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County Borough of Reading

ANNUAL REPORT

OF THE

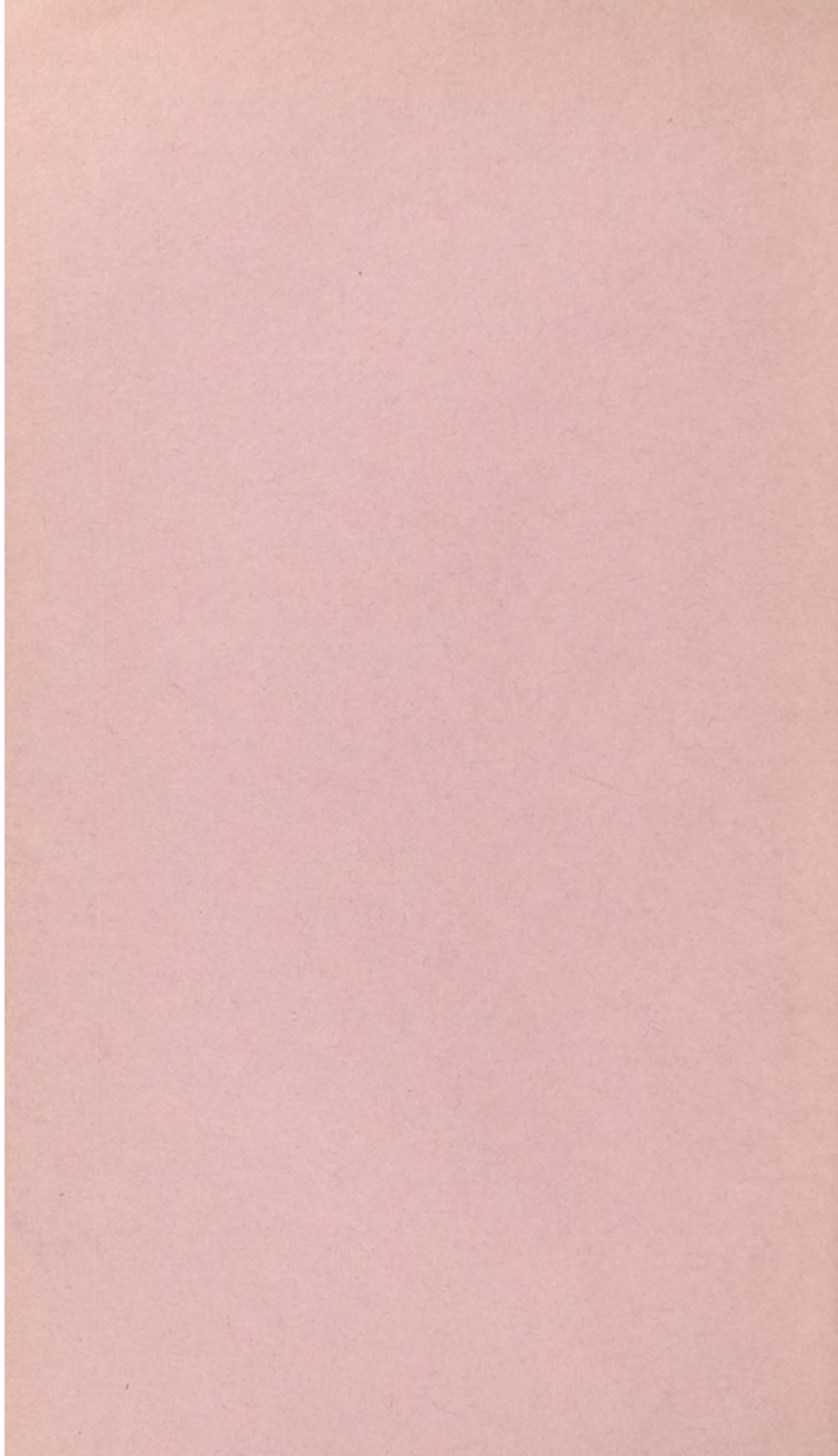
School Medical Officer

FOR THE YEAR

1959

By

E. HUGHES, M.D., D.P.H.



COUNTY BOROUGH OF READING

ANNUAL REPORT

OF THE

School Medical Officer

FOR THE YEAR

1959

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READING EDUCATION COMMITTEE

(as at 31st December, 1959)

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EDWARD THOMAS WALTHAM

Councillors :

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Mr. F. PHILLIPS

Mr. A. J. ROBINSON

Mrs. H. D. KAY

Miss D. M. MILES

STAFF AT 31st DECEMBER, 1959

Principal School Medical Officer:

E. HUGHES, M.D., D.P.H.

Deputy Principal School Medical Officer :

P. K. SYLVESTER, M.B., B.S., D.P.H., D.C.H., D(Obst.)R.C.O.G. (Commenced 9.11.59)

Senior School Medical Officer:

H. I. LOCKETT, M.B., B.S., D(Obst.)R.C.O.G., D.P.H.

School Medical Officers:

VIOLET FRASER, M.B., B.S., M.R.C.S., L.R.C.P.
 ETHEL AMY FISHER, M.Sc., M.B., B.Ch., D.R.C.O.G.
 A. MARTIN, M.B., Ch.B., D.P.H.
 I. F. RALPH, M.B., Ch.B., D.P.H. (Commenced 22.7.59)

Principal Dental Officer:

J. CAMPBELL, L.D.S., R.C.S.(Ed.)

Dental Officer:

C. A. PANK, L.D.S., R.C.S.(Eng.)

Speech Therapists:

ANN ELSBURY, L.C.S.T. (Senior) (Part-time)
 RITA A. LORD, L.C.S.T.
 DOROTHY THOMAS, L.C.S.T.
 MARGOT LAWRENCE, L.C.S.T. (Part-time)

Superintendent Health Visitor and School Nurse

Miss M. WEBBER, S.R.N., S.C.M., H.V.

School Nurses:

Mrs. H. KING	*Miss S. HANSFORD
Miss M. PLATT	*Mrs. L. KINGSLEY (Part-time)
Mrs. J. LEWIS (Part-time)	*Miss H. MORTIMER
Mrs. T. PORTER (Part-time)	*Miss J. SMITH
Mrs. E. MABEY (Commenced 1.4.59)	*Miss M. WILLIAMSON
Mrs. J. GRIFFIN (Part-time)	*Mrs. K. DULBOROUGH (Part-time)
(Commenced 25.5.59)	(Commenced 1.1.59)
*Mrs. A. ALLISON	*Miss E. FEW (Commenced 4.5.59)
*Miss F. GATES	*Miss B. WHITE (Commenced 20.7.59)
*Miss M. GRANT	*Miss B. HEATHCOTE (Commenced 20.7.59)

*Combined Health Visiting and School Nursing Duties

Oral Hygienist

Mrs. V. TAYLOR

Clinic Assistants:

Mrs. D. BOXALL

Miss B. J. McMANUS

Mrs. R. NEALE

Senior Clerk;

Miss W. M. DIX

READING SCHOOL HEALTH SERVICE

To the Chairman and Members of the Education Committee

Ladies and Gentlemen,

I have the honour to present my report on the School Health Service for the year ended December 31st, 1959. Detailed comments on the many aspects of our work are included in the body of the report and, therefore, I am not referring to them in this introduction.

One or two matters do seem worthy of special mention here. The first is the continued shortage of dental surgeons for the School Health Service. The reasons for this are not far to seek. Dentistry itself is not a popular profession, and remuneration in private practice is much higher than in school dental practice. Some members will recall that a few years ago you approved a scheme whereby we enlisted the help of local dentists to treat school children in their own surgeries, but unfortunately this was turned down by the Ministry of Education. The result has been most unfortunate. Under our scheme we were at least able to work out some form of regular inspection and treatment. Under present arrangements, as Mr. Campbell points out, this is quite impossible. It seems to me that if the State undertakes to provide free dental treatment for a section of the population then it should do so at the lowest possible price consistent with efficiency. This is not happening now, and I feel that it is time that the Ministry of Education had another look at the whole subject of the best method of dental treatment of schoolchildren.

Another point which has been worrying me for some time is the lack of adequate facilities for medical inspections, especially periodic medical inspections where large numbers are involved, in our schools. The regulations specify that, "Suitable accommodation shall be immediately available at any time during school hours for the inspection and treatment of pupils by doctors, dentists and nurses. The accommodation for such inspection and treatment shall be well and suitably lighted and heated, and shall be conveniently accessible to a closet, and every room provided for such purposes shall include a lavatory basin with a supply of hot and cold water." Head teachers have always done their best to help us but even they cannot accomplish the impossible. The difficulty is that even in the new schools the definition of 'suitable accommodation' is taken to mean one room. To carry out medical inspections, especially where any numbers are involved, one requires a place where parents can meet and wait; a separate place where they can be interviewed by the Health visitor and a proper history taken; and a third and separate place where the children can be examined by a school medical officer in privacy and away from the noise which accompanies so many school activities. We are now reaching the extraordinary position wherein I am being asked to agree to medical inspections of children being carried out at local authority clinics because the facilities in the school, even the post-war schools, are inadequate or unsatisfactory. This might be excusable in the older schools but it seems inexplicable in the new schools. The reason given, of course, is that there is never enough money to allow for the proper lay-out of school premises.

During the year we lost the services of Dr. O'Donnell, Deputy Medical Officer of Health. Dr. O'Donnell was deputy here for five years and was well-known to all members of the Committee. We wish him well in his promotion to Worcester.

Once again I would like to express my thanks to the Chief Education Officer, his office staff, and teachers in the Reading Schools, for all the help they have given throughout the year. I must also thank the Chairman and Members of the Welfare Sub-Committee of the Education Committee for the interest and support which they have given to this department. My thanks are also due to my own staff for their loyalty and hard work, more especially to Dr. H. I. Lockett, Senior Assistant Medical Officer, for the supervision and compilation of this report.

I am,

Your obedient Servant,

E. HUGHES,

Principal School Medical Officer

ESTIMATE OF THE NUMBERS OF CHILDREN BETWEEN THE AGES OF 5 AND 15 YEARS
IN EACH OF THE NEXT FIVE YEARS

	Between 14 & 15	13 & 14	12 & 13	11 & 12	10 & 11	9 & 10	8 & 9	7 & 8	6 & 7	5 & 6	Total	Increase	Decrease	Cumulative incr. or decr.
31st Aug., 1959	1,682	1,753	2,164	1,926	1,808	1,709	1,656	1,688	1,628	1,598	17,612	—	—	—
31st Aug., 1960	1,753	2,164	1,926	1,808	1,709	1,656	1,688	1,628	1,598	1,594	17,524	—	88	— 88
31st Aug., 1961	2,164	1,926	1,808	1,709	1,656	1,688	1,628	1,598	1,594	1,594	17,365	—	159	—247
31st Aug., 1962	1,926	1,808	1,709	1,656	1,688	1,628	1,598	1,594	1,594	1,749	16,950	—	415	—662
31st Aug., 1963	1,808	1,709	1,656	1,688	1,628	1,598	1,594	1,594	1,749	1,680	16,704	—	246	—908
31st Aug., 1964	1,709	1,656	1,688	1,628	1,598	1,594	1,594	1,749	1,680	1,819	16,715	11	—	—897

SCHOOL CLINICS

Queen's Road Clinic—

Special Examinations and Minor Ailments	... ..	Monday and Friday, 9 a.m.-10 a.m.
Ultra-Violet Light Therapy	...	Tuesday, 2.30 p.m., Friday, 10.30 a.m.
Chiropody Clinic	... ..	Friday, 10.30 a.m.

Whitley Clinic—

Special Examinations and Minor Ailments	... ..	Monday and Friday, 9 a.m.-10 a.m.
Ultra-Violet Light Therapy	...	Monday and Wednesday, 11.30 a.m.

Ashmead School Clinic—

Special Examinations and Minor Ailments	Friday, 2 p.m.-3 p.m.
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Emmer Green School Clinic—

Special Examinations and Minor Ailments	Friday, 9 a.m.-10 a.m.
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Geoffrey Field School Clinic—

Special Examinations and Minor Ailments	Wednesday, 9 a.m.-10 a.m.
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Hill School Clinic—

Special Examinations and Minor Ailments	Wednesday, 9 a.m.-10 a.m.
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Grovelands School Clinic—

Special Examinations and Minor Ailments (for Battle S. School)	...	Monday, 9 a.m.-10 a.m.
Special Examinations and Minor Ailments (for Battle S. School)	...	Friday, 9 a.m.-10 a.m.

Hugh Faringdon School Clinic—

Special Examinations and Minor Ailments	Thursday, 9 a.m.-10 a.m.
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St. Michael's School Clinic—

Special Examinations and Minor Ailments	Wednesday, 9 a.m.-10 a.m.
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Southcote Primary School Clinic—

Special Examinations and Minor Ailments	Tuesday, 9 a.m.-10 a.m.
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Stoneham School Clinic—

Special Examinations and Minor Ailments	Tuesday, 9 a.m.-10 a.m.
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Tilehurst Clinic—

Special Examinations...	By appointment
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Westwood School Clinic—

Special Examinations and Minor Ailments	Monday, 9 a.m.-10 a.m.
---	--------	------------------------

Dental Clinics—

Queen's Road Clinic
 Tilehurst Clinic
 Whitley Clinic

Speech Therapy Clinics—

Ashmead School	...	...	1 Session	The Hill School	...	1 Session
Avenue School	...	...	4 "	Queen's Road Clinic	...	8 "
Emmer Green School	...	...	1 "	St. Michael's School	...	1 "
E. P. Collier School	...	...	1 "	Southcote School	...	2 "
Geoffrey Field School	...	...	3 "	Tilehurst Clinic	...	1 "
Grovelands School	...	...	2 "	Whitley Clinic	...	2 "

MEDICAL INSPECTIONS

The medical examination of school children whether at periodic or at special inspections, is the major duty undertaken by school doctors. During the year 5,865 pupils were seen at routine examinations, an increase of 26 per cent. over the previous year. In 99.8 per cent. of these the general physical condition was recorded as satisfactory, compared with 99.4 per cent in 1958. At these inspections 853 pupils were found to require treatment for some disease or defect: in 324 of these the defect concerned was poor eyesight.

These routine, or periodic, examinations are normally made three times in the school life of each child, at 5, 11 and 14 years respectively. To a limited extent we have provided an additional routine inspection at the age of 8 years and it is hoped to make this general when additional medical staff has been recruited.

In addition, 2,499 children were reinspected, or were seen at special inspections at the request of a parent or teacher. This represented an increase of 17 per cent. over the 1958 figure.

It is interesting to compare the incidence of various types of defect discovered during the examination of 'new entrants' with that of the same defects found amongst 'leavers'. The figures given below suggest that most of the conditions are either cured or brought under control during school life although there are three notable categories of defect which appear to be appreciably commoner in leavers, viz. Visual Defects (apart from Squint), Skin Conditions and Postural Defects.

Number of children per 1,000 examined in 1959 after First Entering or Before Leaving School, who were found to have certain defects requiring observation or treatment.

<i>Defect</i>	<i>Entrants</i>	<i>Leavers</i>
Skin defects	15	37
Visual defects	57	113
Squint	15	7
Deafness	28	14
Otitis media	19	12
Nose and throat defects	76	18
Speech defects	19	0.7
Defects of lymphatic glands	19	1.4
Heart defects	10	13
Lung defects	24	12
Hernia	3.5	0.7
Postural defects	4.5	13
Foot defects	20	18
Epilepsy	1.5	0.7
Disorders of psychological development	7.5	1.4
Psychological instability	12	2.2

Medical examinations for fitness for employment

During the year 573 children, 415 boys and 158 girls, were medically examined for suitability for part-time employment under the Children and Young Persons Act, 1933. Three children, all girls, were found to be unfit for employment on medical grounds.

HANDICAPPED CHILDREN

These are children who because of some disability of mind or body require *special methods of education*, either in separate or special schools or in ordinary schools if this is possible. The authority is required to ascertain the children in their area who need such special educational treatment and the comprehensive Register of all handicapped and potentially handicapped children from birth onwards which has now been built up in the Health Department will undoubtedly greatly facilitate this work.

Apart from this matter of ascertainment, the most important duty of the School Medical Officer in connection with these children is that of ensuring that they obtain, and benefit to the maximum possible extent from, appropriate medical and surgical treatment to help overcome the handicap and to minimise its adverse effects on their educational progress.

The ten categories of children to be considered have been defined in the School Health Service and Handicapped Pupils Regulations, 1953.

(a) **Blind Pupils.** Pupils who have no sight or whose sight is, or is likely to become, so defective that they require education by methods not involving the use of sight.

There are two children on the register. A boy attends Condover Hall, Shrewsbury, and a girl is resident at Sunshine House Nursery School, Leamington Spa.

(b) **Partially Sighted Pupils.** Pupils who by reason of defective vision cannot follow the normal regime of ordinary school without detriment to their sight, or to their educational development, but can be educated by special methods involving the use of sight. The special methods may include the use of optical aids such as a large magnifying lens, good diffuse lighting and specially printed books.

There are ten children on the register. Five girls are resident at Barclay School, Sunninghill, and three boys at Blatchington Court, Seaford. Another boy is being educated at the West of England School for Partially Sighted Children, Exeter.

(c) **Deaf and Partially Deaf Children.** I am obliged to Mr. Daniel Ling for most of the information on which the following comments are based.

One of the things which has struck us has been the way in which our ideas have been modified as time has progressed and, therefore, the publication of an Annual Report provides a very useful opportunity for critical examination of our progress and of our ideas.

The keystone to our scheme lies in a threefold partnership between the E.N.T. Department of the Royal Berkshire Hospital, the Education Department, and the School Health Service. The role of the School Health Service is to provide a bridge between the purely clinical aspect and the purely educational aspect of this problem.

Reference will be found in my report as M.O.H. of the Borough to the scheme we have evolved for the detection of deafness in early infancy. We are very much indebted to Dr. K. P. Murphy of the Nuffield Audiology Unit, Royal Berkshire Hospital for his very considerable help in this work.

Our scheme for the detection of hearing defects in the older pre-school child was described in the 1957 Report and continues more or less unchanged. Under this scheme Health Visitors and School Welfare Officers pose the following questions to parents when they visit them:

1. Is your child talking in sentences?
2. Can you understand everything he says?
3. Does he always understand what you say to him?
4. Does he always answer when called?
5. Have you noticed any apparent defect in his speech?
6. Do you think he has any difficulty in hearing?

It is proposed to add another question—Does he have any ear trouble?

In addition, all nursery schools and classes are visited by teachers of the deaf who screen all children with any communication difficulties. The following table shows the results of these detection procedures during 1959:—

Source of Referral	Children with defective hearing	Children with normal hearing	For further investigation	Total
Health Visitors	2	9	1	12
School Welfare Officers ...	-	4	1	5
Nursery Schools	3	20	-	23
School Medical Officers ...	2	5	-	7
Total	7	38	2	47

Sweep Tests in Infant Departments

Hitherto it has been our practice to confine sweep testing to 5-year old children but during the year it was extended to include six-year olds and we eventually hope to test all children in infants schools. We have extended this scheme because investigations suggested that a certain number of the six-year olds had failed the test which they had passed when they were five years of age, i.e. some defect of hearing had arisen during this twelve months.

The following tables give the relevant information:—

Results of Audiometric Survey of Children aged 5 and 6 years during 1959.

Total number of children tested in Infants Schools:—

	1,623	Retested
	1,273	New entrants
Total	2,896	

Failed Sweep Test
(i.e. no response at
20 d.b. at any one
frequency in
either ear).

	102	Retests
	82	New entrants
Failures	184	

	Retests	New Entrants
(a) Referred to R.B.H.	16	38
(b) Waiting to be seen by S.M.O.	9	14
(c) To be reviewed by S.M.O.	5	6
(d) For re-tests and continued observation at clinic ...	40	9
(e) Did not attend Clinic	19	4
(f) Discharged	11	9
(g) Already attending E.N.T. Out-patients at R.B.H. or own doctor	2	2
Total	102	82

One of the things we have tried to do is to evaluate the effect of surgical or similar treatment on the hearing of children who were referred to hospital. This has proved a more difficult and time consuming task than we anticipated. So far we have only been able to retest 77 out of 131 children who were referred to the hospital and who had appropriate treatment.

The result of the examination of these 77 children will be found in the following table:—

Type of Treatment†	Hearing returned to normal	Hearing Improved	Hearing not significantly changed	Hearing showing deterioration	Total
Removal of Tonsils and Adenoids	30	7	11	4	52
Other	8	2	1	1	12
Under Observation only	7	2	3	1	13
Total	43	11	15	6	77

†It should be borne in mind that this table relates only to the immediate results of one type of treatment. Where this has not succeeded in restoring hearing to within normal limits further treatment will be given and more cases may be expected to improve.

In addition to the foregoing, children are referred for special audiometric investigation at any age during the school life and the following table gives particulars:—

Source of Referral	Number Tested
School Medical Officers	43
Speech Therapists	3
Parents	3
Total	49

Mr. Ling's report on the educational progress of these children reads:—

Home Training for Pre-school Children

Owing to the detection of children with deafness in early infancy it has been possible for the teachers to start work with babies in the first three years of life. At this stage of a child's development it is possible only for somebody with close emotional ties to the baby successfully to lay foundations for future communication skills. Usually this is the mother. The teacher's work with the child is, therefore, mainly through parents. As the child grows older, more and more direct teaching by the specialist teacher is possible.

During 1959, four children aged 0-3 years received help through parent guidance. The youngest of these was the six month old son of deaf and dumb parents. In this case the mother of another deaf child is employed to help in the home as an "additional parent" to the child so that normal speech patterns are to be heard. All four cases are making good progress.

The New Town Nursery/Infant Unit

Since its inception fourteen children (nine boys and five girls) have been admitted to the New Town Nursery/Infant unit. Of these, two have been transferred to normal classes, and three transferred to the Palmer Unit. Of the nine children at present on the roll of the Unit, two attend the nursery classes on a part-time basis.

The George Palmer School Junior Unit.

From November, 1955 to December, 1959, 21 children were admitted to the Palmer Junior School Unit. Of these, fifteen have been enabled to attend normal classes as full-time pupils. It is planned to return a further pupil to an ordinary class in January, 1960.

Peripatetic Teaching for former Pupils of the unit

As mentioned in the discussion of attainments of Palmer Unit children in last year's Report, some children who have been returned to ordinary classes continue to require specialist help. This is particularly true of two of the six children who in 1959 reached the secondary stage of their education. Both were late admissions and their attainments, not up to those of normally hearing children of their own age, need to be improved. They receive regular specialist teaching.

The ever widening content of secondary school work is a potential source of difficulty to partially deaf children, and in order to ensure that progress is maintained, all six children are frequently visited in their schools by the specialist teacher. They are in different secondary schools and at each school one of the members of the staff is responsible for the child's welfare. The other members of the staff have been made aware of the possible difficulties these children may experience. It is too early yet to judge how successful this form of provision will be, but results to date indicate that this help will enable them to benefit fully from their work in the normal stream of education. Since the project is an experimental one, termly reports from the specialist teacher are used in addition to objective attainment tests to assess each child's needs. Should it be shown that the progress of any child is unsatisfactory, then alternative provision will be made. The alternatives may be more concentrated specialist help whilst the child is mainly in the normal stream, admission to a remedial class with specialist help or admission to a school for the partially deaf.

The possibility of a Unit for partially deaf pupils of secondary age has been considered, but it is not at the present time justified since none of the cases in secondary schools now needs full-time special treatment. Looking to the future, there is doubt whether such provision would be justified in any case. Experience in the units has shown that the majority of partially deaf children can be returned to normal classes after various periods of unit treatment whilst of infant or junior age. With

effective early detection, diagnoses and treatment in the Borough there are likely to be only a few severely handicapped children left in the units who require full-time specialist teaching after the age of eleven. Unless a fairly large number of partially deaf children move into the Borough at late junior stage, the numbers are likely to be too small to justify an extension of unit provision for older partially deaf children.

Remedial Help in Ordinary Classes for Slightly Deaf Children

Slightly deaf children, i.e. those who have a hearing defect but no major communication difficulties, are potentially problem cases. Ignored they may fail in ordinary class, but with a minimum of help they may be enabled to do well. The help available ranges from placement in an advantageous position in class to the provision of remedial teaching. Remedial teaching is undertaken in the Borough by specialist teachers who are not teachers of the deaf. Their work with slightly deaf children may extend through to a secondary level. In fact, for four pupils with good intelligence, remedial help in reading was arranged whilst the children were working in a technical/grammar stream. This experiment is still in its early stage but results to date are encouraging.

Children at Residential Schools

It is not possible to make local provision for all children with hearing defects in the Borough. In a period of 10 years only one or two children are likely to be born in the Borough too deaf to benefit from unit treatment. At present three children are on the deaf register, two of these are at Nutfield Priory Secondary School; the other is receiving treatment in a local hospital for bronchiectasis. In addition, three partially deaf girls who were too old for treatment in the George Palmer Unit when this was opened remain at a school in Brighton.

Employment and Welfare of Deaf and Partially Deaf when they Leave School

References to this important aspect of our work will be found in the report of the Medical Officer of Health.

Miscellaneous Data

Incidence of Cases of deafness requiring special educational provision on December 31st, 1959.

Children (aged 0- 16 years) born in Reading	= 28 = 1 per 1,000
Children born outside the Borough	= 14 = 0.5 per 1,000
Total	<hr/> 42 = 1.5 per 1,000 <hr/>

Hearing Aids in Use (0 - 16 years)

It will be seen from the following table that approximately half of the aids in use are of commercial manufacture. Commercial aids (as opposed to Medresco aids) have been issued in certain cases for the following reasons:—

- (a) Supplies of Medresco aids incorporating loop induction coils have been very limited.
- (b) The quality of sound reproduction of certain commercial aids is found to be superior since they (i) are less prone to acoustic feed back, (ii) produce less clothes rub, (iii) provide a wide selective range of frequency response characteristics and, (iv) provide more powerful amplification.
- (c) The commercial aids in use are more robust and damage less easily than Medresco aids.
- (d) Maintenance and repair of commercial aids is more speedily effected.

Hearing Aids in use (0 - 16 years)

	Commercial	Medresco	Total
Issued in former years	22	20	42
Issued in 1959	4	4	8
Total	26	24	50

Causes of Deafness in Children Wearing Aids

1. Familial	12
2. Maternal rubella	2
3. Haemolytic disease	4
4. Anoxia	1
5. Birth Injury	2
6. Virus infection in early infancy	4
7. Meningitis	1
8. Middle ear infection	10
9. No known cause	14
	<hr/> 50

Number of Partially Deaf Children in Ordinary Schools who require a favourable position in class

56 Boys

54 Girls

(These figures exclude pupils in the Partially Deaf Units and former pupils of these Units.)

(d) **Educationally Subnormal Pupils.** Pupils who by reason of limited ability or other conditions resulting in educational retardation require some specialised form of education wholly or partly in substitution for the education given in ordinary schools.

At the end of the year there were 166 pupils classified as Educationally Subnormal 112 boys and 54 girls. Only three of these were at residential special schools, though a further three boys were on the waiting list for such placement. In addition 8 boys and 2 girls were waiting appropriate vacancies in a day special school.

During the year 66 children suspected of being educationally subnormal or in serious educational difficulty were examined by the 'approved' Medical Officers. In each case the examination consisted of an intelligence test, at least one performance test, and a medical examination. The following list gives the results of the assessments of these children.—

	Boys	Girls
Recommended for day special school	22	7
Recommended for residential special school	3	—
Recommended for remedial teaching at ordinary school ...	12	10
Reported to the L.H.A. under sec. 57 of the Education Act,		
(i) as being ineducable	1	—
(ii) as requiring supervision after leaving school	5	4
Other recommendations	1	1

These examinations by the approved School Medical Officers are of very great importance. There are many causes of educational subnormality apart from limited intelligence. Thus a careful physical examination is essential to exclude ill-health which may hamper educational progress by causing frequent absences from school; similarly bad eyesight and deafness must be eliminated as these may be the unsuspected cause of considerable educational retardation. Frequently social factors such as parental irresponsibility and indifference concerning regular school attendance, poor material standards and broken or unhappy homes are found to be not inconsiderable factors in these cases. In other children psychological factors, often rather crudely labelled 'maladjustment' are found to be important in the causation of their educational subnormality, and help may be required from the Educational Psychologist or the Child Guidance Clinic.

Mr. Newham, the Educational Psychologist, has contributed the following remarks concerning the School Psychological Service:—

The duty of an Education Authority is to provide education for the children attending its schools in accordance with—to use the wording of the 1944 Act—their "different ages, abilities, and aptitudes." Quite obviously the teachers in the schools are in the forefront of this endeavour. With some children, however, their efforts do not meet with sufficient success or their attempts are frustrated by influences beyond their control. In order to deal with these exceptions it is desirable for an Authority to have additional services so that the schools may be assisted with their educational aims. A School Psychological Service (S.P.S.) is an additional service for this purpose, and one was commenced in Reading in 1959, though groundwork for its inception was prepared before then.

One of the principal tasks of the S.P.S. is to assist those who have the day-by-day handling of children to deal with the puzzles, problems, and difficulties which they present that are out of the common run. With few exceptions, educational responsibility remains firmly with the schools; the S.P.S. acting in an advisory and consultative capacity. The need for full collaboration and co-operation between school, S.P.S., and home, together with others who may be concerned with a particular child, cannot be stressed too strongly. Those actively involved will, of course vary, depending on individual circumstances.

Much of the day-to-day work of the S.P.S. consists then in seeing children—usually in their schools—in order to assess their attributes and difficulties, subsequent discussions being carried out with those concerned so that appropriate measures can be decided upon. The difficulties which are troubling the children vary considerably. They may be primarily emotional ones, or related to learning at school, or to do with how they get on with adults or other children, though rarely does an upset occur by itself without other aspects of a child's behaviour being affected. Not all, or even a majority of, the children who are seen show their difficulties openly in an unruly, naughty, or eccentric fashion. The psychologist is in a position to help because of his more specialised knowledge of children's behaviour in general, and especially their more unusual behaviour. By the very nature of things children raising queries must be a small minority in any one school, and outside the immediate experience of most parents.

The steps to be taken in the case of any particular child will clearly depend upon the appraisal made of the problems encountered. Very often difficulties are not so much centred in the child, but are reactions to the handling of the child by the adults involved. Efforts to resolve such difficulties, therefore, have much to do with attempting to improve adult understanding and realisation of the child's personality and capacities. In some instances it will be most appropriate for the special facilities of the Child Guidance Clinic to be used, where psychiatric opinion can be included in the assessment and certain forms of treatment provided for children whose difficulties require these measures.

One major facet of the work of the S.P.S. has been outlined. Another most important aspect is the attempt to prevent such problems being created, or at least to minimise their likelihood. There are two principal ways of going about this. What is known about child development, child learning, the effects of stress and strain upon children's behaviour, and so forth, can be brought to the notice of teachers, parents, and, others, in a variety of ways. Some of this knowledge is controversial, almost notoriously so, but only too often well established principles are ignored or their importance insufficiently heeded. The second main approach is the endeavour to derive more effective ways of locating children with problems at a stage when corrective measures would be much simpler and before they fester into complex, entangled, and often poignant, situations.

(e) **Epileptic Pupils.** Pupils who by reason of epilepsy cannot be educated under the normal regime of ordinary schools without detriment to themselves or other people.

The School Health Service has under observation 32 pupils who are known to have had epileptic seizures. In 15 of these the attacks have taken the form of *grand mal*; the others suffer from *petit mal* or minor epilepsy.

In many of these children the attacks have been mild and infrequent or readily controlled by anticonvulsant drugs and they have been able, with the generous co-operation of their teachers, to continue their education in ordinary schools. Six more severely affected children attend the Avenue Special School where the careful supervision possible in a school of this type has been helpful in curtailing the frequency and severity of the seizures. Special care is taken to see that the child remains alert and interested as intellectual preoccupation is a recognised factor in the prevention of epileptic attacks.

Five of the children are so severely affected by their epilepsy that it is necessary for their education to take place in a residential school.

(f) **Maladjusted Pupils.** Pupils who show evidence of emotional instability or psychological disturbance and require special educational treatment in order to effect their personal, social or educational readjustment.

These 'difficult' children present problems of abnormal behaviour which may interfere with their educational progress or even bring them into conflict with the law. The causes of 'maladjustment' are numerous; they may lie in the child or in his environment and frequently in both. Thus the child may have a poor intellectual endowment or an abnormal temperament; these may make it difficult for him to conform to the pattern of behaviour expected for someone of his age. More commonly there are powerful influences in the home making for feelings of instability and unhappiness which impose great stress on the immature personality; such are parental disharmony or separation or lack of warmth towards this particular child.

Whenever possible it is desirable that these children should be kept at home and attempts made to modify the causative factors there by counselling the parents. Occasionally it may be necessary to admit the child to a hostel for maladjusted children; the child continues to attend an ordinary school. At the end of the year there were five children in such hostels. In some cases residential schooling has been advised. There were ten boys and six girls resident in schools for maladjusted children during the year.

The report of Dr. M. E. Ward, Psychiatrist, Reading Child Guidance Clinic, reads: The clinic has kept up to date with current referrals, new cases referred are visited immediately and the large majority are seen at the clinic within a few weeks. The waiting list for treatment has also been considerably reduced. The total number of cases seen is almost exactly the same as last year.

It was not possible to fill the vacancy for a full-time Psychiatric Social Worker during the year, but we were fortunate in having part-time assistance from Mrs. Rogosa, supplemented by Mrs. Crossman part of the year. Mrs. Liddle has now been appointed to the post of Psychiatric Social Worker and will join the clinic staff in January, 1960.

Mr. Newham joined the staff as Educational Psychologist on April 1st, 1959.

A table on the sources of referral shows there has been an increase in referrals from family doctors and hospitals consultants. The number of cases from family doctors now equals that from the School Medical Department. Increasing contact with the family doctor is welcome, the doctor being in the best position to know the family situation and troubles which so often underlie the child's difficulties. The referrals from the hospitals include Reading children referred for diagnostic interview to the Child Psychiatric Clinic at the Royal Berkshire Hospital, and later transferred for treatment to the Child Guidance Clinic. Referrals from the School Medical Officers have decreased, this may be partly accounted for by increasing use of the Educational Psychologist, who may examine and advise direct on many cases seen in the schools which do not need the complete investigation of the whole Child Guidance Clinic team.

All children seen at Reading Borough Clinic from January 1st, 1959 to December 31st 1959:

No. of cases brought forward from 31.12.58	...	...	...	...	...	155
No. of New Cases referred	...	...	...	...	...	72
No. of Cases re-opened during the period	...	...	...	...	...	11
Total No. of Cases seen for Consultation and Treatment	...	...	...	...	...	175

No. of Cases Closed	...	...	...	...	...	83
After Consultation and Advise Only	...	...	...	...	...	7
Adjusted	...	...	...	...	...	6
Improved	...	...	...	...	...	46
No change	...	...	...	...	...	6
Prematurely closed	...	...	...	...	...	12
No. of Cases closed Not Seen	...	...	...	...	...	2
No. of cases closed after Social Work Only	...	...	...	...	...	4

No. of Interviews:—						
For Psychiatric Examination	...	...	...	...	...	63
For Intelligence Test	...	...	...	...	...	78
For Treatment, including remedial coaching	481

No. of P.S.W. and S.W. Interviews	338
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No. of children admitted to Hostels for Maladjusted Children	2
No. of children discharged from Hostels for Maladjusted Children	7
No. of children in Hostels on 31.12.59.	...	...	...	...	...	5

Sources of Referral, Child Guidance Clinic cases, January 1st, 1959 to 31st December, 1959

School Medical Officers	19
General Practitioners	19
Probation Officers	5
Children's Officers	10
Hospitals and other Psychiatric Clinics	15
Court	3
Parents	1
									72

(g) **Physically Handicapped Pupils.** Pupils who by reason of disease or crippling defect cannot, without detriment to their health or educational development, be satisfactorily educated under the normal regime of ordinary schools.

Only 5 children need residential schooling, the remainder of the physically handicapped attend ordinary schools, the appropriate Department of the Avenue School, or require home teaching.

The report of Dr. A. Martin on the Physically Handicapped Department of the Avenue School reads:—

Excluding children in the special class for cerebral palsy, the number of physically handicapped pupils attending the Avenue School at the end of 1959 was 29. Of these more than two thirds were crippled by hereditary or congenital defects (i.e. defects determined at or before birth): cerebral palsy(7), congenital heart disease (5), congenital dislocation of hips (2), congenital deformity of limbs, congenital deformity of spine, congenital malformation of urogenital tract, fragilitas ossium, haemophilia and talipes equinovarus. Other causes of physical handicap were: paralytic poliomyelitis (3), amputation of leg, obesity, post T.B. meningitis, rheumatic heart disease and traumatic hemiplegia. With the decline of such post natal factors as osteomyelitis, rheumatic fever, tuberculosis and possibly poliomyelitis, as causes of physical handicaps the relative importance of ante natal influences is now attracting much research and it is hoped that these detailed investigations will help to discover why such defects occur and perhaps lead to measures for preventing them.

In the treatment of deformities physiotherapy and surgery are invaluable. Physiotherapy plays its important role on the school premises: seven children were attending the physiotherapist at the end of the year and it is likely that more will benefit now that a full time appointment has been made. Inadequately functioning muscles are constantly exercised and little used joints kept mobile ensuring as full a use as possible of whatever functions exist. Various orthopaedic aids and operations, selected at the appropriate time of growth and disability, offer that additional help in overcoming a particular dysfunction. Two pupils were admitted to hospital during the year for such treatment.

One of the aims of the Physically Handicapped Department is to enable each pupil to come to terms with his or her handicap so that as far as possible normal educational and social progress can be made and the eventual satisfactory placement in the ordinary school environment or in employment can be achieved. It is the individual understanding and constant cheerful encouragement by the teaching staff which makes such an aim feasible.

Special Class for Cerebral Palsy

A brief account of this new class at the Avenue School was given in last year's report.

At the end of this year there were 7 pupils in this unit, 5 of them being girls. In general the staff of the school are very pleased with the progress of these children and

they report especially the great improvement in their feeding habits and social adaptation. The feeling seems to be that an important function of the school is to help these children to help themselves: at home many of them had, not unnaturally, been over-protected and had lost initiative as a result. It is worth emphasising, I think, that the unit is by no means merely concerned with broaching formal educational skills. The aims include the evaluation of potential intelligence levels; social education; training in precision movement and locomotion; physiotherapy and speech training.

Mr. Squire, Consultant Orthopaedic Surgeon, visits the unit from time to time to advise on the physical aspects of care. These visits are particularly valuable.

Classification of Cerebral Palsy Cases

(1) According to Educational Potentialities						(2) According to Age		
							Boys	Girls
(a)	Pre-school	...	...	...	...	Under 5 yrs.	4	3
(b)	Ordinary school	...	...	...	...	5-10 yrs.	8	6
(c)	Avenue Special school	...	...	...	...	10-16 yrs.	9	5
(d)	Cerebral Palsy class at Avenue School	...	...	...	...
(e)	Residential schools	...	...	...	...
(f)	Formally ascertained as ineducable	...	...	...	...
(g)	Partially deaf unit	...	...	...	...
(h)	Home teaching	...	...	...	...

(h) **Pupils Suffering from Speech Defects.** Mrs. A. C. Elsbury, Senior Speech Therapist, reports:—272 patients attended the clinic during 1959—189 boys and 83 girls.

148 cases of dyslalia

14 cases of dyslalia due to hearing loss

16 cases of dyslalia due to low intelligence

25 cases of retarded speech development

45 cases of stammering

7 cases stammering plus dyslalia

8 cases of cerebral palsy

3 cases of cleft palate

3 cases of dysarthria

3 cases of disordered vocal resonance

94 discharged cured or greatly improved

8 discharged for non-attendance

7 left the district before treatment was completed

3 refused treatment

160 continued into 1960

Clinics were held at the Queen's Road, Whitley, Southcote and Tilehurst centres and at The Avenue, The Hill, Emmer Green, Grovelands, Southcote, St. Michael's, Ashmead, E.P. Collier and Geoffrey Field Schools. A certain amount of time was set aside for school and home visiting. Owing to the increasing numbers of children found to be in need of speech therapy the staff of the department has now been increased to two full-time and two part-time therapists.

It will be noticed that the defect which accounts for the greatest number of children attending the speech clinic is dyslalia. What is dyslalia? Its literal meaning is "difficulty in speaking," and the term embraces the many forms of defective articulation characterised by the substitution, distortion and omission of sounds. It is classified under three headings according to the degree of severity—simple, multiple and general dyslalia.

All sounds are in pairs, both sounds of the pair being articulated in the same manner, apart from the fact that one is voiced and the other is not. For example "p" is the voiceless equivalent of the voiced "b". Not always are both sounds in a pair found in the English language, as with "l", the voiceless counterpart of which is the Welsh "ll", as in "Llanelly." Simple dyslalia is the defective articulation of one sound or pair of sounds. Perhaps the most common example of this is a lisp in which "th" is substituted for "s", and the voiced "th" is substituted for "z." These two substitutions are used constantly. Multiple dyslalia is the defective articulation of several sounds or pairs of sounds, and general dyslalia is the term used to describe the defective articulation of numerous sounds. In the case of a general dyslalia speech is very often unintelligible—Harry Hemsley's impersonation of the child Horace, once so popular on variety shows, was an excellent example of this. The child with general dyslalia can nearly always produce correct sounds in isolation, but substitutes and varies his substitutions in conversation. It can be said, therefore, that the substitutions in simple and multiple dyslalia are fixed, but in general dyslalia they are fluid.

All children pass through a stage of "lalling," when learning to talk and this is a perfectly normal phase in the development of speech in infancy. The form of words is changed by substituting one sound for another and by omitting or eluding sounds. When these alterations persist after the normal age for adjustment, lalling becomes dyslalia. This age varies greatly with each child and is subject to many factors, but the average age for the full development of the speech pattern is approximately $3\frac{1}{2}$ -5 years.

The causes of dyslalia are many and varied and often the original cause is lost in the mists of speech development. Frequently several factors may be found, each of which could help to create or perpetuate defective sounds.

The causes may be divided into two groups—organic and functional. The defects of the majority of dyslalic children are functional in origin, although many parents, teachers, and doctors seem anxious to discover an organic cause—tongue-tie, a high, arched palate, faulty dentition or other similar factors. While not wishing to underestimate the importance of these conditions, I must point out that such organic irregularities are rarely the primary causes of dyslalia. Many children with normal speech possess these abnormalities and conversely, many children with defective articulation have absolutely normal speech organs. There is no doubt, however, that organic abnormalities are certainly a handicap to the achievement of normal pronunciation if there is defective speech present, but it is usually possible to teach compensatory methods of producing sounds to overcome this difficulty. For example, Paul, aged seven years, has a slight tongue tie and is unable to raise his tongue tip sufficiently to contact the ridge behind his top teeth for an "l" sound. He can, however, make an excellent "l" sound by placing the tip of his tongue against his teeth.

There are two important organic causes of dyslalia which must not be overlooked—deafness and mental deficiency. If there is any doubt as to the possible cause of a child's dyslalia, the speech therapist refers the patient for hearing or intelligence testing or both. The question of correct diagnosis is important in the direction of treatment.

Many of the functional causes of dyslalia originate from the home. The importance of parental influence on the development of normal speech is very considerable. Many parents make little effort to teach their children to talk or to provide them with adult standards of pronunciation. Often they think that "baby

talk " is attractive and, therefore, encourage the child to continue to talk in this way. I should stress here that " baby talk " is an important part of speech development and should be encouraged when a child is making his first efforts at speech. It is natural for a baby to repeat syllables such as "baba" and "gee-gee," and it can do far more harm than good to insist on too adult a standard of speech at an early age. Some over-anxious parents will correct too much, too often and too soon with the result that the child becomes negative to all correction and persists with his articulatory errors.

The age of onset of speech is an important consideration when dealing with a dyslalic child. As has been mentioned earlier, all children are dyslalic to a certain extent when learning to talk and obviously a child who did not begin to say his first real words until the age of three years, could not be expected to be as free of articulatory errors at five or six years as a child who started to talk at eighteen months. Some children who have a normal or even above average intelligence are slow in beginning to talk.

There are also psychological factors which can cause dyslalia. A feeling of insecurity can result in a child developing faulty speech simply as a means of drawing attention to himself. John, aged seven years, has a happy and secure home background, but has been lacking in confidence and a feeling of security since birth, when he very nearly died. He has always been over-dependent on his mother who has tried her best to remedy this with little success. He recently moved from the home where he had lived since he was born, and has since developed a multiple dyslalia. It seems that his sense of insecurity has been increased by his move to unfamiliar surroundings and he is trying to draw even more attention to himself with his defective speech.

Some dyslalic children who may have very acute hearing when tested, have a poor auditory memory span as the cause of their faulty speech. They find great difficulty in imitating sequences of sounds and in discriminating between one sound and another, in spite of the fact that there is no organic hearing loss.

These are some of the more common causes of defective articulation. It will be understood how difficult it is to isolate one particular cause, as the habit of defective speech usually originates at the beginning of speech development and continues until some effort is made to correct it.

It is impossible to give here a detailed description of the treatment of dyslalia, as there is so much detail involved but I shall attempt to outline the general principles. With the exception of psychological dyslalia, the treatment of articulatory disorders follows the same general plan. Firstly, the child must be helped to realise that he is making errors which must be eradicated. For this reason, children rarely commence treatment until after the age when the speech pattern should be fully developed, to avoid making them too speech conscious at too early an age. Very often the patient is not aware of his faults, as his immediate family can understand him and other people fail to comment on them due to embarrassment. This does not mean that the child is to be nagged and corrected continually, but he must be made aware of the fact that he is making incorrect sounds in order that he can help himself to rectify his mistakes. Next the cause of the defect, if still existent, must be eliminated or if they are no longer present their influence must be counteracted. The child must then be helped to recognise the correct ways of making sounds and to discriminate between those sounds and his own mistakes. This is made possible by intensive ear training, often done by means of play when dealing with young children.

The next important step is the teaching of the production of the necessary sounds at will. This, too, is often accomplished by play methods. A child is rarely able to produce a correct sound by imitation, but if asked to make a train noise—"ch, ch, ch" or a snake noise—"s s s"—will usually manage to do so at once. Once the dyslalic can produce a particular sound in isolation he has to learn to build it into his speech. This is done by keeping a practice book in which the speech therapist writes work to be

practised at home. The sound is first of all learned in nonsense syllables, as these have no previously formed incorrect associations in the child's mind, as would have words if practised immediately. After the child has mastered the syllables easily, he practises words containing his particular sounds and then the words are incorporated into sentences and rhymes. The dyslalic is then expected to be able to correct himself in conversation, with the aid, if necessary, of parents and teachers. Co-operation between the speech clinic and the home and school can be invaluable in the successful treatment of articulatory defects.

The treatment of dyslalia is essentially very slow. It is impossible to correct faulty speech habits of several years standing in several weeks. Naturally the exact methods of treatment and the rate of progress must vary with the individual child, but it is true to say that in the great majority of cases the dyslalia disappears completely, and in the few remaining instances (except in the case of a severely mentally handicapped child), speech therapy effects a great improvement.

(i) **Delicate Pupils.** Pupils who by reason of impaired physical condition need a change of environment, or cannot, without risk to their health or educational development, be educated under the normal regime of ordinary schools.

Only one child in this category is at a residential school, while another is on the waiting list for such.

Dr. I. F. Ralph reports on the delicate Department of the Avenue School as follows:—

Nowadays, as a result of steadily improving standards of nutrition, housing, health and social services in the community, the truly delicate child in need of the amenities of this department is almost a rarity. For several years the number of children in the Delicate Department has been decreasing and 1958 saw a further fall. At the end of the year there were 14 children on the books. Many suffer from additional physical handicaps and most are backward. The Department continues to provide these pupils not only with the individual teaching so necessary for children who are frequently absent from school, but also with closer medical supervision and nursing care than would be possible in an ordinary school. In several cases the resultant improvement in general health has been most striking and very satisfactory educational progress has been made.

The Avenue Special School and Home Teaching for Handicapped Pupils

The older part of the school now comprises eight classes for educationally sub-normal children, each with a maximum capacity of 20 pupils, making a total of 160 places for E.S.N. children. In the newly built extension there are three classes for physically handicapped and delicate children (mixed), each with a maximum capacity of 20 children, making 60 places in all. In addition, there is a cerebral palsy unit for the very bad spastic cases; the capacity of this has never been strictly defined but up till now it has not been considered desirable for more than eight children to be accommodated.

The advisability or otherwise of education in a special school is rather a controversial topic and no doubt much will depend on the relative merits of the schools in any particular area. In this department we have always had a high regard for the Avenue School and our feeling is that we would like to recommend more children for admission to the E.S.N. department if it were possible to do so. Unfortunately a waiting list still exists. The official Ministry of Education recommendation is that there should be one place in a special school for E.S.N. children per 100 of the school population, i.e. on a 1% basis. Our provision in Reading barely comes up to this standard and, of course, the increasing birthrate will show its effect here. My own feeling is that a better standard would be 1.5% places for E.S.N. children. There

are many children with an I.Q. of over 70 who are recommended for special education in an ordinary school, and my observations, for what they are worth, would lead me to have considerable reservations about this method of education. Nothing fails like failure and I feel that a large number of these children would be happier and better accommodated if they could be admitted to an extended Avenue School, even if only for a limited period.

The cerebral palsy unit is an excellent little unit but unfortunately it is not yet possible to admit really young children. I feel that each Cerebral palsy unit should have a nursery wing if children are to obtain the maximum benefit from the training given by the teacher and the physiotherapist. The basic difficulty was, of course, that enough money was not allowed by the Ministry of Education to provide the facilities which we would have liked to have provided. When this unit was first opened we did hope that by the age of 9 or 10 years children would have been either deemed ineducable or have been fit for transfer to the physically handicapped department. As the result of experience, I think our hopes were probably a bit optimistic, and it has not been possible to transfer the older children so easily. There is the obvious danger that the age range in one class would be too great.

Mr. G. Ross, M.A., Headmaster, reports:—

The extension of the E.S.N. Department of the school was completed by the admission of twenty boys and girls in April in addition to the normal intake to replace children leaving school or being transferred to other schools.

This department is now constituted on an eight class basis which permits of a finer age grouping and more appropriate training for the youngest children.

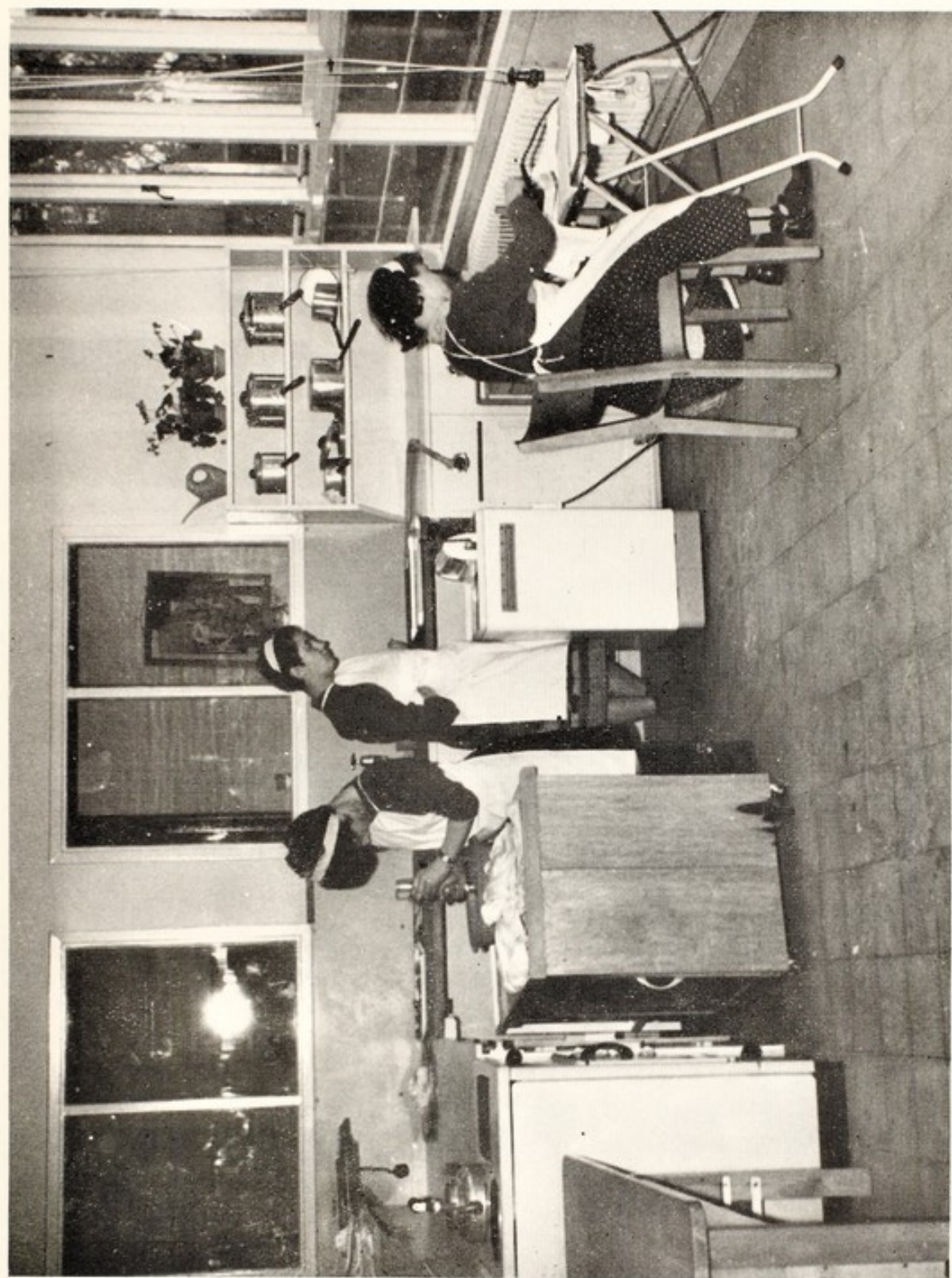
Although this increase involved bringing into use the two old wooden huts formerly making the delicate school, it is hoped that a complete re-building programme will shortly be undertaken.

The old school reached its 50th Anniversary in 1959, coinciding with the 50th Anniversary of the school health service. The history of special education service in Reading is the history in miniature of that service in England with Reading in the front with the most progressive authorities.

In the autumn of 1901 special classes were started in Oxford Road School. By the Spring of 1902 the special classes started their separate existence and in 1905 they were moved to Elm Park Wesleyan Hall and the craft rooms of Battle School were borrowed for practical instruction. Planning for a new school was accelerated by the unsatisfactory nature of these arrangements and in July 1909 Whitley Special School was opened at the top of Northumberland Avenue. In November of 1909 the "Cripple" Department started with twelve children and a year later the school had settled down with a roll of 43 retarded and 19 physically handicapped children. In June 1911 twelve delicate children were admitted to form a third department of the school.

Since the "open air" treatment of such children started in the Rhineland it was appropriate enough that in 1915 German prisoners of war helped to erect the wooden classrooms which accommodated these children until their moving to the new extension last year. Since these early days there have been many changes in both the number of the children on the roll of the school and the nature of the handicap which compelled their admission.

Increase in the population of Reading accounts for the comparatively steady increase in the roll of the E.S.N. department. Medical, social and economic factors, however, have all in varying degrees influenced admission to the delicate and physically handicapped departments, and in recent years there has been a tendency for the delicate children to remain in this department for progressively longer periods and the physically handicapped children who formerly spent most, if not all of their school years in the special school, to become fit for transfer to ordinary school in a much



AVENUE SCHOOL Domestic Science Room

shorter time. In addition many illnesses which often meant that a child so afflicted had to attend a special school are now so treated as to make such admission unnecessary and although survival from several formerly fatal illnesses has meant the influx of children recovering from such illnesses, there has been a diminution in the rolls of both departments. There has been, too, a lessening difference in the educational treatment of both groups of children. In September, therefore, the two types of children were combined to form three classes, a combination which gave a better age and ability grouping as well as facilitating the arrangements for practical instruction.

Thirty-one physically handicapped and fifteen delicate children form these three classes and the fourth group is confined to the special cases of severely handicapped spastic children.

Four boys and three girls with physical handicaps and two boys and one girl with delicate health, were admitted to the school during the year. One delicate boy left for employment and another boy returned to ordinary school. Three boys were temporarily transferred to hospital schools and a girl received home teaching during a lengthy period of inability to attend school. A boy whose physical and educational recovery was gratifyingly successful was sent for training in agriculture and he has now been placed on a farm.

A physically handicapped girl left for hospital treatment and a little boy receiving home teaching was added to the roll for part-time education.

There left from the educationally sub-normal department four boys and seven girls for employment; two boys went to residential school and another to the occupation centre, while thirty-two boys and fourteen girls were admitted to the school.

Once again this year was marked by a successful outing, on this occasion to Hengistbury Head, and His Worship the Mayor and Mayoress not only were our guests on Prize Day but joined us in our Christmas Service. Sports day and swimming gala were somewhat more restricted in scope than formerly but in open tests, thirty children were awarded certificates of competency from the Reading Schools Swimming Association. In addition a boy who has only one leg gained his first swimming certificate.

Home Teaching. Throughout the year twenty-eight children were taught at home or in hospital for varying periods of time. Five children mentioned in last year's report continued to be taught at home and especially perhaps in such cases of prolonged inability to attend school, is established the importance of home teaching in maintaining the physical and mental well-being of the child. On the other hand interruptions to school life by illnesses can have a serious effect on the child's progress and here, too, lessons in hospital or during convalescence at home help to modify the loss of schooling. Some details of such cases exemplify the work of the panel of teachers.

Case 1

A boy suffering from haemophilia who has had prolonged intermittent absences was so assisted in his studies as to deserve recommendation for continued academic work or training in accountancy or administration.

Case 2

A burning accident necessitated a prolonged absence of an eleven year old boy and during the depressing and difficult days of his treatment his courage and spirit were maintained by daily visits for lessons in class work and in craft and painting.

Case 3

Another boy of the same age also suffering from severe burns was kept occupied and cheerful while in hospital before transfer for specialist grafting treatment.

Case 4

A very lonely little ten year old boy, ill from diabetes, was stimulated to a better approach to his lessons before leaving for the Shaftesbury Home.

Case 5

A cheerful little nine year old whose recklessness led to a broken leg certainly appreciated mental activity during his enforced physical inactivity.

Case 6

Peter was a keen farmer who wanted to do everything his father did, but when he fell from a moving tractor he received severe injuries. While fit he blandly admitted his preference for the fields rather than the classroom, but while in bed he received a new stimulus to work and acquired a sound interest in reading to help him during his long convalescence.

Case 7

So too did a frightened little boy whose unresolved fracture necessitated several weeks of treatment.

Short time teaching. There was short time teaching in the wards at Battle Hospital and the Royal Berkshire Hospital for two little boys recovering from injuries in road accidents, two boys awaiting admission to special school, and two girls whose pleasant quick recovery made short their period of ward teaching. Different, however, was the case of a seven year old little girl suffering from Nephritis who has alternated between home and hospital for several months, and an older girl of thirteen years of age whose spinal jacket gave her the appearance of great discomfort. Not only did she attempt her lessons with enthusiasm but from her prone position she achieved, with her craft teacher, the making of a lovely pair of gloves. A younger girl suffering from a similar spinal condition has had her lessons all this year at home, in hospital, or at convalescent home. Later in the year teaching was given to two cases of children suffering from non-infectious attacks of pulmonary tuberculosis.

THE SCHOOL DENTAL SERVICE

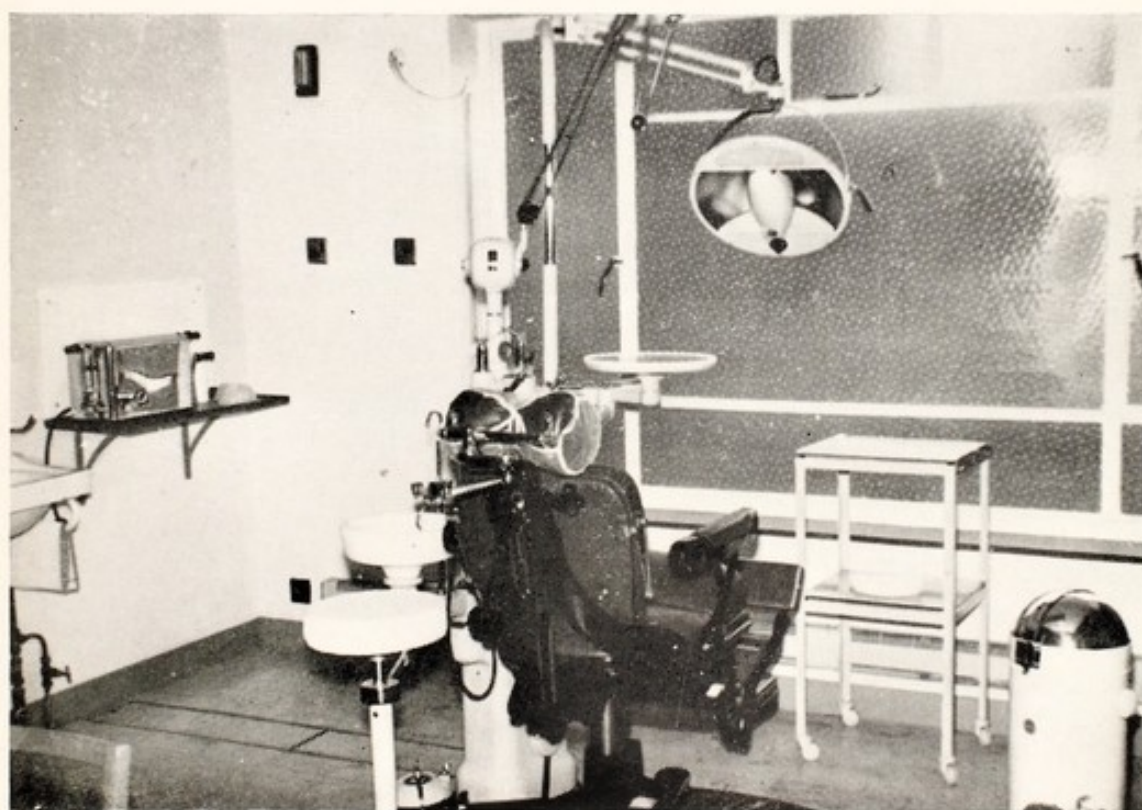
Mr. J. Campbell, L.D.S., R.C.S., reports:—

The staffing position, during the year, has not improved, there being only one full-time officer, namely myself, and one part-time, working ten sessions per week. A second part-time officer, working three sessions per week, left the service in January.

The new clinic at Tilehurst was officially opened on Friday, February 27th, but unfortunately, having no dental officer available, it could not be put into operation. In November, I decided to open the clinic for two sessions weekly, taking the sessions myself, working on the Tilehurst Schools. I am pleased to report that the response has been very good. The attendance for treatment has been 88.7% of the number of appointments made. It is most disappointing that we cannot secure the services of a full-time dental officer for this clinic, as we are receiving many requests from parents who previously refused treatment, that they may be allowed to change and attend the clinic with their children. This is also taking place at the main clinic, at Queen's Road.

On routine inspections we find approximately 56% of the children require treatment, 44% requiring no treatment. The approximate rate of acceptance is 47%.

A brief comparison of the figures, in the main table, with those of 1958, will give an idea of the position, at the present time.



TILEHURST DENTAL CLINIC

Routine inspections were made in thirty-five schools, showing an increase of 2,631 over 1958. Of the 6,327 children requiring treatment, 3,903 were girls and 3,424 boys and of the figure of 3,947 not requiring treatment, there were 1,924 girls and 2,023 boys. The twenty-two other patients, who were treated at Whitley Clinic, were not classified. Casuals, or specials, have dropped by 87.

Entrant infants inspected numbered 704 and of these 384 were found to require treatment.

As expected, fillings have increased by 1,469, the actual number of teeth conserved by 1,143.

Extractions have also shown an increase of 707, involving the loss of 297 permanent and 410 deciduous teeth.

Dentures and Orthodontic treatment are dealt with in the subsequent paragraphs.

Oral Hygiene. The attendances of children to this department, again, show an increase. 2,816 children made a total of 2,843 visits. The total figure of 2,816 is made up of 1,847 who required further treatment and 969 who were referred for clean and polish only.

Children from the Blue Coat School, Christ's Hospital and 17 patients from the Occupation Centre, also attended.

Dentures. The number of dentures supplied remains fairly constant, 27 in the current year, 3 less than the previous year's total. Repairs numbered 5.

Orthodontics. Numerous applications for this type of treatment, continue to come in, but the cases must be carefully selected where the most benefit to the patient can be achieved. As I have said before, many cases are purely a matter of appearance and cannot be undertaken under the present staffing conditions. Another point to be remembered is that these cases are very time consuming and would interfere with conservation work. A number of cases, not listed in Section 11 of the main table, are those where judicious extraction can relieve over-crowding.

At the present moment we have 32 current cases. Once again, the number of cases discontinued, for lack of co-operation is small as most parents are keen to have the work done and co-operate in every way.

Thirty-six appliances have been supplied and nineteen repaired.

The following lists the detail of treatment carried out:—

(1) Number of pupils inspected by the Authority's Dental Officers:—

(a)	At Periodic Inspections	...	...	...	...	10274	
(b)	As Specials	...	...	...	...	1016	
					Total (1)		11290
(2)	Number found to require treatment	...	...	...			6349
(3)	Number offered treatment	...	...	...	...		5055
(4)	Number actually treated	...	...	...	...		2999
(5)	Number of attendances for treatment	...	...	...			7778
(6)	Half-days devoted to:—Periodic Inspection	...	...	...	62		
	Treatment	...	...	...	824		
					Total (6)		886

(7)	Fillings: Permanent Teeth	...	...	...	...	4669	
	Temporary Teeth	...	...	...	...	433	
							Total (7) 5102
(8)	Number of teeth filled: Permanent Teeth	...	...	...	...	3955	
	Temporary Teeth	...	...	...	...	425	
							Total (8) 4380
(9)	Extractions: Permanent Teeth	...	...	...	...	954	
	Temporary Teeth	...	...	...	...	1868	
							Total (9) 2822
(10)	Adminstration of General Anaesthetics	...	...	...	...		820
(11)	Orthodontics: (a) Cases commenced during year	...	...	...	...		35
	(b) Cases carried forward from previous year						30
	(c) Cases completed during year	...	...	...	...		24
	(d) Cases discontinued during year	...	...	...	...		9
	(e) Pupils treated with appliances	...	...	...	...		34
	(f) Removable appliances	...	...	...	...		28
	(g) Fixed appliances	...	...	...	...		8
	(h) Total attendances	...	...	...	...		430
(12)	Number of pupils supplied with dentures	...	...	...	...		27
(13)	Other operations: Permanent Teeth	...	...	...	...	672	
	Temporary Teeth	...	...	...	...	775	
							Total (13) 1447

This table details the treatment given to children who have scholarships to non-council Schools. The list also includes the treatment of patients from the Occupation Centre:—

	No. Treated	No. Attendances	No. Extractions	No. Fillings	No. Anaesthetics	No. Discharged
Blue Coat School	3	13	3	12	1	3
Christ's Hospital	3	9	—	9	—	3
Occupation Centre	24	68	38	24	15	16

The above cases also attended the Oral Hygienist.

INFECTIOUS DISEASES

1. **Tuberculosis in Schoolchildren.** Only five children studying at maintained schools were notified as cases of pulmonary tuberculosis in 1959, compared with 12 in the previous year. All were primary infections and there was no necessity to carry out contact investigation at the schools attended by these children.

2. **B.C.G. Vaccination.** During the year 1,161 school children received B.C.G.

The results are shown below:—

B.C.G. VACCINATIONS—1959

Year of Birth	No. Selected	Acceptances	%	Absent	Skin Tested	Pos.	Neg.	Abs.	% Pos.	Received B.C.G.
1945	1412	1187	84.06	181	1006	94	826	86	10.2	826
1946	388	292	75.2	19	273	14	255	4	5.2	255

In addition, 80 children born in 1944 who had missed B.C.G. vaccination previously, for various reasons, were vaccinated.

As mentioned in last year's Report, we have been participating in a scheme under the directorship of Dr. K. Neville Irvine to assess the potency of batches of the British freeze-dried B.C.G. vaccine now in use. We have been using the Heaf method for tuberculin testing and this technique has been found to be very satisfactory.

It has been usual to refer children showing a strongly positive result at the initial tuberculin test for chest radiography and I think it is worth noting that 4 of the 5 cases of pulmonary tuberculosis in Reading schoolchildren mentioned in the previous section were discovered in this way.

3. **Ringworm of the Scalp.** Nine children of school age were treated for ringworm of the scalp; one of these was referred to hospital. In addition, 7 contacts were examined. The average absence from school of infected cases was six to eight weeks.

4. **Pediculosis.** The school nurses made 40,142 head inspections during the year and found evidence of pediculosis in 167 pupils. This incidence of infestation is less than one third of that found in 1958. Cleansing notices were issued in 18 cases.

5. **Other Infectious Diseases.** Details of notified cases are given in the final section of this report. Sonne dysentery was prevalent during the year and the number of notified cases undoubtedly considerably underestimates its true incidence amongst the school population.

DEATHS IN SCHOOLCHILDREN

Eleven Reading children of school age died during the year, six boys and five girls.

Three of the deaths were due to accidental drowning; two boys aged 9 and 11 years respectively and one girl of 10.

Measles was responsible for two deaths; a 5 year old boy died of pneumonia complicating the disease and a 5 year old girl of measles encephalitis.

Pneumonia complicating fibrocystic disease caused the deaths of two girls aged 6 and 7 years.

Two boys with congenital heart disease died of heart failure at the age of 11 and 14 years respectively.

A 5 year old boy died of meningitis due to a haemolytic streptococcus. A 5 year old girl died of the Stevens-Johnson syndrome.

SPECIAL CLINICS

1. **Minor Ailment Clinics.** Three hundred and eighty-six children received treatment for minor ailments. The main complaints were skin diseases, suspected fractures, bruises and eye conditions.

2. **Remedial Exercises.** Remedial exercises for skeletal defects such as poor posture and flat feet were supervised at Queen's Road and at Whitley Clinics during the year for 48 pupils; 30 girls and 18 boys.

3. **Ultra-Violet Light Therapy.** This was available during the year at Queen's Road Clinic and at Whitley Clinic. In future it will be available at Tilehurst Clinic also. The conditions for which this form of treatment is most commonly recommended include debility and catarrhal conditions.

22 boys	{	received an average of 90 minutes each
29 girls		

Children treated were in the 5-11 years age group.

4. **Chiropody Clinic.** Mrs M. L. Abraham reports:—

This report covers the first complete years' work and the children treated have been all ages—from Nursery School to those within the school leaving year. The total number of attendances was 181 (45 cases).

The greater number of cases attending the clinic were for verruca pedis, boys and girls seemed about equal in numbers, many around 11-13 years of age.

Nail Conditions. About 5 cases of ingrown or broken nails (Boys). On enquiry the history of football without protective foot wear (not at P.E.), or too short boots had been the cause.

Rashes. On the feet of three boys seemed attributable to recent use of stretch nylon socks. After treatment and return to wool mixture socks this condition cleared almost at once. In one case of athlete's foot there was a family history, but again there was recent change to nylon socks.

Deformities. Mainly girls with Hallux Valgus. In the older girls 13-15 years the cause seemed to be "Fashion" shoes. In others, both boys and girls, the deformity was of one or more toes, usually the 4th or 5th digits. Treatment is combined with advising special remedial exercises.

Callosities and Corns. A small number. Advice on shoe fitting seemed generally needed.

5. **Enuresis Alarm.** During the year an Electric Enuresis Alarm apparatus for the treatment of nocturnal enuresis has been lent to the parents of certain children with persistent nocturnal enuresis of long standing. Of five cases treated in this way during 1959, two can be regarded as cured, one appeared to besome what benefited and two were not helped by the apparatus.

HEALTH EDUCATION

Miss M. Webber, Superintendent Health Visitor/School Nurse reports:—

Teaching of Parentcraft in Schools. This has continued throughout the year. All secondary Modern Schools with the exception of one include these talks in their Housecraft syllabus. A very close link has been forged between the Health Visitors taking these classes and the teachers in the schools.

98 Classes have been given throughout the year.

Westwood Secondary Modern School: Pre-Nursing Course. As an experiment, commenced in January, the pupils who were taking the above course were given demonstrations in practical nursing at the Southcote Clinic. It was much appreciated by the girls and it was felt by the Headmistress of the school that much could be gained by these girls and also it gave them added interest during the course at school.

The course has now become part of their preparation for this pre-nursing course and the pupils attend each week throughout the three terms.

31 classes have been given during the year by one Health Visitor.

SCHOOL MEALS SERVICE

The following report has been received from Miss P. E. Hall, the School Meals Organiser:—

During the year 1959 the percentage of children taking dinners increased to 47.2% of those present, which is the highest percentage achieved up to the present time. The difference between the national average of Counties and County Boroughs and this Borough has been steadily reduced year by year. One most noticeable aspect has been that during the hot dry summer of 1959 the number of children taking meals was not reduced as usual, but showed a slight increase over the Spring Term.

Owing to certain increases in the price of butchers' meat and the method of calculation used by the Ministry of Education, it was found almost impossible to provide the usual quantity of meat on the plate, for the money allowed. In order to avoid reduction, more tinned meat has been served, which has been much enjoyed by the children. It may be remembered that potatoes were very expensive at times and, during those times, bread or rolls were served in addition to a small portion of potato. This also seems popular if not continued too long. Eggs were plentiful and cheap and most Supervisors made good use of them, to help give variety in the menus. Fruit was bottled in all kitchens as usual, although each fruit was not available for long, owing to the drought.

A new scullery was opened at Katesgrove Junior School in order to comply with the Hygiene Regulations; this has improved the dining facilities at the school considerably.

Westwood School was planned at a time when there was spare kitchen capacity in the Borough and was therefore planned originally for 350 meals to be prepared daily. Before the kitchen was completed, it was known that the demand for meals would probably be in the region of 500 per day, so that somehow equipment for 500 meals was fitted in. As can be imagined, this has made it an extremely difficult kitchen to run. It has now been possible to extend the kitchen area, which has been a considerable improvement. Plans were also approved to extend the dining room, the work being carried out during the Christmas holidays.

The One-Day Conference was held at Geoffrey Field School in April; one subject which the School Meals Staff ought to know something about was included in the programme for the first time—it was "Correct Methods of Lifting." The majority

of the staff have to lift heavy articles during the day, and it appears it is frequently done quite incorrectly. We were told that less stress and strain would be felt if it were always done in the way that was demonstrated.

Parents' Associations and other women's organisations continue to take an interest in, and wish to hear, more about the School Meals Service; as a rule, they are surprised to hear how the meals are planned to an exact nutritional pattern. This often answers criticism about the heavy type of meals provided. The standard which was laid down in 1955 is that 650-1,000 calories should be provided, depending on the age and sex of the children. The meal should supply an average of 20 grams of protein of animal origin and 25-30 grams fat.

School dinner arrangements have gradually become much more individualistic, and each school having its own particular method and atmosphere, it is delightful to see a very mediocre scheme change into one which is really satisfactory and attractive. Once again, the tone of the school and the attitude of the teachers is reflected in the dinner arrangements, and I should like to thank all the teachers who have helped in this way.

PHYSICAL EDUCATION

The Organisers of Physical Education report:—

In previous reports we have mentioned and compared the progress made in physical education in the primary and secondary schools. That comparison has shown a more rapid development in the former where the pace set by the wider use of modern equipment and methods has overrun, and sometimes outstripped, the slower progress of the secondary departments, especially at the transitional period. The gap has been narrowing, however, during the past few years. By bringing the teachers together for discussion and instruction and by eliminating the segregation of departments for training courses, it is pleasing to report now that difficulties experienced in physical education on transferring from primary to secondary education are exceptional.

This co-operation and understanding between colleagues is reflected on the success of their work. They have been helped by our policy of introducing new apparatus of a similar character into both types of schools and by modifying the equipment already held in stock. During the year work was completed to modernise the gymnasium at Caversham Secondary School and indoor climbing apparatus was installed at Geoffrey Field Junior School, E. P. Collier Primary School and The Avenue School. In addition, out-door frames were constructed at several nursery and infant schools. This expenditure of money and effort has helped and stimulated both teachers and pupils to maintain the high standard of work in Reading. Further, these improvements may help to attract specialist teachers to Reading to fill the perennial vacancies in the staff.

This development, however, has emphasised the lack of storage rooms especially in our older schools. A start has been made to overcome this difficulty by providing suitable apparatus stores at Caversham Secondary School and Caversham Primary School while plans are in hand for similar facilities at Grovelands School and The Manor School.

Playing Fields. Ground-staff problems have been serious throughout the year. Sickness and resignations have created (and are creating) difficulties not easily overcome thus throwing a greater burden of work on the remaining groundsmen. All credit is due, therefore, to the Supervisor and his staff for their efforts in maintaining the high standards of our fields.

Tennis courts have been completed at Kendrick School and the long-awaited courts at The Grove are now under construction. These courts will be of great value in our work for schools and clubs. The playing field at Hugh Faringdon R. C. School

was brought into use during the year and the general appearance of this area marked it as one of the better fields taken over by the Authority. Work is now in progress to extend the playing field at Ashmead School and satisfactory progress is being made prepare the extensive areas surrounding the buildings at Southlands. It will be necessary to provide additional staff in Spring 1960 to cope with this development.

Future plans for playing fields might readily include the preparation of the site St. Annes' R. C. School and also the ground earmarked for use by Grovelands.

We are most grateful for use of the private recreation grounds at Brock Barracks, Huntley & Palmers, Pulsometer and Reading University.

Swimming. A total of 44,000 attendances at public baths was recorded during the year, a high figure considering that Arthur Hill Bath was closed for several months during the winter. In addition, many children from Westwood School enjoyed the facilities for swimming at Queen Annes' School. We are grateful to the Head Mistress for her willing co-operation.

The use of Coley Baths for mixed classes during school hours proved to be a successful experiment and helped to meet the growing demand for swimming opportunities.

Great progress has been made during the year to provide a learners' swimming bath at Ashmead School and all concerned are to be congratulated on their enthusiasm. A similar indoor bath is contemplated for Geoffrey Field Junior School, and an outdoor bath for Southcote School is being considered. Here, again, the efforts of the staff, parents and pupils to raise money for such projects at these schools are deserving of the highest praise.

The appointment of the Swimming Instructor at the beginning of the year gave stimulus to this activity. His co-operation with the teachers concerned, both in schools and in the Swimming Association, has been very satisfactory. Interest and keenness are increasing rapidly and the demands for swimming facilities have outgrown the provisions of the existing baths in Reading.

Courses and Visits. Individual teachers were encouraged to attend vacation courses, groups of teachers visited schools in other areas, exchange visits between primary and secondary schools in the town were arranged and training courses were conducted for netball, hockey, rounders, skittleball, shinty, swimming, association and rugby football and basic movement training.

In conclusion the organisers wish to thank everyone who has assisted them in their work throughout the year.

ROAD ACCIDENTS

We are indebted to Mr. A. Iveson, the Chief Constable, for the information on which the following remarks are based.

During the year there was a decrease of 28 casualties compared with those of the previous year. It is usual for boys to outnumber girl casualties, and in the year 1959 it will be seen that the proportion is approximately 3 : 1. Again child cyclist accidents exceed those in the "pedestrian" group, stressing the added danger to which the cyclist is exposed and the need for continued positive instruction in the art of safe cycling.

*Analysis of Road Accidents for the year 1959,
involving Children of School Age.*

Month	Boys	Girls	Cy- clists	Pedest- rians	Pass- engers	Injury			Total
						Slight	Serious	Fatal	
January	2	1	1	1	1	3	—	—	3
February	3	—	1	1	1	3	—	—	3
March	8	2	7	3	—	9	1	—	10
April	5	2	2	5	—	5	2	—	7
May	6	1	4	3	—	7	—	—	7
June	11	2	8	5	—	10	3	—	13
July	6	1	5	—	2	6	1	—	7
August	3	4	2	3	2	6	1	—	7
September	2	3	3	2	—	4	1	—	5
October	10	3	6	7	—	11	2	—	13
November	1	2	1	2	—	3	—	—	3
December	9	2	4	7	—	7	4	—	11
Totals	66	23	44	39	6	74	15	—	89

SPECIAL INVESTIGATIONS

(1) **Colour Vision in School Children.** Dr. I. F. Ralph reports:—

Colour Vision is tested with Ishihara plates at the Routine Medical Inspection of Children in the 11-12 years age group. Children who fail this test are invited to attend the School Clinic for a lantern test, which enables a more reliable assessment of their colour vision to be made. At the end of November an Edridge Green Colour Perception Lantern was installed. This is more comprehensive than the Giles Archer lantern formerly used. Thirty-three children have been tested with the new lantern and it has been possible to reassure nine of these that their colour vision is, after all, normal. As far as possible, children with defective colour vision are advised regarding future employment, but the failure of most industries to specify colour vision standards often makes it very difficult to give definite advice.

(2) **Investigation of the Incidence of certain Conditions amongst School-children.**

To supplement the information recorded in the medical records during the routine examination of schoolchildren it has been decided to keep a special register of all children suffering from each of the four conditions, Asthma, Epilepsy, Heart Abnormalities and Obesity. As this scheme was not started until March 1959 it is unlikely that the figures given are fully comprehensive.

Asthma. In all 114 children were noted to suffer from asthma. One of these is at a residential school and two attend the Avenue School. The remainder attend ordinary schools; the attacks of asthma were noted to be very mild or infrequent in many of these.

Epilepsy. Details of our findings have been given in the section of this report dealing with Handicapped Children.

Heart Conditions. Thirty-five children were noted to have some abnormality of the heart. Two attend the Avenue School, two others receive Home Teaching; the remainder are not incapacitated to any serious extent and they attend ordinary schools.

Analysis of the diagnoses shows that 9 have various forms of congenital heart disease, 8 have rheumatic heart disease and the others have systolic murmurs or slight abnormalities of pulse rhythm which are probably not significant of disease but require observation.

Obesity. There were 80 children in ordinary schools who were, in the opinion of the school medical officers, so overweight as to require special observation and treatment. In addition 3 obese pupils attend the Avenue School and one receives Home Teaching.

STATISTICAL DATA

PART I

Medical Inspection of pupils attending maintained and assisted Primary and Secondary Schools (including Nursery and Special Schools).

(A) Periodic Medical Inspections

Age Groups Inspected (By year of birth)	No. of Pupils Inspected	Physical Condition of Pupils Inspected			
		SATISFACTORY		UNSATISFACTORY	
		No.	% of Col. 2	No.	% of Col. 2
(1)	(2)	(3)	(4)	(5)	(6)
1955 and later	302	298	98.7%	4	1.3%
1954	794	793	99.9%	1	.1%
1953	776	774	99.75%	2	.25%
1952	133	132	99.25%	1	.75%
1951	498	498	100%	—	—
1950	92	92	100%	—	—
1949	106	105	99.06%	1	.94%
1948	307	305	99.35%	2	.65%
1947	1,260	1,260	100%	—	—
1946	243	243	100%	—	—
1945	457	457	100%	—	—
1944 and earlier	897	896	99.9%	1	.1%
Total	5,865	5,853	99.8%	12	.2%

(B) Pupils found to require treatment at Periodic Medical Inspections

Age Groups Inspected (By year of birth)	For defective vision (excluding squint)	For any of the other conditions recorded in Part II	Total individual pupils
1955 and later	2	32	31
1954	28	97	118
1953	23	101	114
1952	3	11	13
1951	20	40	56
1950	5	15	19
1949	7	16	19
1948	35	21	56
1947	64	104	168
1946	19	26	40
1945	36	44	74
1944 and earlier	82	75	147
Total	324	582	853

(C) Other Inspections

Number of Special Inspections	...	...	...	759
Number of Re-inspections	...	...	...	1,740
			Total	2,499

(D) Infestation with Vermin

(a)	Total number of individual examinations of pupils in schools by school nurses or other authorised persons	...	...	...	40,142
(b)	Total number of individual pupils found to be infested	...	...		167
(c)	Number of individual pupils in respect of whom cleansing notices were issued (Section 54 (2) Education Act, 1944)	...	...	...	18
(d)	Number of individual pupils in respect of whom cleansing orders were issued (Section 54 (3) Education Act, 1944)	...	...	...	—

PART II

Defects found by Medical Inspection during the year.

(A) Periodic Inspections

Defect or Disease	PERIODIC INSPECTIONS							
	Entrants		Leavers		Others		Total	
	(T)	(O)	(T)	(O)	(T)	(O)	(T)	(O)
Skin	14	16	37	13	46	39	97	68
Eyes— <i>a.</i> Vision	56	59	118	35	150	78	324	172
<i>b.</i> Squint	18	11	5	5	24	25	47	41
<i>c.</i> Other	7	3	1	15	6	8	14	26
Ears— <i>a.</i> Hearing	13	44	2	17	20	26	35	87
<i>b.</i> Otitis Media	11	27	1	15	10	18	22	60
<i>c.</i> Other	2	6	—	6	8	10	10	22
Nose and Throat	56	96	6	19	35	103	97	218
Speech... ..	19	20	—	1	15	13	34	34
Lymphatic Glands	5	34	—	2	—	22	5	58
Heart	—	20	2	15	1	25	3	60
Lungs	7	42	3	13	13	51	23	106
Developmental— <i>a.</i> Hernia... ..	2	5	1	—	3	4	6	9
<i>b.</i> Other	4	14	2	7	13	29	19	50
Orthopaedic— <i>a.</i> Posture	5	4	13	4	27	18	45	26
<i>b.</i> Feet	20	20	14	11	40	24	74	55
<i>c.</i> Other	10	30	13	30	26	36	49	96
Nervous System— <i>a.</i> Epilepsy	—	3	1	—	1	5	2	8
<i>b.</i> Other... ..	1	3	2	3	3	11	6	17
Psychological— <i>a.</i> Development	—	15	—	2	—	39	—	56
<i>b.</i> Stability	3	22	—	3	4	29	7	54
Abdomen	—	5	—	—	3	7	3	12
Other	4	4	1	—	2	7	7	11

(T)=Treatment

(O)=Observation

(B) Special Inspections

Defect or Disease	SPECIAL INSPECTIONS	
	Pupils requiring Treatment	Pupils requiring Observation
Skin	173	—
Eyes— <i>a.</i> Vision	17	2
<i>b.</i> Squint	4	1
<i>c.</i> Other	27	1
Ears— <i>a.</i> Hearing	4	3
<i>b.</i> Otitis Media	9	3
<i>c.</i> Other	26	1
Nose and Throat	19	14
Speech	5	4
Lymphatic Glands	1	3
Heart	1	6
Lungs	3	2
Developmental— <i>a.</i> Hernia... ..	—	3
<i>b.</i> Other	1	4
Orthopaedic— <i>a.</i> Posture	1	—
<i>b.</i> Feet	2	1
<i>c.</i> Other	18	15
Nervous System— <i>a.</i> Epilepsy	—	4
<i>b.</i> Other	—	2
Psychological— <i>a.</i> Development	7	11
<i>b.</i> Stability	1	7
Abdomen	12	2
Other	395	3

PART III

Treatment of pupils attending maintained and assisted Primary and Secondary Schools (including Nursery and Special Schools)

(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	80
Errors of refraction (including squint)	377
Total	457
Number of pupils for whom spectacles were prescribed ...	385

(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	25
(b) for adenoids and chronic tonsillitis	206
(c) for other nose and throat conditions	15
Received other forms of treatment	3
Total	249
Total number of pupils in schools who are known to have been provided with hearing aids:—	
(a) In 1959	6
(b) In previous years	42

(C) Orthopaedic and Postural Defects

	Number of cases known to have been treated
(a) Pupils treated at clinics or out-patients departments ...	55
(b) Pupils treated at school for postural defects	—
Total	55

(D) Diseases of the Skin

	Number of cases known to have been treated
Ringworm—(a) Scalp	9
(b) Body	4
Scabies	4
Impetigo	17
Other skin diseases	94
Total	128

(E) Child Guidance Treatment

	Number of cases known to have been treated
Pupils treated at Child Guidance Clinics	175

(F) Speech Therapy

	Number of cases known to have been treated
Pupils treated by speech therapists	272

(G) Other Treatment Given

	Number of cases known to have been treated
(a) Pupils with minor ailments	386
(b) Pupils who received convalescent treatment under School Health Service arrangements	6
(c) Pupils who received B.C.G. vaccination	1,161
(d) Pupils who received U.V.L. therapy	51
Total	1,604

Cases of Infectious Disease in School and Pre-School Children for the year 1959

Disease	At All Ages	Under 1 year	1 and under 3 years	3 and under 5 years	5 and under 10 years	10 and under 15 years
Scarlet Fever... ..	112	1	5	38	56	12
Whooping Cough	68	8	13	16	27	4
Measles	2,003	73	445	584	856	45
Acute Pneumonia (Primary or Influenzal) ...	19	1	4	5	7	2
Acute Poliomyelitis (Paralytic)	-	-	-	-	-	-
Acute Poliomyelitis (Non-Paralytic)	1	1	-	-	-	-
Diphtheria	-	-	-	-	-	-
Enteric or Typhoid Fever (excluding Paratyphoid) ...	-	-	-	-	-	-
Food Poisoning	-	-	-	-	-	-
Erysipelas	-	-	-	-	-	-
Dysentery	30	1	5	4	13	7
Meningococcal Infection	1	1	-	-	-	-
Acute Encephelitis (Infective)	-	-	-	-	-	-
Acute Encephelitis (Post-Infectious)	1	-	-	-	1	-
	2,235	86	472	647	960	70

