1	2	1	4	0.59	673	—	—	1	1	0.15
13 years	548	274	1	—	—	1	0.36	274	—	—	—	—	—
14 years and over	4,833	2,417	—	—	—	—	—	2,416	—	—	—	—	—
Totals	20,011	10,009	26	26	7	59	0.59	10,002	4	3	2	9	0.09

Number of cases of hernia complicated with hydrocele or undescended testicle	3
(2 successfully operated on; 1 awaiting operation)	

ENURESIS CLINIC

We have continued to use the pad and bell apparatus for our bed-wetters. There is no other form of treatment which can give such consistently effective results. The apparatus can act as a good guide to the emotional set-up in the home. Most homes accept the help this can give with alacrity and co-operate completely.

Unsatisfactory co-operation is a common cause of failure to get good results. Occasionally the parent and child are afraid of the apparatus and will avoid using it, or use it in an unskilful and unsatisfactory way, so that electrical contacts are incomplete and the bell does not ring. Another reason for failure may be that a child sleeps so heavily that he is not awakened by the bell. I might add that the bells usually ring loudly enough to awaken the whole household and occasionally next door neighbours (so we are told). It is often necessary to put them on to Dexedrine last thing at night when a child sleeps so very soundly.

There is no need for the restriction of fluids between tea and bedtime. In fact, I am not sure that it is not an advantage for a child to be allowed to drink as much as he likes, as it seems to bring the child more readily to the voluntary realisation that his bladder needs emptying. It is impressed on parents that the child should be awakened, got out of bed and made to switch off the bell and empty his bladder. They should not undertake any of the former for him. I think this is important in order to recondition the reflex which has been allowed to become submerged.

The total number treated during the year was 73, 53 of whom were boys and the remainder girls. It is regretted that one or two children could not be treated as the parents could not arrange for them to sleep alone.

Since we commenced this form of treatment in late 1959, over 350 youngsters have used the apparatus. A small number have had second periods of treatment. Amongst failures are those whose mums are unwilling to let their children grow up, i.e. the over-possessive parent who would do everything for her child.

The waiting list is still relatively high but the supply of apparatus is now adequate so that most children can be dealt with in the course of three months.

URINE TESTING IN SCHOOLS

I have always felt that our medical inspection work as done in schools was incomplete as we never were able to test urines and so when Dr. Macfie asked me if it would be possible to arrange to check urines in school for sugar and offered to help economically by arranging a supply of a large number of Clinistix, I felt it would be worthwhile to overcome any practical difficulties and arrange this test, at any rate, in the Leaver Groups. It seemed sensible to check urines for albumen at the same time.

The figures below are illuminating. They show that any fears we may have that we are missing important conditions cannot be sustained.

Number Inspected		Stix Re-action	Stix Re-action	Full Re-action	
		Albumen	Glucose	Albumen	Glucose
Boys	5,295	38 (0.72%)	21 (0.40%)	2* (0.04%)	1* (0.02%)
Girls	4,772	41 (0.86%)	3 (0.06%)	3 (0.06%)	— —
Total	10,067	79 (0.78%)	24 (0.24%)	5* (0.05%)	1* (0.01%)

* Includes one boy who re-acted to both Albumen and Glucose.

SPINAL AND OTHER MOVEMENTS

Toe-Touching Survey 1960-61 :

As I mentioned earlier in this report, Mr. Waugh's interim conclusions would be quoted as well as our own results.

Mr. Waugh has very kindly let me have the following interim conclusions:—

1. The total number of cases (507) was adequate to obtain significance in general correlations at 1% level or better.
2. Taking a scale above and below the floor level the statistical average "touching point" corrected from available data is 1.23 inches *above* floor level. This is accounted for by the fact that although there are more touchers than non-touchers the average distance by which the non-touchers fall short is much greater than the overplus of the touchers.
3. Of all children examined:—
Can touch toes 61%
Cannot touch toes 39%
4. No. of girls who can touch toes—171 is 57% of all touchers.
No. of girls who cannot touch toes—72 is 36% of all non-touchers.
Thus the girls are significantly better as toe-touchers than boys.
5. The standard deviations of all the arrays of factors are greater for the *non*-touchers than for the toe-touchers who are more homogeneous.
6. There is a small positive correlation between weight and ability to touch toes.
i.e. The touchers are statistically slightly heavier than the non-touchers. This is so in the case of *both* boys and girls.
7. There is no correlation between height, waist and toe touching ability.
8. There is no correlation between span and toe-touching. (Several boys with 60" span miss the floor by 6").
9. There is a significant positive correlation of .2 between cervical 7 to lumbar 5 and ability to touch toes.

10. There is no correlation between length of arms and ability to touch toes.
11. There is a significant **negative** correlation of $\cdot 25$ between length of leg and ability to touch toes.
12. **Spinal Flex** : Slight, but significant (less than $\cdot 1$) correlation between this and ability to touch toes.
13. **Spinal Ext.** : Significant correlation $\cdot 18$ between this and ability to touch toes.
14. **Hamstrings**

This is the most highly significant of all the factors. Note that as the angles are given in the tables the correlation $\cdot 65$ is a negative one, that is, the smaller the angle here the better the ability (statistically) to touch toes.

15. There is a little positive correlation between Hyperextension 1st Metacarpus joint and ability to touch toes (about $\cdot 15$).
16. In conclusion the two important factors conducive to toe touching are:—
 1. Low values of Hamstring angles.
 2. Short legs.

Dr. More has given me the following report:—

Dr. Sprenger became interested in spinal movements in 1958 and asked Dr. Ward and myself to examine a considerable number of children, then aged 7 to 9 years, and to measure their ability to toe touch from both a standing and a sitting position. The intention was to measure this yearly throughout the rest of their school life and note any changes. Unfortunately, due to illness of medical officers and pressure of ordinary programme commitments, there was a lapse of two years.

This year we completed a follow-up of 1,202 of those originally in the survey. A number of other children originally seen have been lost through movement out of the City.

The results are as follows:—

	<i>Boys</i>		<i>Girls</i>	
	<i>No.</i>	<i>Percentage of number seen</i>	<i>No.</i>	<i>Percentage of number seen</i>
1. Total seen	613	100	589	100
2. Able to toe touch	477	77·8	497	84·4
3. Unable to toe touch ..	136	22·2	92	15·6
4. Unchanged:—				
(a) able to toe touch last examination	436	71·1	475	80·6
(b) unable to toe touch last examination	74	12·1	35	5·9
5. Changed:—				
(a) able to toe touch last examination, now unable	65	10·6	56	9·5
(b) unable to toe touch last examination, now able ..	38	6·2	23	3·9

SURVEY OF OVERWEIGHT CHILDREN

The graph shows much the same distribution of fatties as were noted in 1960 when we did our previous survey, namely that a rather high proportion of overweight youngsters occurs in the age groups around puberty especially in girls whose physical maturity is earlier than that of boys.

Our main concern is that our numbers tend to increase and indeed we seem to have almost a hundred more overweight children than two years ago. Increase, by the way, on this occasion seems to be more pronounced in the boys than in the girls. Although our record figure was in a girl of 14+ years who weighed twenty stones. Apart from the physical difficulties the fatty is up against, one must bear in mind and I think this is generally accepted, that excessive carbohydrate intake is the usual cause of the overweight condition. This is also the item in the diet which leads to tooth decay. I feel a survey of the dental condition of our fatties might be quite revealing.

OBESE CHILDREN

We frequently receive requests from Consultants and General Practitioners to reduce the carbohydrate intake of their obese child patients. I am most happy to report that the School Meals Service Department have always willingly co-operated by serving smaller portions of potatoes and by replacing the pudding course with raw fruit. This seems to be an effective way of reducing the calorific value of a school dinner by some 250 calories.

Dr. Ward has let me have the following details of her experiences in the recent treatment by her of obesity in school children.

"Concern has been felt for some time about the increasing number of fat children to be found at all ages. These children present a picture of general obesity and are relatively inactive, being unable to take part in games with any degree of success or comfort. They are the butt of their classmates' remarks and, contrary to the popular conception of the fat person as being comfortable and contented, they are frequently miserable and unable to mix with others with ease.

I am convinced that obesity is almost always the result of eating too much carbohydrate which is a common fault in the eating habits of children and adults. I have, therefore, endeavoured to help a number of these fat children to attain a more satisfactory weight by reduction of their carbohydrate intake.

Treatment : Some forty children, boys and girls of ages ranging from 9 to 15 years, have been treated for obesity during the last two years at the clinics at which I attend as Medical Officer. The children selected were considerably overweight for their age and height. They also professed a desire to lose weight and attain a more pleasant appearance. In addition, there had to be co-operation from their parents.

The child was carefully examined to ascertain that he was quite healthy. He was then put on a 1,400 calorie diet which was reduced in all forms of carbohydrate but had a plentiful supply of protein and some fat.

BOYS

Number of Children
expressed as
percentage
of age group

4.0
3.8
3.6
3.4
3.2
3.0
2.8
2.6
2.4
2.2
2.0
1.8
1.6
1.4
1.2
1.0
0.8
0.6
0.4
0.2

Age in Years

5 6 7 8 9 10 11 12 13 14 15 16

+++++ 1960

— 1962

45

4.0
3.8
3.6
3.4
3.2
3.0
2.8
2.6
2.4
2.2
2.0
1.8
1.6
1.4
1.2
1.0
0.8
0.6
0.4
0.2

Age in Years

5 6 7 8 9 10 11 12 13 14 15 16

+++++ 1960

— 1962

45

4.0
3.8
3.6
3.4
3.2
3.0
2.8
2.6
2.4
2.2
2.0
1.8
1.6
1.4
1.2
1.0
0.8
0.6
0.4
0.2

Age in Years

5 6 7 8 9 10 11 12 13 14 15 16

+++++ 1960

— 1962

45

4.0
3.8
3.6
3.4
3.2
3.0
2.8
2.6
2.4
2.2
2.0
1.8
1.6
1.4
1.2
1.0
0.8
0.6
0.4
0.2

Age in Years

5 6 7 8 9 10 11 12 13 14 15 16

+++++ 1960

— 1962

45

4.0
3.8
3.6
3.4
3.2
3.0
2.8
2.6
2.4
2.2
2.0
1.8
1.6
1.4
1.2
1.0
0.8
0.6
0.4
0.2

Age in Years

5 6 7 8 9 10 11 12 13 14 15 16

+++++ 1960

— 1962

45

4.0
3.8
3.6
3.4
3.2
3.0
2.8
2.6
2.4
2.2
2.0
1.8
1.6
1.4
1.2
1.0
0.8
0.6
0.4
0.2

Age in Years

5 6 7 8 9 10 11 12 13 14 15 16

+++++ 1960

— 1962

45

GIRLS

Number of Children
expressed as
percentage
of age group

4.0
3.8
3.6
3.4
3.2
3.0
2.8
2.6
2.4
2.2
2.0
1.8
1.6
1.4
1.2
1.0
0.8
0.6
0.4
0.2

Age in Years

5 6 7 8 9 10 11 12 13 14 15 16

+++++ 1960

— 1962

45

4.0
3.8
3.6
3.4
3.2
3.0
2.8
2.6
2.4
2.2
2.0
1.8
1.6
1.4
1.2
1.0
0.8
0.6
0.4
0.2

Age in Years

5 6 7 8 9 10 11 12 13 14 15 16

+++++ 1960

— 1962

45

4.0
3.8
3.6
3.4
3.2
3.0
2.8
2.6
2.4
2.2
2.0
1.8
1.6
1.4
1.2
1.0
0.8
0.6
0.4
0.2

Age in Years

5 6 7 8 9 10 11 12 13 14 15 16

+++++ 1960

— 1962

45

4.0
3.8
3.6
3.4
3.2
3.0
2.8
2.6
2.4
2.2
2.0
1.8
1.6
1.4
1.2
1.0
0.8
0.6
0.4
0.2

Age in Years

5 6 7 8 9 10 11 12 13 14 15 16

+++++ 1960

— 1962

45

4.0
3.8
3.6
3.4
3.2
3.0
2.8
2.6
2.4
2.2
2.0
1.8
1.6
1.4
1.2
1.0
0.8
0.6
0.4
0.2

Age in Years

5 6 7 8 9 10 11 12 13 14 15 16

+++++ 1960

— 1962

45

In order to help him in the first month or so of his treatment, he was given "Dexedrine" (dexamphetamine sulphate 5 mgm. tablets) 1 or 2 tablets daily to be taken half an hour before breakfast and lunch. This merely reduced his appetite and made him more comfortable while he was learning to eat much less.

He was weighed and measured each 4 to 6 weeks. After his weight had fallen and he was becoming more accustomed to a smaller carbohydrate intake, his "Dexedrine" was reduced and finally stopped.

Results : In practice, the co-operation of parents and child is often difficult to maintain. The start is good but enthusiasm flags and the temptation of biscuits, sweets, etc., proves too great. This happened in some fifty per cent of cases.

When, however, parents and youngsters are anxious and determined to effect a reduction in weight, the results may be spectacular.

e.g. A girl aged 14 years 4 months: A very miserable girl of great size, weight 186 lbs. height 62½". Given two tablets "Dexedrine" daily and a 1,400 calorie diet, she rapidly lost weight as follows:—

February	..	..	Weight 186 lbs.	Height 62½ ins.
March	..	..	" 170½ "	" 62½ "
May	..	..	" 162 "	" 62½ "
June	..	..	" 154½ "	" 62½ "

—a weight loss of 31½ lbs. in five months. Linda's personality showed a great improvement. She became friendly and much more self confident.

In twenty-five per cent of the cases, the results have been good, and in another twenty-five per cent there has been some loss of weight, but the effort has not been great enough on the part of the parent and child.

There have been no side-effects resulting from the use of "Dexedrine" and there has been no difficulty in reducing and eventually completely withdrawing the dose.

There are few patients as pleased and grateful as the one-time fat youngster who has reduced to a reasonable size."

PSEUDO HYPERTROPHIC MUSCULAR DYSTROPHY SURVEY

I am indebted to my colleagues in the School Health Service Group of the Medical Officers of Health Society for their co-operation in completing my questionnaire. A summary of their replies is given opposite.

Dr. Sinclair has very kindly analysed the data and has made the following observations:—

The objects of the survey were:—

1. to obtain information on the general level of intelligence of muscular dystrophy cases, and
2. to find if any relationship existed between progression of the disease and change in intellectual ability.

Questionnaires were completed and returned in respect of 93 cases.

Intelligence in general :

In 70 of the 93 cases, I.Q. estimations had been performed. Nearly all had only had a single assessment made, and in most cases the method of testing was not specified. Results are shown below:—

I.Q.	No. of cases	Average distribution of I.Qs. in general population	
40—49	1	57.1% are below 90	25%
50—59	2		
60—69	10		
70—79	16		
80—89	11		
90—99	16	31.4% are between 90—110	50%
100—109	6		
110—119	4	11.5% are 110 or over	25%
120—129	1		
130—139	2		
140+	1		

These figures suggest a generally lower I.Q. level as compared with the distribution of intelligence in the general population, although the sample is probably too small to be of any statistical significance.

In the 23 cases where the I.Q. had not been assessed, 11 were described as below average, 8 as average, 2 as above average, and in 2 cases no comment was made. These figures conform roughly to the assessed results.

I feel that one can draw the conclusion that the intellectual level of known cases of pseudo hypertrophic muscular dystrophy is below the average of the general population, and that this may be due to the condition itself. On the other hand, one must bear in mind that this is a sex-linked inheritable condition and that those families in which the condition is known to occur may, if their intelligence is high, limit or avoid procreation, so that only the poorer intellectual types are having families, being unaware of the hereditary implications. It always amazes me how little families know of their first cousins even when they live in the same neighbourhood. One can readily understand why they do not realise that there may be a "family tendency to paralysis," (as I was informed of this on only one occasion).

The usual difficulty crops up with a survey of this sort, viz. that standards vary a great deal and it is well nigh impossible to word questions to cover all possibilities. I might add that I did not expect details of a girl to turn up amongst the completed forms.

SCHOOL ACCIDENTS

Dr. More has let me have the following report on accidents to school children.

"This year I have only paid particular attention to the accidents occurring during physical education, swimming and games. There were 268 of these out of the total accident figure of 793.

The following is a brief analysis of the 268 accidents:—

1. Number of accidents reported, occurring at physical education, swimming and games—268 or 33.8% of the total.

2. Type of school:—
 - (a) primary and special—67 or 25% of (1) above
 - (b) bilateral, secondary and comprehensive—151 or 56.3% of (1) above
 - (c) grammar and secondary technical—50 or 18.7% of (1) above
3. Sex:—
 - (a) Number of accidents to boys—164 or 61.2% of (1) above.
 - (b) Number of accidents to girls—104 or 38.8% of (1) above.
4. Number of accidents occurring during physical education and dancing—113 or 42.2%. Number of accidents occurring at games and swimming—155 or 57.8% of (1) above.
5. Number of accidents which were apparently serious—70 or 26% of (1) above."

DEATHS OF CHILDREN OF SCHOOL AGE DURING 1962

Analysis of causes :

Road accidents	..	..	..	..	..	3
Other accidents	..	..	..	..	..	3
Drowning	..	..	..	..	..	1
Malignant Growths	..	..	..	..	..	2
Acute infectious conditions	..	..	..	..	..	1
Leukaemia	..	..	..	..	..	1
Congenital heart	..	..	..	..	..	1
Epilepsy	..	..	..	..	..	2
Following operation	..	..	..	..	..	1
Fibrocystic Disease of the Pancreas	..	..	..	..	..	1

As usual, 1961 apart, accidental conditions are the main cause of the loss of these young lives. In the case of road accidents, we have checked to make sure there was no contributory cause such as defective hearing or vision but there was no history or knowledge of these defects in any of them. The child who was drowned was educationally sub-normal and in the lower groups of this handicap and two children died from Carbon Monoxide poisoning due to wrong use of a paraffin heater.

Two youngsters who died of asphyxia secondary to epilepsy were not known to us as epileptics, a disturbing situation indeed, and a happening which I do not remember hearing of before.

CONCLUSION

In the pages of this official report I have attempted to enlarge upon figures which are by necessity mainly routine. I take this opportunity to thank the members of the Special Services Sub-Committee for their encouragement throughout the year. I am pleased to refer to the continued loyalty and co-operation of the School Health Service staff both professional and clerical and to acknowledge the assistance received from Head Teachers, from other departments of the Corporation and from various voluntary social agencies. My thanks are also given 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.

APPENDIX A.
MEDICAL INSPECTION AND TREATMENT RETURN
Year ended 31st December, 1962

**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				Pupils found to require treatment (excluding Dental Diseases and Infestation with Vermin)		
		Satisfactory		Unsatisfactory		For defective vision (excluding squint)	For any of the other conditions recorded in Part II	Total individual pupils
		No.	% of Col. 2	No.	% of Col. 2			
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1958 and later	807	807	100	—	—	8	128	135
1957	1,465	1,465	100	—	—	55	213	252
1956	1,988	1,988	100	—	—	87	307	381
1955	373	372	99.73	1	0.27	25	67	80
1954	2,290	2,290	100	—	—	194	291	463
1953	1,272	1,272	100	—	—	102	159	245
1952	1,917	1,917	100	—	—	220	231	422
1951	3,171	3,171	100	—	—	285	343	604
1950	1,347	1,347	100	—	—	159	148	292
1949	548	548	100	—	—	108	61	162
1948	3,042	3,041	99.97	1	0.03	335	294	601
1947 and earlier..	1,791	1,790	99.95	1	0.05	422	183	586
Total ..	20,011	20,008	99.99	3	0.01	2,000	2,425	4,223

TABLE B.—OTHER INSPECTIONS

Number of Special Inspections	..	..	..	..	..	..	..	12,355
Number of Re-inspections	..	..	..	..	..	..	..	10,258
Total								22,613

TABLE C.—INFESTATION WITH VERMIN

(a)	Total number of individual examinations of pupils in schools by school nurses or other authorised persons	..	..	..	..	..	152,551
(b)	Total number of individual pupils found to be infested	..	..	..	..	..	3,745
(c)	Number of individual pupils in respect of whom cleansing notices were issued (Section 54 (2), Education Act, 1944)	..	..	..	..	..	69
(d)	Number of individual pupils in respect of whom cleansing orders were issued (Section 54 (3), Education Act, 1944)	..	..	..	..	..	56

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
		(3)	(4)	(5)	(6)	(7)
4	Skin	T	45	100	214	359
		O	18	2	16	36
5	Eyes—					
	(a) Vision	T	172	598	1,230	2,000
		O	175	39	355	569
	(b) Squint	T	133	98	388	619
		O	22	1	20	43
	(c) Other	T	16	13	37	66
		O	5	—	13	18
6	Ears—					
	(a) Hearing	T	32	16	56	104
		O	33	10	61	104
	(b) Otitis Media	T	17	13	30	60
		O	15	6	21	42
	(c) Other	T	10	9	18	37
		O	5	1	4	10
7	Nose or Throat	T	283	39	242	564
		O	204	9	117	330
8	Speech	T	22	3	48	73
		O	26	—	21	47
9	Lymphatic Glands	T	2	1	4	7
		O	9	—	10	19
10	Heart	T	7	9	12	28
		O	24	2	41	67
11	Lungs	T	25	36	53	114
		O	71	2	75	148
12	Developmental—					
	(a) Hernia	T	15	—	14	29
		O	10	—	17	27
	(b) Other	T	23	21	68	112
		O	49	12	176	237

TABLE A.—PERIODIC INSPECTIONS—*continued*

Defect Code No. (1)	Defect or Disease (2)	Periodic Inspections				
		Entrants		Leavers	Others	Total
		(3)	(4)	(5)	(6)	(7)
13	Orthopaedic—					
	(a) Posture	T	1	2	9	12
		O	4	2	15	21
	(b) Feet	T	19	2	42	63
		O	15	3	19	37
	(c) Other	T	34	36	88	158
		O	20	6	43	69
14	Nervous System—					
	(a) Epilepsy	T	3	8	15	26
		O	6	2	24	32
	(b) Other	T	4	6	9	19
		O	1	—	40	41
15	Psychological—					
	(a) Development ..	T	7	1	19	27
		O	44	—	22	66
	(b) Stability	T	7	2	26	35
		O	16	2	19	37
16	Abdomen	T	3	1	12	16
		O	2	—	11	13
17	Other	T	—	2	17	19
		O	18	7	48	73

TABLE B.—SPECIAL INSPECTIONS

Defect Code No. (1)	Defect or Disease (2)	Special Inspections	
		Pupils Requiring Treatment (3)	Pupils Requiring Observation (4)
4	Skin	135	44
5	Eyes—(a) Vision	943	2,287
	(b) Squint	233	474
	(c) Other	34	5
6	Ears—(a) Hearing	43	237
	(b) Otitis Media	37	17
	(c) Other	109	17
7	Nose or Throat	597	351
8	Speech	19	52
9	Lymphatic Glands	—	16
10	Heart	3	119
11	Lungs	—	174
12	Developmental—		
	(a) Hernia	2	15
	(b) Other	13	205
13	Orthopaedic—		
	(a) Posture	2	11
	(b) Feet	34	53
	(c) Other	23	93
14	Nervous System—		
	(a) Epilepsy	1	49
	(b) Other	1	33
15	Psychological—		
	(a) Development	121	82
	(b) Stability	164	120
16	Abdomen	2	15
17	Other	211	529

**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	707
Errors of refraction (including squint)	5,536
Total	6,243
Number of pupils for whom spectacles were prescribed	2,120

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	112
(b) for adenoids and chronic tonsillitis	1,457
(c) for other nose and throat conditions	147
Received other forms of treatment	1,193
Total	2,909
Total number of pupils in schools who are known to have been provided with hearing aids:—	
(a) in 1962	16*
(b) in previous years	68†

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

† { Includes eleven pupils living in the Nottinghamshire County Council Area.
Includes three 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	429
(b) Pupils treated at school for postural defects	—
Total	429

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

	Number of cases known to have been treated
Ringworm— (a) Scalp	1
(b) Body	3
Scabies	39
Impetigo	60
Other Skin Diseases	2,948
Total	3,051

TABLE E.—CHILD GUIDANCE TREATMENT

	Number of cases known to have been treated
Pupils treated at Child Guidance Clinic	508

TABLE F.—SPEECH THERAPY

	Number of cases known to have been treated
Pupils treated by speech therapists	294

TABLE G.—OTHER TREATMENT GIVEN

	Number of cases known to have been dealt with
(a) Pupils with minor ailments	4,497
(b) Pupils who received convalescent treatment under School Health Service arrangements	26
(c) Pupils who received B.C.G. Vaccination	2,863
(d) Other than (a), (b) and (c) above:	
1. by the Authority: U.V.R.	24
2. by the Authority: paediatrics	103
3. at hospital: paediatrics	72
4. at hospital: general medicine	368
5. at hospital: general surgery	517
Total (a)—(d)	8,470

Dental Inspection and Treatment carried out by the Authority during the year ended 31st December, 1962

Dental and orthodontic work:

I Number of pupils inspected by the Authority's Dental Officers:

i At Periodic Inspections	7,388	} Total I	12,759
ii As Specials	5,371		
II Number found to require treatment			12,091
III Number offered treatment			11,400
IV Number actually treated			8,050

Dental work (other than orthodontics):

I Number of attendances made by pupils for treatment, excluding those recorded at (c) I below

17,560

II Half-days devoted to:

i Periodic School Inspection	23	} Total II	2,265
ii Treatment	2,242		

III Fillings:

i Permanent Teeth	9,840	} Total III	9,906
ii Temporary Teeth	66		

IV Number of teeth filled:

i Permanent Teeth	8,800	} Total IV • 8,862	
ii Temporary Teeth	62		

V Extractions:

i Permanent Teeth	5,928	} Total V	17,906
ii Temporary Teeth	11,978		

VI Administration of general anaesthetics for extractions † 7,035

VII Number of pupils supplied with artificial teeth 161

VIII Other Operations:

i Permanent Teeth	1,239	} Total VIII	1,255
ii Temporary Teeth	16		

Orthodontics:

i Number of attendances made by pupils for orthodontic treatment		1,744
ii Half-days devoted to orthodontic treatment		243
iii Cases commenced during the year		92
iv Cases brought forward from previous year		26
v Cases completed during the year		56
vi Cases discontinued during the year		7
vii Number of pupils treated by means of appliances		108
viii Number of removable appliances fitted		143
ix Number of fixed appliances fitted		—

906 X-ray films were also taken

* 796 local anaesthetics were given for fillings

† In addition 91 local anaesthetics were given for extractions

Handicapped Pupils requiring Education at Special Schools or Boarding Homes

	Blind (1)	Partially Sighted (2)	Deaf (3)	Partial Hearing (4)	Physically Handi- capped (5)	Delicate (6)	Mal- adjusted (7)	E.S.N. (8)	Epileptic (9)	Speech Defects (10)	Total Cols. (1)-(10) (11)
A. During the calendar year ended 31st December, 1962, number of handicapped pupils newly assessed as needing special educational treatment at special schools or in boarding homes ..	—	1	5	2	14	8	16	106	6	1	159
B. (i) of the children included at A, number newly placed in special schools (other than hospital special schools) or boarding homes ..	—	1	5	1	8	5	12	36	4	1	73
(ii) of the children assessed prior to 1st January, 1962, number newly placed in special schools (other than hospital special schools) or boarding homes	1	1	1	1	3	4	1	45	—	1	58
Total (B(i) and B (ii)	1	2	6	2	11	9	13	81	4	2	131
C. At 20th January, 1963, number of handicapped pupils:—											
(i) requiring places in special schools—											
(a) day	—	—	—	—	—	—	—	61	—	—	61
(b) boarding	—	—	—	—	3	3	1	—	1	—	8
(ii) included at (i) had not reached the age of 5 and were awaiting:—											
(a) day places	—	—	—	—	—	—	—	—	—	—	—
(b) boarding places	—	—	—	—	—	—	—	—	—	—	—
(iii) included at (i) who had reached the age of 5, but whose parents had refused consent to their admission to a special school, were awaiting:—											
(a) day places	—	—	—	—	—	—	—	—	—	—	—
(b) boarding places	—	—	—	—	—	—	—	—	—	—	—

	Blind (1)	Partially Sighted (2)	Deaf (3)	Partial Hearing (4)	Physically Handi- capped (5)	Delicate (6)	Mal- adjusted (7)	E.S.N. (8)	Epileptic (9)	Speech Defects (10)	Total Cols. (1)-(10) (11)
D. At 20th January 1963, number of handicapped pupils											
(i) on the register of (1) maintained special schools as:—											
(a) day pupils	—	—	25	8	61	25	1	387	1	1	509
(b) boarding pupils	—	4	—	—	4	3	—	1	2	—	14
(2) non-maintained special schools as:—											
(a) day pupils	—	—	—	—	—	—	—	—	—	—	—
(b) boarding pupils	6	—	4	4	6	7	—	2	7	1	37
Total	6	4	29	12	71	35	1	390	10	2	560
(ii) on the registers of independent schools under arrangements made by the Authority ..	—	—	1	—	—	—	4	—	—	—	5
Total (D(i) and D(ii)) ..	6	4	30	12	71	35	5	390	10	2	565
(iii) boarded in homes and not already included under (i) and (ii) above	—	—	—	—	—	1	16	—	—	—	17
Total (D(i), (ii) and (iii)) ..	6	4	30	12	71	36	21	390	10	2	582
E. On 20th January, 1963, number of handicapped pupils (irrespective of the areas to which they belong) being educated under arrangements made by the Authority in accordance with Section 56 of the Education Act, 1944:—											
(i) in hospitals	—	—	—	—	—	—	—	—	—	—	—
(ii) in other groups (e.g. units for spastics, convalescent homes)	—	—	—	—	—	—	—	—	—	—	—
(iii) at home	—	—	—	—	1	—	—	—	—	—	1

F. During the calendar year ended 31st December, 1962

(i) Number of children reported to the Local Health Authority under Section 57(4) of the Education Act, 1944

(ii) Number of children whose cases were reviewed under the provisions of 57A of the Education Act, 1944

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

34
1
1

APPENDIX B.

TREATMENT ARRANGEMENTS

<i>Clinic</i>	<i>Treatment carried out</i>	<i>Consultant Sessions</i>	<i>School Medical Officer attended</i>	<i>Children's attendances during 1962 for minor ailments</i>
Central— 28 Chaucer Street	Minor Ailments, Electrical .. Paediatrics .. Refractions .. E.N.T. .. Dental ..	Weekly 5 sessions weekly 2 sessions weekly	Tuesday and Friday a.m.	7,812*
Bulwell— Main Street, & Springfield School	Minor Ailments Refractions .. Speech Therapy Dental ..	Monthly	Monday and Thursday a.m.	6,363
Clifton— Southchurch Drive ..	Minor Ailments Refractions .. Speech Therapy Dental ..	Weekly	Wednesday p.m.	6,713
†Ernest Purser— Wilford Road	Minor Ailments Speech Therapy	—	—	624
Leenside— Canal Street	Minor Ailments Dental ..	—	Thursday p.m.	6,217
Padstow— Bestwood Estate and Burford School	Minor Ailments	—	Monday a.m.	11,997
Player— Beechdale Road ..	Minor Ailments Refractions .. Speech Therapy Dental ..	Weekly	Monday and Thursday a.m.	13,284
Portland— Westwick Road	Minor Ailments	—	—	2,142
Rosehill— St. Matthias' Road	Minor Ailments Refractions .. Speech Therapy Dental	Weekly	Thursday p.m.	8,250
Scotholme— Beaconsfield Street ..	Minor Ailments	—	Tuesday a.m.	4,561
WilliamCrane— Aspley Estate	Minor Ailments Speech Therapy	—	Monday a.m.	7,426
Child Guidance— 34 Clarendon Street	Psychiatric .. Speech Therapy ..	4 sessions weekly	Tuesday p.m. and Wednesday a.m.	—
Orthodontic— 36 Clarendon Street ..	Orthodontic	—	—	—

* Including U.V.R., Ionisation and Proetz cases.

† Closed April 1962.

