[Report 1965] / School Medical Officer of Health, Salop / Shropshire County Council.

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SHROPSHIRE EDUCATION COMMITTEE

School Health Service

REPORT

OF THE

Principal School Medical Officer

1965

COUNTY HEALTH DEPARTMENT, SHIREHALL, SHREWSBURY
JUNE, 1966

INDEX

To The Chairman and Members of the Shropshire Education Committee

MR. CHAIRMAN, LADIES AND GENTLEMEN,

I have the honour to present the Annual Report of the Principal School Medical Officer for the year 1965.

Local Education Authorities can provide for every child in their schools, irrespective of social class, creed or denomination, race or colour, a careful **Routine Medical Examination** at three critical points in his school career. This results in complete screening of the whole school population, and the value of this system lies in the fact that with conscientious field work and good supervision and administration, it should be virtually impossible for any child's defect to escape unnoticed. After thirty five years School Medical work I remain as unimpressed in 1966 as in 1931 by arguments that "magic spotting.' or "sampling by intuition" can replace such routine work.

Recently "mass screening" procedures have been advocated for whole populations, to uncover what has been picturesquely described as the "clinical iceberg"—a lot of people with undiagnosed ills.

This latter is a proposition very different from Routine School Medical Inspection. **Mass screening** of adult populations pre-supposes available adequate resources of time, staff and money. If we could compel 100% of the population to submit themselves for examination, instead of the 6% or so health-minded and mostly healthly people who came forward in one of the earliest and best documented voluntary schemes of this kind, there would be a better case.

The national Education System makes 100% screening of early age groups practicable and gets the citizen off to a good start.

If we are told "Family doctors already know about the defects you find," the simple exercise described on p. 7, does not suggest that this is true. Unless the family doctor has the time and enthusiasm to screen systematically all the children on his list—a departure which might conceivably operate one day—it seems he may know of about half the defects detected in school. In 1965, cases of **Verruca** discovered numbered 87, of which 51 were not diagnosed. Of 40 cases of **Athlete's Foot,** 33 were not diagnosed. Recent visits to three schools discovered that out of 147 pupils with Verruca or Athlete's Foot, 125 were not under treatment. Indeed these latter conditions are often neglected by the victims themselves. Their detection and treatment by County Council Chiropodists would release sessions for less obvious medical disabilities, and might well be tried if the family doctors were willing.

Shoes that are too narrow cramp and cripple toes.

The incidence of **lousiness** increased from 3.0 to 3.4% which seems quite unwarranted and neither figure defensible. The ceremonial of Informal Cleansing Notices followed by Formal Cleansing Orders enjoined by Regulation is already over-elaborate and over-indulgent, but can be used to cure the condition by the Local Education Authority's officers doing the work. If we want the incidence reduced, the deliberate prosecution of persistent offenders when necessary has proved to have a most salutary effect.

The **Katharine Elliot School** has been operating in its new premises for nearly two years and its interesting work on behalf of Handicapped Pupils is described on p. 17.

Of late years emphasis has properly been laid on the value of domiciliary visiting of the homes of **Handicapped Children.** Home circumstances discovered by the visiting worker help the latter to understand the problems of the child better, and his adaptation to the circumstances which will still influence him most. So more time is being devoted to the visiting of the homes of Handicapped Children. To take advantage of all the agencies which are concerned in effecting a good end-result for the Council's educational efforts, an ad hoc after-care committee meet periodically to plan and supervise the post-graduate launching of the handicapped pupil into the more competitive and less protected world of adult life. The contributions of the many agencies concerned and referred to on p. 19. are intended to ensure as happy an outcome as possible, and have in Shropshire anticipated measures now being enjoined on the whole Country by the Department of Education and Science as necessary and desirable. Shropshire have indeed and for many years under the wise guidance of their Education Committee and their Chairman Sir Offley Wakeman and their Chief Officer Mr. Martin Wilson, provided for Handicapped Children a far reaching and comprehensive service which can stand comparison with any other Local Education Authority.

In the Report of the **Senior Dental Officer,** Mr. Clarke's contribution is characteristically clear and encouraging. Though he has problems of insufficient staff, he has secured for the Shropshire School Dental Service a favourable reputation both centrally and locally. As the Minister's report and the successes at local shows attest, his own enthusiasm and hard work help the health of our school children substantially.

In his capacity of **Senior Speech Therapist,** Mr. Paulett describes the good work done by himself and his too-few assistants. His allusions to the Katharine Elliot School lead us on naturally to the highly technical work he affords us in Audiology, and his account of this subject on pp. 26—31, is a model of clear exposition.

Implicit in his opening paragraphs is the familiar problem of trying to do justice to everything with only limited resources, not only of money, but of staff available. Without Training Schools or Universities and with the bright lights of cities some distance away, and despite the charms of Shropshire, young and enthusiastic staff seldom come forward or stay long without additional reason. Those who so persistantly advocate immediate and free-for-all schemes for universal screening procedures for all the population do not tell us how nor whence we are to attract to Shropshire more than our share from the limited numbers graduating in medical and nursing and other special fields, and of the money made available by the Treasury for all the Health Services. In Health Visiting and School Work the present deliberately selective care of the feckless few would suffer were all the apparently healthy to be pursued.

Practically anything can be accomplished—at a price—and the price of some of these 'new deals' can and does cause abandonment of more conventional and custom-tried and valuable work.

Audiology Tests for young children merit priority over other claims, because ground lost educationally in earliest years may never be recovered, and severe educational handicap is an unfair addition to physical deafness with its so limiting effects.

The account and results tabulated of **Infant Hearing Tests** illustrate the exacting and time consuming work necessarily needed to reach clear conclusions. Because we can't do everything, and because of the loss to the Service during 1965 of specially trained staff, routine 'sweep frequency' hearing tests for school entrants were only one-fifth of last year's totals, but a whole-time audiometrician has now been added to the Establishment and has commenced work. Severe deafness of both ears in 76, and 800 cases of moderate deafness in 2,000 children **referred** (not of course out of **any** 2,000 children chosen haphazardly) show how real the problems are.

It will be noted that 47 children were referred to our Medical Audiology Clinics by the Aural Surgeon himself. We are proud of our association with this helpful Consultant ; we lent him an Audiometer lately while his was being repaired, exemplifying integration in practice. Mr. Paulett rightly stresses the joint approach and "team recommendations" as being the essence of this work.

In his concluding paragraph on **Audiology** on p. 31, Mr. Paulett records some serious thought, on the one hand retrospective research to see how much good all this work effects and on the other hand a reiteration of the plea that 'communication' is everything in Education and in life itself.

Again there follows naturally the report by Miss Green the Teacher of the Deaf, from whose pen, too, we expect and obtain imagination and good philosophical reasoning. Some of her writing in this year's report gives to the uninitiated more insight and a better appreciation of the needs of the deaf child. She deserves congratulations for her humanitarian expositions of subjects so technical that they would be little understood by most of us if it were not for the clarity of explanation in which her yearly contributions seem to grow.

In the field of **Child Guidance,** the appointment by the Birmingham Regional Hospital Board to Shrewsbury of a Consultant Psychiatrist for Children's Psychiatric work was very welcome in the Summer of 1965. Dr. Benady is seconded for seven sessions to lead the Council's Child Guidance team, to whose good work he pays tribute on p. 35. The prospects in this field look brighter, one hopes, than for many years. One of the most urgent needs to help forward Dr. Benady's forward-looking plans seems to me to be the recruitment of 2 or 3 Psychiatric Social Workers. Like most medical auxiliaries, the numbers of these are few relative to requirements, and, like other young people, they seem to prefer the climate of Teaching Schools and other attractions of London. Thought should be given to the need and to possible ways to attract some to Shropshire, where the standard of children's work offers excellent prospects for good experience and work in surroundings salubrious psychologically no less than materially.

The Council have always given their Health Department's **Immunisation** programme every encouragement, and very good and painstaking efforts have produced good acceptance rates and relative freedom from Infectious Disease. No doubt there may be some changes of procedure if the new charter for Practitioners requires this, but these will not, it is hoped, prove any handicap to maintaining records of a high immunisation state in Salop children.

Health Education is faithfully dealt with on p. 39, by Mr. Harris, and again much that is portended recently in Government circles about the need for **Sex Education of young people** is already probably as far ahead in Shropshire as in most places. Great thanks are due to Mrs. Owen whose able and devoted work is so acceptable to the young people and their teachers.

It is probably worth recording the belief of my medical colleagues and myself that accredited Council's doctors should, for a variety of reasons, themselves play some substantial part in this work. Without doubt sex problems of young people have strong medical connotations. A constant worry to our Governments is the increase in Venereal Disease among 'beginners.' This stems from promiscuity, and the latter from abnegation of moral standards implicit in any civilised culture. It is the most natural thing in the world for the young to want to, and ask why they can't, throw these conventions overboard. They ask for advice on these very subjects more than for anything else, and we must give it to them with candour. When I asked a married woman doctor a few years ago for her views about the much advertised 'intercourse before marriage,' she said quite seriously "Let us think, you and I, of the arguments for intercourse before marriage, and what we can say in its favour." We sat in silence for some minutes . . . apparently unable to produce one valid argument, and probably reviewing the many pains and tears and tragedies we

had encountered among our young patients over our two medical lifetimes. The Health Committee and Council in December 1964 gave me categorical directives on the need for teaching moral conventions and against any suggestion of conniving at less ; further experience has made me very grateful to them, for the blandishments of the iconoclasts are all too attractive to the willing young, and it only needs one advocate of easy standards to undo the work of years: often to the unhappiness or ruin of the young listener. So, as a Head Teacher wrote to me this morning as I draft this "I have a feeling that this particular part of the work should be done by a doctor—the right doctor !"

That having been said, another important reason why the Principal School Medical Officer should himself take an active part is that he is the advisor to the Council, and their link with teachers and pupils on School Health matters, and he should be learning all the time and directly from the latter what they are asking and thinking. Such limited amount of this work as I contrive to do myself keeps impressing on me how necessary it is, in taking responsibility for such work, to keep learning from the young people what they think themselves.

Childhood has an initial bias towards chastity, all too soon to be violently assailed at every point. A University Student wrote to me from her Hall of Residence, where thay had been reviewing some of our material, with their criticism that "It did not present enough of a strong case against it (i.e. sexual experiment) because even if it is (addressed) to a reasonably mature audience *they would basically all prefer to be told not to, and given some good reasons.*" More than ever I am impressed by the need to keep the young very frankly and candidly and fully informed about "the other side of the picture" to counteract the blatant advertising and advocacy of sexual licence from so many sources—enough to puzzle our Bishops ! It is from the young audiences that the Principal School Medical Officer, who is responsible, must learn, and he himself must keep in touch with them. This may be the more neccessary if he is elderly, which they seem generously inclined to discount if he is a doctor.

Many Psychiatrists and workers in the education side of this field recoil from 'teaching morals' and say they ought to be wholly 'non-directive.' Surely there is some muddled thinking behind this reluctance ?

An eminent Psychiatrist told a London audience of doctors that we should not be interested to apportion praise or blame, and that people could enjoy equally good mental health whether they were moral, amoral or immoral—but he seemed obviously uncomfortable and lacked conviction. Long afterwards, I realised he was an Analyst and was only restating an attitude which might be appropriate for an Analyst towards the patient on his couch. In an interesting passage in one of his written works, he explained at some length that if an Analyst condoned immorality, the patient's confidence in the Psychiatrist would be undermined because the patient would know he was wrong.

When a Health Department purveys information to audiences of adolescents who ask for it, the case is far different. We are neither Analysts nor Psychiatrists, but are setting out, with the audience, to discover whether we can advise them from long medical experience what may be the best answers to the categorical questions they keep asking of us.

Of these questions, the currently most popular concern **Venereal Disease, Contraception** and **Abortion.**

When the Venereologists told the Council of the British Medical Association in December, 1960, of their great concern about the increased number of young people who were contracting **Venereal Diseases** while still in their teens, there was immediately set up a special and widely-based Committee who in January, 1964, presented their lengthy report on "Venereal Disease and Young People," with which, they said, "moral factors are inextricably involved."

The Report and the doctors found it impossible to leave morals out of account. They drew attention to a Registrar-General's table demonstrating that two out of three babies born to girls under 20 years of age were conceived out of wedlock, and that the total number of such births had doubled between 1948 and 1961. The whole report was a strong recommendation to chastity.

One Psychiatrist told them : "There is absolutely no body of responsible opinion within the Psychiatric branch of the medical profession which subscribes to the thesis that discipline in sex is harmful to the mental equilibrium or productive of neurosis in itself", and another said, "The views of the Psychiatrists whom I know are that the disadvantages of promiscuity greatly outweigh any possible advantages. This is apart from any moral code. Psychiatrists would not advise people to indulge in pre-marital intercourse."

An excellent précis of this long Report is published by the British Medical Association as a 'Family Doctor' Booklet*, which provides, in language easily understood, the answers to all the related questions.

During the week that I am writing this in May 1966, family doctors at a local meeting have been expressing their great concern at the illegitimacy rate in their young patients, and their horror at the idea that the teaching of **Contraception** should be undertaken to relieve this. These practical and experienced doctors seemed profoundly shocked at such cynicism. Another woman doctor wrote in February 1966 "Do not let us deceive ourselves. If we advocate contraceptive facilities for unmarried girls we are not only condoning, we are encouraging 'loose living,' and the results will be more—not fewer— sad, unwanted children. Universal contraception is not the answer to illegitimate babies."

Illegal **Abortions** were estimated only a few years ago to number 50,000, but to-day are believed to number 100,000 to 200,000 annually. Even of legalised Abortions it is the doctors who are the most outspoken in condemnation. At a recent meeting of Gynaecologists speaker after speaker stressed the dangers of this operation, even in the most favourable conditions. Are doctors to spend their time and skill in a manner which most of them deplore and for which they were never intended ? The latest Reports from the Ministry of Health in January 1966, show that Abortion is now the commonest cause of Maternal Death. Psychological damage to the mother is probably universal, and often tremendous.

The 'facts of life' are by no means limited to physical biology. We can and indeed we must stick to facts, but our medical experience affords us no lack of these. Biology without morals is irrelevant to human behaviour and can do much harm, even if some Psychiatrists limit "morals" to no more than the "mores" of racial culture.

Mrs. Owen is a near-ideal exponent, but the Principal School Medical Officer, who is constantly in touch with national medical facts and thoughts, must not, I feel, "leave it all to teachers" by a long way. Unhappiness, conscience, guilt and the prices paid for self-indulgence—so well known to doctors in particular—are the most important 'facts of life' of all.

* "V.D. The Facts", B.M.A. House, Tavistock Square., W.C.1., 1/-, or substantially less for quantities from the Health Department, Shirehall, Shrewsbury.

When I came to Shropshire, I was fortunate in finding in the County Health Department an admirable staff, most of whom, I am glad to say, are still with us. Dr. Crowley, who does by far the most of our School Health work, has greatly enlarged our horizons, and all are engaged in ever increasing enterprises to help the Health of the School Child.

Our associations with the Education Department are happy, and successive Chairmen and members of the Education (Welfare) Sub-Committee have given us constant encouragement and support. To all of these, and to our School Health Staff in particular for their good work and support and comradeship, I would like to record, with my best wishes for their future, how much I have enjoyed working in Shropshire for and with you all.

I have the honour to be

Your obedient Servant,

T. S. HALL,

PRINCIPAL SCHOOL MEDICAL OFFICER.

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*MARGARET H. F. TURNBULL, M.B., Ch.B., D.P.H.

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School Dental Officers :

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PETER HOWE, L.D.S.
GEORGE B. WESTWATER, L.D.S.

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*Also District Medical Officer of Health

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CLIVE EVERINGHAM

Apprentice Dental Technician :

MARK MASON (appointed 1st September, 1965)

Dental Auxiliary :

PAMELA A. UPTON

Dental Hygienists :

MARY HATFIELD (appointed 1st January, 1965)
NANCY SMITH

Consultant Children's Psychiatrist (part-time) :

DAVID R. BENADY, M.B., B.S., M.R.C.S., L.R.C.P., D.C.H., D.P.M. (appointed 1st October, 1965)

Educational Psychologists :

JOHN L. GREEN, B.A.
DAVID R. JONES, B.Sc.(Hons.), Teacher's Diploma
MARGARET THOMAS, B.A., (part-time)

Child Guidance Social Workers :

BETTY BOYCOTT, Social Science Diploma (London)
RITA M. GARRARD, Social Science Diploma (London)

Audiologist/Senior Speech Therapist :

EDWARD PAULETT, L.C.S.T., Dip.Aud.

Speech Therapists :

JILL BELLIS, L.C.S.T., L.G.S.M. (resigned 30th November, 1965)
CYNTHIA M. MAUGHAN (née Percival), L.C.S.T. (resigned full-time 16th July, 1965) (appointed part-time 17th September, 1965)
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Physiotherapists :

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PAMELA NEELY (part-time)
EILEEN M. WEBB (part-time) (appointed 1st March, 1965) (resigned 30th September, 1965)

Consultant Chest Physician (part-time) :

ARTHUR T. M. MYRES, B.A., B.M., B.Ch., M.R.C.P., M.R.C.S., L.R.C.P.

Report for the year 1965

GENERAL

The area covered by the Local Education Authority comprises 861,800 acres ; and in June, 1965, the home population, as estimated by the Registrar-General, was 317,270, an increase of 5,390 compared with 1964.

The number of pupils on the school register in 1965 was 49,697, compared with 48,639 in the previous year—an increase of 1,058.

At the end of the year, there were in the County of Salop, including the Borough of Shrewsbury, the following schools :

	Schools	*Departments*	*Pupils on Register*
Non-Residential :			
Nursery Special School	1	1	36
Nursery	3	3	130
Primary (County)	79	79	15,670
Primary (Voluntary)	155	155	13,616
Secondary Modern (County)	25	25	10,538
Secondary Modern (Voluntary)	2	2	895
Secondary Grammar (County)	9	9	4,077
Secondary Grammar (Voluntary)	5	5	1,543
Comprehensive (County)	4	4	2,814
Residential :			
Secondary	1	1	116
Special	3	3	184
Hospital	1	1	78
TOTAL	288	288	49,697

The table below shows the establishment of principal posts in the School Health Service and the staffing position at 31st December, 1965 :

	Establishment	*Staff at 31st Dec., 1965*
Principal School Medical Officer	1	1
Deputy Principal School Medical Officer	1	1
Senior Medical Officer	1	1
Administrative Medical Officer	1	1
School Medical Officers—whole-time	12	3
—part-time		12
Principal School Dental Officer	1	1
Dental Officers—whole-time	11	4
—part-time		3
Dental Auxiliaries	4	1
Orthodontists—whole-time	1	—
—part-time		2
Dental Hygienist	2	2
Dental Technician	2	2
Apprentice Dental Technician	1	1
Senior Dental Surgery Assistant	1	1
Dental Surgery Assistants—whole-time	12	9
—part-time		3
Audiologist/Senior Speech Therapist	1	1
Speech Therapist—whole-time	5	1
—part-time		1
Physiotherapists—whole-time	1	—
—part-time		2

Inclusive of the Principal School Medical Officer and his Deputy, the total medical staff undertaking all School Health Service duties, including administrative work, on 31st December, 1965, was equivalent to approximately 7¼ whole-time officers.

The nursing staff employed in the School Health Service at the end of 1965 was 4 whole-time and 14 part-time School Nurses, while part-time service was also rendered by 22 full-time Health Visitors and 28 District Nurse-Midwives who were employed by the Local Health Authority.

MEDICAL INSPECTION AND TREATMENT

Routine Medical Inspections.—Section 48 of the Education Act, 1944, requires the Local Education Authority to provide for the medical inspection, at appropriate intervals, of all pupils in attendance at maintained schools, including County Colleges. This Section also requires parents to submit their children for such inspection when so requested by an authorised officer of the Authority.

Under the National Health Service Act, 1946, children can receive treatment from medical practitioners who have contracted with the Local Executive Council to provide general medical services ; and children found on examination by a School Medical Officer to be suffering from any defect are, save for certain agreed conditions, referred to their own doctors. Such pupils are followed up by the School Nurses and any necessary specialist advice or treatment is arranged either through the family doctor or directly with one or other of the hospitals in the area of the Birmingham Regional Hospital Board, as listed on page 14.

The School Medical Officer and Nurse should confer with the family doctor about children in whose health they are all concerned, and if each tries to understand the functions and responsibilities of the other, their work can be integrated in the child's interests.

Generally, parents take much interest in the School Health Service, and the majority with children in the younger age groups attend routine medical inspections. If any special problem is raised by a parent when meeting the School Doctor at routine medical inspections, a special appointment can be made for a fuller review or examination at home or at a school clinic (see page 12 in this Report).

The school leaver's routine medical inspection at about 14 years is aimed at assessing the child's health so that any necessary treatment may be arranged, or advice given before he or she leaves school. Any reluctance of the older children to discuss their problems or accept advice is lessened by the growing custom of teachers and medical officers discussing adolescent difficulties in a friendly and uncensorious atmosphere with the pupils, who seem generally to appreciate in this connection our more recent efforts, as elaborated on page 40 of this Report.

In this County the following procedure obtains :

(i) *Routine Inspections :*

Routine medical examinations are carried out of pupils in three age groups (*a*) Entrants—on admission to school, usually 5 years, (*b*) Intermediates—at 11 years, and (*c*) Leavers—at approximately 14 years.

School Nurses are asked to visit each school prior to the inspection to test the vision of all children listed for examination.

Routine examination of the 8 year olds has now been dispensed with, but all pupils noted for re-examination on account of a defect and any referred for special examination by the Head of the school are seen by the examining Medical Officer once a year. Every pupil in the 8 year group, however, undergoes a vision test by the School Nurse as mentioned above, and during 1965 some 2,297 pupils in this age group were given vision tests, 14 being recommended for treatment and 93 for observation. Heads are encouraged to refer children in this age group for special examination because the interval between the first and second routine examinations is now six years.

There were approximately 49,000 pupils on the School Register in 1965, with about one third due for routine examination. The number having routine inspection was in fact 14,630. In an area, the numbers examined vary with the numbers of the Medical Officers employed, and the other demands made upon their time. Vaccinations, immunisations, health education talks, and an increasing amount of audiology which is a very valuable service, reduce time available for routine medical inspections.

(ii) *Special Inspections and Re-examinations :*

In addition to the inspection of pupils in the three age groups mentioned in Section (i) above, special examinations are made of pupils referred on account of defects by Head Teachers or School Nurses, including children who are in need of special educational treatment. Annual re-examinations are also made of children found to have a defect requiring observation.

The numbers of pupils examined as specials and re-examinations in 1965 were 1,364 and 11,741 respectively, making a total of 13,105 examinations.

Co-operation and Co-ordination.—Good co-operation exists between School Medical Officers, School Nurses and Family Doctors. It is helpful to discuss any problem with the child's general medical practitioner and this method appears to work to mutual advantage and makes for a better service for the children.

Appreciation is acknowledged of the help and co-operation of Head Teachers who, often at some inconvenience to themselves, make the school medical inspections successful. Our School Health work is generally recognised as an important part of the Local Education Authority's statutory commitments.

N.S.P.C.C. Inspectors are very good about helping children from unsatisfactory homes, and the Education Welfare Officers assist in securing the attendance of pupils for special examinations of all types.

The Shrewsbury Branch of the British Red Cross Society have been helpful in providing escorts to accompany handicapped children travelling to and from Convalescent Homes.

To these, to the St. John Ambulance Brigade Association, to the Women's Voluntary Services and to many kind individuals who provide services for children on their behalf, we record our grateful thanks.

Summary of Defects found at Routine Medical Inspections.—Local Authorities have power to modify medical inspection procedure by discontinuing certain routine examinations and arranging instead for the examination of children selected, not by age but by other criteria such as lack of physical or educational progress, high rate of absenteeism, or from lists drawn up by the Head Teacher, School Medical Officer and School Nurse in consultation.

At a meeting of School Medical Officers in 1964 the case for and against selective medical examinations came under discussion and mention was made of the fact that the supporters of selective medical examinations took the view that all defects found at routine school medical inspections might already be known to the children's general medical practitioner. It was, therefore, decided to obtain more concrete evidence about this by asking School Medical Officers to complete, on the conclusion of each routine medical inspection at Junior and Infant Schools, a return stating the number and type of defects found amongst pupils at the inspection and for comparison purposes the number of such defects probably known to the family doctor. The latter information was largely obtained from parents attending the inspection and must, therefore, be treated with some reserve.

The information obtained during the course of this study which extended from October 1964 to December 1965 related mainly to examinations in the 5 year school entrance group and the results are summarised below :

No. of Primary Schools Visited	234
No. of Defects Found	2,707
No. of Defects possibly known to family doctor	1,339
No. of Defects possibly not known to family doctor	1,316
No. of Defects where there is doubt whether known to family doctor	52

It is interesting to note that in the two categories where there is usually the highest proportion of defects found at routine medical inspection, namely eye and ear defects, the results were as follows :

	Eye	*Ear*
No. of Defects found	600	369
No. of Defects possibly known to family doctor	271	200
No. of Defects possibly not known to family doctor	318	169
No. of Defects where there is doubt whether known to family doctor	11	—

Treatment of Eye Conditions.—In order that children may obtain maximum benefit from education, any visual defects should be detected as early as possible, and corrected as far as possible. A child's ability to learn is closely related to the possession of normal vision and in this County all children in the five year old group are tested shortly after entry to school with special material so that visual defects may be detected and rectified as formal education begins. Children found to have visual defects even as slight as 6/9 in one or both eyes without spectacles are "followed up" at approximately three monthly intervals by the School Nurse and if the vision subsequently deteriorates they are immediately referred to the School Medical Officer who will if considered necessary refer the patient to a Consultant Ophthalmologist. All pupils suffering from visual defects are in any case seen by the School Medical Officer as annual re-examinations as explained in section (ii) page 6 above.

Our Ophthalmic Consultants stress that children thought to be suffering from squint should be referred to them at as early an age as possible when the results after treatment are likely to be correspondingly more satisfactory. Most children suffering from squint are discovered by Health Visitors long before school age and are referred to their family doctors for further investigation and treatment. Colour vision is tested at the age of 11 years by means of special material.

During the year, 4,538 children were dealt with for defective vision or other eye conditions, 4,229 being referred to Ophthalmic Medical Practitioners or Ophthalmic Opticians, and 309 being treated by Ophthalmic Consultants at the Shrewsbury Eye, Ear and Throat Hospital.

Of the 15,994 pupils examined by School Medical Officers, 9 were noted as having had squint operations during the year, and 39 to be receiving orthoptic exercises; 46 other pupils were referred for specialist treatment on account of squint; and 274 were noted for observation for the same condition.

Reports are often received from School Nurses that children—mainly the older ones—for whom spectacles are prescribed do not wear them and it has been necessary to write to parents to secure their co-operation, since the remedy lies mainly in their hands.

Defects of Ear, Nose and Throat.—The school population is now healthier with higher living standards and better material social and medical care; and less surgical treatment is needed in this field. Where treatment is needed, the advice and treatment of the Consultant Otolaryngologists are readily available.

Of the 15,994 children medically examined by the School Medical Officer, 92 were referred to the Ear, Nose and Throat Specialist during 1965 and another 1,260 were noted for observation on account of tonsil and adenoid conditions.

Operations for the removal of tonsils and adenoids were performed on 453 Shropshire school children in hospitals of Nos. 15 and 16 Hospital Management Committee Groups. This number includes children attending private and independent schools not maintained by the Local Education Authority and who are, therefore, outside the scope of the School Health Service.

Orthopaedic Defects.—There are seven Orthopaedic After-Care Clinics in Shropshire attended by an Orthopaedic Specialist and an Orthopaedic Nurse.

During 1965, of 15,994 pupils medically examined by the School Medical Officers, the following were noted as suffering from varying degrees of orthopaedic defect and referred to the Orthopaedic Surgeon where treatment was considered necessary :

	Treatment	*Observation*
Posture	6	173
Feet	21	581
Other Conditions	32	413

Defects of posture or feet account for an appreciable number of orthopaedic defects and during the year, 47 pupils were found by School Medical Officers to be receiving corrective exercises by Physical Education Specialists in schools.

Diseases of the Skin.—The numbers of Shropshire school children known to have been treated during 1965 for diseases of the skin (other than of the feet) are indicated below :

Ringworm—scalp	2
—body	11
Scabies	1
Impetigo	32
Other skin diseases	15
TOTAL ..	61

Care of the Feet.—Since 1959 routine foot inspections of pupils in attendance at Grammar, Technical, Modern and Senior Schools have been carried out by School Medical Officers. In addition Head teachers are asked to report any cases of suspected Verruca occurring amongst pupils in their schools in order that School Nurses may examine these pupils and where necessary refer them to School Medical Officers at the Child Welfare Centres.

Children found on inspection to have Verruca are excluded from swimming, showers and participation in bare foot physical education until the condition has been treated and cured. Cases discovered are referred to the family doctor concerned and kept under observation by the School Nurse who also ensures that treatment is carried out.

Particular attention is paid in schools to the most likely spots for the spread of infection, e.g. gymnasium floors, swimming baths, etc., and these are disinfected.

During 1965, the School Medical Officers carried out 14 special foot inspections involving 4,509 pupils, and 87 cases of verruca (36 already having treatment and 51 which had not been diagnosed) were discovered. In addition, School Medical Officers found 40 cases of suspected Athlete's Foot (7 under treatment and 33 undiagnosed) together with 40 other foot conditions mainly corns. Cases of Verruca and Athlete's Foot not under treatment were referred to the family doctors and followed-up by the School Nurse. The Medical Officers found that foot hygiene was generally satisfactory but several referred to the increase in the number of corns caused by wearing tight shoes with pointed toes.

Footwear.—Correct footwear for school children is still a problem in the "teenage" group. Naturally these children want to be fashionable and they will wear most unsuitable shoes. During Health Education talks and at school medical inspections, emphasis is placed upon the need for suitable footwear and it is reassuring to note that shoe firms are now making shoes which are both fashionable and suitable. Parental guidance is most essential in this field.

Treatment of Minor Ailments.—Since the introduction of the National Health Service Act in 1948, minor ailment clinics do not play a large part in school work, because most of the conditions which could be seen at such clinics are dealt with by the family doctor. Some minor ailment clinic facilities are in fact still offered at child welfare clinics.

At the "School Nurse" session and the "School Doctor" sessions at Bridgnorth, Market Drayton, Oswestry and Wellington Welfare Centre, 54 children made 62 attendances in 1965. Examinations by the School Doctor totalled 41 and 20 of the children were referred to their own doctor.

Nutrition.—According to the various reports of the School Medical Officers, Shropshire school children seem healthier than they have ever been and the nutrition figure which attained 100% in 1961 has since remained at that level. General improvement in the satisfaction of material requirements has reduced unsatisfactory nutrition to a minimum. In some cases satisfactory nutrition has been followed by obesity; though this is not a common problem it is a difficult one. The higher protein diet desirable for obese children is expensive and may not be acceptable to them. School Medical Officers at medical inspections advise children and parents about diet.

Convalescence.—On the recommendation of School Medical Officers, 18 pupils were provided with free holiday convalescence during 1965. Selected cases were those where rest, good food and fresh air were essential to recovery and generally these children came from poor or problem homes. If a fairly long period of treatment is required, the child is regarded as a delicate pupil and placed in an Open Air School.

Holidays, usually of a few weeks duration, were arranged for the 18 children concerned through the School Health Service and under a scheme quite distinct from the convalescence facilities provided through the National Health Service normally used for adult patients.

Cleanliness Inspections.—School Nurses carry out routine inspections for verminous infestation of pupils in all Primary Schools, follow-up inspections being made of pupils found to have nits or lice. Such inspections in Secondary Modern and Grammar Schools are now arranged only at the request of the Heads.

Following cleanliness inspections in Primary Schools early each term, an Informal Cleansing Notice is issued to the parent of any pupil found to be verminous. Such pupils are re-examined one week later. If still found to be verminous, Formal Cleansing Notices are served on the parents, requiring them to disinfest and to present the children for re-examination by the School Nurse at the end of three days. If at this latter re-examination a pupil is found to be still verminous, a Formal Cleansing Order may be issued from the School Health Office instructing the Nurse to convey the pupil to the nearest School Clinic to be cleansed by her.

During 1965, a total of 94,450 head inspections was carried out by the School Nurses, and of the 36,181 pupils on the registers of schools inspected 1,218 children were found to be verminous, some on more than one occasion. This represented a figure of 3.4 per cent of the school population who were found to be verminous during the year.

It was found necessary during the year to issue 24 Formal Cleansing Notices and 9 Cleansing Orders. No legal proceedings were instituted in this connection during the year.

Infestation is mainly confined to children whose home conditions are unsatisfactory. In such cases School Nurses have the task of dealing with parents and older members of the household, who neglect personal hygiene and consequently re-infest the younger children.

Work of School Nurses.—School Nursing is undertaken by 18 School Nurses (4 whole-time and 14 part-time), 22 Health Visitors and 28 District Nurses (who are estimated to devote about 7 per cent of their time to this work). In addition to their visits to schools for head inspections, the School Nurses are required to attend routine medical inspections. Children ascertained by the School Medical Officers to be suffering from defects of any kind are either referred to the family doctor for treatment or noted for observation ; and the subsequent follow-up work of the School Nurses, together with the number of days given to routine medical inspections is indicated in the following table.

Staff	Staff		Medical Inspection days	Treatment Cases				Observation Cases			Totals	
	Number	Whole-time equivalent		Visited	Not Visited	Total	Treated	Visited	Not Visited	Total	Cases	Visi
School Nurses	4	4	163	1,298	143	1,441	1,441	174	53	227	1,668	2,52
Part-time School Nurses	14	3.31	113	679	1,190	1,869	1,869	260	373	633	2,502	1,39
Health Visitors	22	6.16	309	1,151	695	1,846	1,846	366	348	714	2,560	2,10
District Nurses	28	1.96	51	446	68	514	513	123	82	205	719	85
TOTAL ..	68	15.43	636	3,574	2,096	5,670	5,669	923	856	1,779	7,449	6,87

Employment of Children.—In accordance with the provisions of Section 59 of the Education Act, 1944, all pupils reported by the Chief Education Officer as being engaged in work outside school hours are examined by a School Medical Officer to ensure that they are not being employed in a manner likely to be prejudicial to health or to render them unfit to obtain the full benefit of education.

After this initial examination, each child is seen annually at routine medical inspection, or at an earlier date if the School Medical Officer recommends such an arrangement.

Only children of 13 years or more are allowed to take up employment, which is restricted by statute and may not exceed two hours on school days. Work before 7 a.m. is prohibited. Employment in a number of occupations connected with hotels, public entertainments, licensed premises, racing tracks, etc., is prohibited and no child may be employed to lift, carry or move anything so heavy as to be likely to cause him injury.

Experience shows that part-time work is in no way harmful to most children; it gives them a sense of responsibility and acts as an introduction to full-time employment.

Of 673 pupils examined during 1965, it was necessary to recommend re-examination in two cases after intervals of one and three months respectively.

Medical Inspection of Pupils resident in Boarding Schools and Special Boarding Schools.—Special arrangements are made for the medical examination of children in boarding schools or resident in special boarding schools within the County, as under :

Bridgnorth	Apley Park
Ellesmere	Petton Hall
Shifnal	Haughton Hall
Wem	Trench Hall

During 1965, School Medical Officers examined 306 pupils in residence, anything relevant to the well being of the children being passed on to the Head of the school. Every pupil in these residential establishments is on the list of a local Medical Practitioner providing General Medical Services under the National Health Service Act.

Arrangements were also made during the year, at the request of the Robert Jones and Agnes Hunt Orthopaedic Hospital authorities, for the local School Medical Officer to undertake vision testing of approximately 80 pupils attending the Hospital School. These tests are carried out each term and pupils having defective vision are referred to an Ophthalmic Consultant for treatment.

Education of Children in Hospitals.—The Robert Jones and Agnes Hunt Orthopaedic Hospital have a permanent arrangement with the Education Committee for the provision of special educational facilities. At Copthorne Hospital, Shrewsbury, patients recommended for special tuition attend a class regularly at the hospital by a tutor provided by the Education Committee.

In other hospitals in the County, when a child is admitted whose stay is likely to be prolonged, special arrangements are made for individual tuition if the medical condition permits.

SCHOOL CLINICS PROVIDED BY THE LOCAL EDUCATION AUTHORITY

The following is a list of clinic sessions made available by the Local Education Authority at which school children may attend. School doctors' sessions operate concurrently with general child welfare clinics. In addition to the clinics listed, there are two Mobile Dental Units which are operated in the north and south of the County respectively. The time at which clinics are held are liable to be modified, but up-to-date information on clinic sessions may be obtained from the Health Department, Shirehall, Shrewsbury, or from the School Medical Officer concerned at a local level.

List of School Clinics as at 1st March, 1966

Medical Officer and District	Centre	Frequency of Sessions
Dr. Barker Wem	Wem	Audiology — As required Dental — Four sessions weekly
Dr. Capper Ludlow	Bishop's Castle	Audiology — As required
	Church Stretton	Audiology — As required
	Cleobury Mortimer	Audiology — As required
	Ludlow	Audiology — One—two sessions monthly Child Guidance — Two sessions monthly Dental — Four sessions weekly Ophthalmic — Three sessions monthly
Dr. Cartwright Dawley— Madeley	Dawley	Audiology — One session monthly Dental — Three sessions weekly Speech Therapy — One session weekly
	Madeley	Audiology — As required Dental — Three sessions weekly Orthopaedic — Two sessions monthly Speech Therapy — One session weekly
Dr. McCaully Market Drayton	Market Drayton	Audiology — As required Child Guidance — As required Dental — Four sessions weekly School Doctor — One session weekly Speech Therapy — Two sessions weekly
Dr. MacDonald Wellington	Oakengates	Audiology — As required Dental — As required
	Wellington	Audiology — One session weekly Child Guidance — Five sessions weekly Dental — Eight sessions weekly School Doctor — One session weekly

Medical Officer and District	Centre	Frequency of Sessions
Dr. Mackenzie Shrewsbury	1 Belmont	Audiology .. .. One—two sessions weekly Speech Therapy .. One session weekly
	5 Belmont	Dental .. .. Sixteen sessions weekly
	Condover Hall, Nr. Shrewsbury	Speech Therapy .. One session weekly
	Katharine Elliot School .. .. (Woodcote Way)	Speech Therapy .. One session weekly Hearing Assessment Three sessions monthly
	Education Department, Shirehall	Child Guidance .. Seven sessions weekly
	White House	Audiology .. .. As required
Dr. Marczewski Shifnal	Albrighton Junior School ..	Audiology .. .. As required
	Much Wenlock	Audiology .. .. As required
	Shifnal	Audiology .. .. As required
Dr. Moore Oswestry	Oswestry	Audiology .. .. As required Child Guidance .. Two sessions monthly Dental .. .. Four sessions weekly Ophthalmic .. .. Two sessions monthly Orthopaedic .. .. One session weekly School Doctor .. One session weekly School Nurse's Session One session weekly Speech Therapy .. Two sessions weekly
Dr. O'Brien Newport	Hadley	Audiology .. .. As required School Doctor .. One session monthly
	Newport	Audiology .. .. As required Dental .. .. Three sessions weekly
Dr. Smith Ellesmere—Whitchurch	Ellesmere	Audiology .. .. As required Dental .. .. Four sessions weekly
	Whitchurch	Audiology .. .. Two sessions monthly Dental .. .. Four sessions weekly Speech Therapy .. One session weekly
Dr. Turnbull Bridgnorth	Bridgnorth (Northgate)	Audiology .. .. One—two sessions monthly Child Guidance .. One session monthly Dental .. .. Four sessions weekly School Doctor .. One session monthly
	Highley	Audiology .. .. As required

HOSPITAL AND SPECIALIST SERVICES

Children found to be suffering from defects requiring either the advice of a Consultant or in-patient treatment are referred, preferably in collaboration with their family doctor, to the following hospitals, all of which come under the Birmingham Regional Hospital Board. Children suffering from chest conditions are seen by a Chest Physician at one of the Chest Clinics.

General Medical and Surgical Conditions :

The Royal Salop Infirmary, Shrewsbury
Copthorne Hospital, Shrewsbury
The North Staffordshire Royal Infirmary, Stoke-on-Trent
The Kidderminster and District General Hospital, Kidderminster
The Wolverhampton Royal Hospital, Wolverhampton
The Staffordshire General Infirmary, Stafford

Eye Conditions :

The Eye, Ear and Throat Hospital, Shrewsbury
The North Staffordshire Royal Infirmary, Stoke-on-Trent
The Staffordshire General Infirmary, Stafford
The Kidderminster and District General Hospital, Kidderminster
The Wolverhampton and Midland Counties Eye Infirmary, Wolverhampton

Ear, Nose and Throat Conditions :

The Bridgnorth and South Shropshire Infirmary, Bridgnorth
Copthorne Hospital, Shrewsbury
The Eye, Ear and Throat Hospital, Shrewsbury
Ludlow and District Hospital, Ludlow
Oswestry and District Hospital, Oswestry
Shifnal Cottage Hospital, Shifnal
Whitchurch Cottage Hospital, Whitchurch
New Cross Hospital, Wolverhampton
The North Staffordshire Royal Infirmary, Stoke-on-Trent
The Staffordshire General Infirmary, Stafford
The Kidderminster and District General Hospital, Kidderminster
The Wolverhampton Royal Hospital, Wolverhampton

Orthopaedic Conditions, including Fractures :

Royal Salop Infirmary, Shrewsbury
The Robert Jones and Agnes Hunt Orthopaedic Hospital, Oswestry
The Kidderminster and District General Hospital, Kidderminster

X-ray Treatment of Ringworm :

The Midland Skin Hospital, Birmingham

Special Forms of Treatment not elsewhere available :

The Birmingham Children's Hospital, Birmingham

HANDICAPPED CHILDREN

Case finding of Handicapped Pupils.—A handicapped pupil may be defined as one suffering from a disability of mind or body which is likely to interfere with normal growth, development and ability to learn. Approximately one child in every hundred who survives the hazards of the neonatal period may ultimately require special care, treatment and parent guidance for some form of severe handicap.

The Education Act 1944 brought provision for the education of handicapped children within the framework of the educational system and imposed upon Local Authorities the duty of providing sufficient suitably equipped and staffed schools to give all pupils the opportunity of education consistent with age, aptitude and ability. Authorities were also given the duty of finding children who require special educational treatment and of providing this, if necessary, from the age of two years.

For the purposes of the Education Act there are ten categories of handicap :

Blind	Educationally Subnormal
Partially sighted	Epileptic
Deaf	Maladjusted
Partially Hearing	Physically Handicapped
Delicate	Speech Defective

Detection and Ascertainment.—All births are notified to the Local Health Authority and by the latter to their Health Visitors, who take responsibility for visiting the home and advising the parents from the eleventh day of the child's life.

Children suffering from obvious handicaps such as total deafness, severe physical disability, etc., are discovered long before they reach school age and Health Visitors contintually watch for any signs of handicap. The need for early discovery must be stressed, and parents, family doctors, school medical officers, health visitors and teachers should refer any child thought to be suffering from a handicap so that assessment and any special educational treatment or training may be decided upon without harmful delay.

Two registers are maintained in the School Health Service Section—a "Register of Handicapped Pupils" and an "At Risk" Register, the latter giving details of all children in whom the possibility of deafness caused by adverse influences in the pre-natal and post-natal periods is considered to be the greatest, e.g. premature infants, twins, children of mothers who have had a virus infection during pregnancy, etc. These "At Risk" categories are referred to again under "Audiology" on page 27 of this report. Consultant Paediatricians advise the School Health Service about any handicapped children who are under their care.

During 1965 pupils ascertained under the provisions of the Handicapped Pupils and School Health Service Regulations numbered 422—327 by School Medical Officers and 95 by the Consultant Psychiatrist, and a summary of the findings and recommendations to the Local Education Authority is given below. In addition 456 children found to be speech defectives were brought under treatment by the Speech Therapists, whilst a further 913 children were found at the Medical Audiology Clinics to have defective hearing as a result of which recommendations and referrals were made in 654 of these cases.

HANDICAPPED PUPILS

Category	Pupils Specially Examined	Not Handicapped	Temporary exclusion from School	Special Educational Treatment Recommended			Reported to Local Health Authority		Pupils not requiring supervision on leaving school	Under treatment by Psychiatrist
				In Ordinary School	In Special School	Home Tuition	Unsuitable for education at school	Friendly supervision on leaving school		
Blind	2	—	—	—	2	—	—	—	—	—
Partially Sighted	2	—	—	—	2	—	—	—	—	—
*Deaf	—	—	—	—	—	—	—	—	—	—
*Partially Hearing	—	—	—	—	—	—	—	—	—	—
Delicate	16	—	—	—	11	5	—	—	—	—
Educationally Sub-Normal	268	37	2	97	68	—	23	33	8	—
Epileptic	—	—	—	—	—	—	—	—	—	—
Maladjusted	95	—	—	—	17	—	—	—	—	78
Physically Handicapped	36	—	—	—	23	13	—	—	—	—
TOTAL	419	37	2	97	123	18	23	33	8	78

* All children suspected of being deaf or partially hearing are now dealt with not by the individual School Medical Officer but by a Specialist Audiology Team, whose recommendations are referred to on page 30.

As well, the Medical Officers also carried out a further 408 examinations of handicapped pupils in connection with unsatisfactory school attendance, the provision of transport to and from school and the review of home tuition cases.

The following table gives details of the numbers of pupils ascertained by the School Medical Officers and Consultant Psychiatrist during the period 1956 to 1965 :

		(1) Blind (2) Partially-sighted (3) Deaf			(4) Partially hearing (5) Delicate (6) Educationally subnormal			(7) Epileptic (8) Maladjusted (9) Physically handicapped			
		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	TOTAL
Examined:	1956	2	4	4	5	60	363	2	41	18	499
	1957	5	5	—	2	35	341	4	43	22	457
	1958	2	2	—	11	24	204	5	120	34	402
	1959	1	3	1	6	36	247	2	116	39	451
	1960	1	—	4	3	42	299	1	62	35	447
	1961	—	2	2	2	31	283	5	65	18	408
	1962	2	2	—	3	21	247	1	99	22	397
	1963	—	3	1	2	15	252	6	99	21	399
	1964	3	3	—	—	26	292	9	30	18	381
	1965	2	2	—	3	16	268	—	95	36	422
Recommended for Special School :											
	1956	2	4	3	5	31	110	1	7	9	172
	1957	5	5	—	2	22	78	4	16	12	144
	1958	2	2	—	11	18	46	5	13	10	107
	1959	1	3	1	6	30	48	2	12	7	110
	1960	1	—	4	3	27	59	1	10	10	115
	1961	—	2	2	2	21	71	5	15	9	127
	1962	2	2	—	3	16	52	1	20	10	106
	1963	—	3	1	2	11	43	5	15	8	88
	1964	3	3	—	—	17	51	6	20	3	103
	1965	2	2	—	3	11	68	—	17	23	126

Report to Local Health Authority.—The Mental Health Act, 1959, which came into force in November, 1960, amended Section 57 of the Education Act, 1944, and introduced certain changes in the law relating to children of the age of two years or more who suffer from a disability of mind rendering them unsuitable for education at school. The effect of these changes is broadly to extend the rights of parents, to amend legal procedure in some respects, and to simplify some of the administrative arrangements.

During 1965 a total of 56 children was recommended for report to the Local Health Authority under Section 57 of the Education Act as amended—23 under sub-section 4 as being unsuitable for education at school and 33 as being in need of friendly supervision after leaving school. The comparable figures for 1964 were 30 and 35 respectively.

Katharine Elliot School.—The following account of this interesting project has been compiled from the contributions of Mr. A. I. Rabinowitz, B.A., the school's Principal, whose work in integrating the educational, medical and social considerations affecting the handicapped children has been so constructive in getting the programme to such a successful start in its new permanent premises.

Begun by the Education Department in 1958 in temporary premises in Shrewsbury as an experimental class for handicapped children under school age, the objectives have been to bring children into contact with each other, to help them to develop a sense of independence, to assess their mental and physical potential and to give the parents guidance in dealing with their children's management.

The children in the school may come from any part of the County, provided that the journey can be completed within a reasonable time, and transport is provided by the Local Education Authority. The range of handicaps in the School is intentionally wide—the blind and partially-sighted, the partially hearing, those with cerebral palsy and other physical handicaps and a smaller number of children whose major problems are social or intellectual. The integration is deliberate for the children help and stimulate one another.

In September, 1964, the Unit was transferred to a newly constructed and fully equipped Centre situated at Woodcote Way, Monkmoor Road, Shrewsbury, and was re-named the Katharine Elliot School by permission of Baroness Elliot of Harwood who had been Chairman of the Steering Committee which guided the Carnegie Survey into the needs of young handicapped children and their families, and who has since been appointed Chairman of the Carnegie United Kingdom Trust. The new Unit was built from money provided by the Carnegie & Sembal Trusts, but many of the very desirable refinements, such as special chairs and tables, were given by the local branch of the Spastics Society, who have been more than generous. The Hydrotherapy Pool which is a very valuable addition to the amenities was provided with the help of funds made available by Mr. Richard Hearne ("Mr. Pastry") from the charities sponsored by him for such swimming pools. Again through the kindness of Mr. Hearne the school has been provided with a "Sunshine Coach" of the type which has already been made available for many children's organisations by the generosity of the Variety Club of Great Britain.

The four aims of the Centre are assessment, education, guidance and co-operation. Children are admitted for appropriate periods of assessment so that decisions concerning their future may be taken in the fullest possible knowledge of their potential and attainments. The School provides for education and social training consistent with the attainments, handicaps and needs of the children. The staff of the School and Medical Specialists who visit it in a consultant capacity are available to give advice and help to parents. The School forms a focal point where parents, teachers, specialists and consultants meet to discuss common problems and ways of meeting them.

Of the 40 children who attended the Katharine Elliot School in 1965 :

15 had defects associated with cerebral palsy ;
4 had Spina Bifida and similar or associated conditions ;
6 were blind or partially sighted ;
4 were deaf or partially hearing ;
2 had severe speech defects ;
4 suffered from emotional disturbances ;
2 were of poor intelligence and in the process of being assessed ; and
3 were suffering from other syndromes including on e child with Hirschsprung's disease

Children are admitted to the School between the ages of 2 and 7 years, and remain there as long as the regime of the School is of benefit to them, or until their period of assessment is satisfactorily completed and a suitable placement is found for them.

In addition to the Principal who is a Psychologist with many years' experience of teaching in ordinary and special education, the staff of the School, which at present accommodates about 40 children of whom 21 attend full time and 19 part-time, includes 2 full time and 2 part-time teachers, 4 nursery assistants and a receptionist. Their work is complemented by that of 2 part-time Physiotherapists who supply physiotherapeutic services, our Audiologist/Chief Speech Therapist who provides parent guidance and assists the teaching staff in the treatment of children with hearing defects and speech difficulties, a part-time Speech Therapist and a Social Worker who is a trained Health Visitor with special experience, and Medical Consultants.

Dr. J. C. Macaulay, Consultant Paediatrician, and Mr. G. K. Rose, Consultant Orthopaedic Surgeon, have special close association with the school and hold Assessment Clinics there, whilst Mr. E. N. Owen, Aural Surgeon, also attends Hearing Assessment Clinics which are arranged at this School.

From the County's School Medical Service, Dr. A. D. Barker attends the School approximately 11 sessions per month and carries out physical examinations and assessments of the children as well as meeting the parents. The valuable work which Dr. N. V. Crowley, Senior Medical Officer, has done in the past has been referred to in previous reports.

The meals are provided from the adjacent Junior Training Centre and re-prepared at the School in order to suit the tastes and needs of the individual children.

The health of the children at the School has been generally good throughout the year.

Home Visiting by School Medical Officers.—Much of the work of the School Health Service is concerned with the moral and social problems of the children in addition to their health and educational progress and it is in the field of the handicapped child that the School Medical Officer can help parents with the many problems to which a handicapped pupil is heir, advising them how best to use all that is available through the National Health and School Health Services. Our School Medical Officers are given lists of handicapped children living in their areas and are expected to pay special attention to these children either in school or by home visiting. Some cases have to be referred to the Central Office for further advice and discussion.

Dr. A. D. Barker spent during the year approximately three half day sessions per month on home visiting. Sometimes accompanied by Miss M. E. M. Evans, the Health Visitor/Social Worker, Dr. Barker visited the homes of very young handicapped children to examine and assess them, to discuss the question of their educational future with the parents and in general to give them help and guidance in the understanding and management of their children. Details of those young children who are considered suitable for attendance at the Katharine Elliot School for Handicapped Children referred to on page 17 are passed to the Chief Education Officer. Mr. Rabinowitz, as Principal of the Katharine Elliot School, also visits with Miss Evans the homes of all those children who attend the school or are recommended for future admission.

The following are the numbers of handicapped children in the various categories who received domiciliary visits. They are, of course, also seen in the schools and clinics : home visits are carried out as often as the Medical Officers consider necessary.

HANDICAPPED PUPILS REQUIRING HOME VISITING

	Pupils on List	*No. Visited*	*No. not Visited*	*Visits made*
Blind	20	14	6	16
Partially-sighted	35	30	5	32
Deaf	16	11	5	15
Partially Hearing	81	53	28	64
Some Hearing Loss	68	45	23	47
Delicate	232	179	53	200
Educationally Subnormal	661	438	223	515
Epileptic	103	73	30	180
Maladjusted	29	25	4	34
Physically Handicapped	411	317	94	394
Speech Defective	25	23	2	25
	1,681	1,208	473	1,522

Supervision of School Leavers.—The importance of providing help, guidance and after-care for handicapped children leaving school cannot be over emphasised and the transition period to adult life is fraught with anxieties and difficulties.

The School Medical Officer, at the last routine medical examination of each pupil, makes a report if he considers the pupil unsuitable for work of any particular type. When the pupil leaves school this report is sent by the Head together with the "School Leaving Report," to the Local Vocational Guidance Officer to ensure that any pupil, on leaving school, is not placed in employment for which he or she is either mentally or physically unsuited.

Handicapped pupils are also encouraged to enrol in the Register of Disabled Persons and so obtain through the Ministry of Labour sheltered employment and also special educational training open to Registered Disabled Persons.

Special arrangements exist to deal with the problem of after-care for pupils leaving Petton and Haughton Hall Residential Schools, and Mental Welfare Officers and Youth Employment Officers do, in suitable cases, visit the special school before the child actually leaves. Each case is then followed-up at home to ensure that the child settles down in employment and becomes satisfactorily adjusted to post-school life with its personal and social problems.

School leavers from Haughton Hall and Petton Hall who require supervision are followed-up by the Female and Male Mental Welfare Officers respectively and these officers attend the case conferences at the Special Schools concerned.

In Shropshire, arrangements for the continued supervision of handicapped school leavers and for their placing in employment do in the majority of cases work satisfactorily, particularly for leavers in the Education Committee's own schools. In the interests of uniformity of procedure throughout the County, and to keep the cases of handicapped children constantly under review in the twelve months preceding the school leaving date and for the following five years, an After-Care Committee has been set up and co-ordinates the efforts of the various bodies concerned, namely the Education, Children's, Health and Welfare Departments, and the Ministry of Labour's Rehabilitation and Youth Employment Service.

Special Residential Schools for Educationally Subnormal Pupils.—Special Residential Schools for children who are educationally subnormal are provided by the Local Education Authority—boys at Petton Hall (92 places) and girls at Haughton Hall (62 places). The pupils have intelligence quotients between 50 and 80 and stay until 16 years of age.

Because of the unsatifactory condition in which some of the pupils were returning to the schools after holiday periods, Health Visitors make "follow-up" visits during each holiday to the homes concerned. This is primarily to establish a good relationship with both child and family and also to ensure that each pupil is receiving any necessary medical or nursing care and returns to school free from infection and infestation.

SCHOOL REPORT OF THE PRINCIPAL DENTAL OFFICER

Once again I have to report that no increase in professional staff occurred in the Dental Service in 1965, and in fact during the year one part-time dental officer resigned his appointment. It was unlikely that this particular officer would, in any case, have remained with us for any length of time as he was developing his own practice in the area in which he resided but nevertheless whilst in the Council's employment he gave valuable service. We have advertised periodically in the British Dental Journal, and have had some response ; letters asking for details have been received, full and detailed information is sent by return if possible, and that, ladies and gentlemen, is the last we hear from the enquirer. There was one exception which concerned a promising applicant, who had devoted several years to the School Dental Service. This Officer who travelled for interview from Inverness was keen to settle in the softer, quieter climate of Shropshire, and was impressed with the organisation of the Authority's Dental Service and the high standard of the equipment. Unfortunately we could not offer him any chance of promotion from Assistant Dental Officer to say Senior Dental Officer (a new grade recently approved by Whitley Council) nor the inducement of a five day week and he reluctantly declined the offer of a post with the Authority.

The dental service has now reached the stage where although it has modern well-equipped clinics situated at the most important populated areas of the County, many of them are only occupied part of the time by either part-time officers or full-time officers dividing their time between two centres. Neither centre is, therefore, receiving the full attention of the officer concerned for the case load increases and there is a consequent build-up of the waiting lists at each centre.

The remedy for this situation probably lies in the suggestions put forward in the report of the inspecting dental officer from the Department of Education and Science who visited the County in May 1965, and the two most important paragraphs from the report are reproduced below :

"Considering the shortage of staff, which is dealt with below, the dental services are well organised and efficient. The output of work is satisfactory and is above average in nearly every category of treatment, while the orthodontic service is an exceptionally good one. However, lack of staff has led to an inspection interval far greater than the annual one that is necessary. Until more staff is available it may be advisable in places to concentrate on the inspection of rural school children and, generally, the younger ones."

"Only when the requirements set out in the Model Scheme for a School Dental Service (Appendix C to the Health of the School Child, 1962/63) are met and suitable provision made for maternity and child welfare patients can staffing be regarded as satisfactory. It is appreciated that the Authority are well aware of the need for more staff, especially in the Wellington—Dawley—Madeley area, and have advertised regularly. The difficulties are real ones but many authorities

are now finding it less difficult to recruit than a few years ago. The fact that dental officers in Shropshire have few promotion prospects may lead to difficulties in recruiting and retaining staff and the Authority will wish to consider the establishment of area or senior posts which, in addition to being a recruiting inducement, could be justified for such reasons as administrative work, responsibility for specific aspects of the service, and supervision of other dental officers/auxiliaries. More auxiliaries should be employed as two surgery clinics are available. The Authority's policy of encouraging staff to attend postgraduate and refresher courses and of permitting field studies and clinical research are commended."

Obviously if we are to provide a comprehensive dental service then we must have the staff, and must therefore try to interest people in a post with the authority. This is a highly competitive labour market so we must use every inducement. If we could do so, this authority without any doubt whatsoever could have one of the finest Dental Services in the country.

You will remember that in my last report I mentioned the fact that special clinics were being held for handicapped and difficult children ; these clinics we are continuing to develop. Many children in these categories are now being referred to us for treatment, by General Dental Practitioners.

In the field of Dental Health Education, two exhibitions were organised this year—at Oswestry and Burwarton Shows respectively. The Oswestry exhibit was awarded a second prize ; this was a feather in the cap for Mr. Field, School Dental Officer at Market Drayton, who was responsible for its organisation. At the Burwarton Show, as an experiment, we borrowed the mobile exhibit from the General Dental Council and although limited in size, and therefore scope, it proved to be popular with the public.

In order to bring the service into line with developments in Prosthetic Dentistry, it is hoped to install in the dental laboratory at 5 Belmont, Shrewsbury, equipment for the production of dentures and appliances in chrome cobalt. This material has many advantages over acrylic resins (plastics), especially in strength and lightness. In order that all information concerning this new material is available Mr. Everingham, one of the Council's Dental Technicians, has, at the time of writing this report, just returned from the suppliers where he has attended a two day course of instruction in the technique of chrome cobalt casting.

At the beginning of 1965 we introduced a new Dental Officer's daily record sheet in order to provide the information required in the modified form of annual return which had been produced by the Department of Education and Science.

A summary of the work done during the year is given below :

Mobile Dental Units.—The figures below show that the Mobile Dental Units are being used effectively and are a great help.

Schools treated	23
Pupils treated	776
Total attendances	1,655
Number of treatment sessions	257
Number of gas sessions	15
Fillings	1,903
Extractions	553
Other operations	196

Work done during the year (these figures **include** those relating to the Mobile Dental Units):

Attendances and Treatment :	*Ages 5 to 9*	*Ages 10 to 14*	*Ages 15 & over*	*Total*
First Visit	3,232	3,475	981	7,688
Subsequent visits	3,965	6,301	2,210	12,476
Total visits	7,197	9,776	3,191	20,164*
Additional courses of treatment commenced	385	346	118	849
Fillings in permanent teeth	2,561	7,963	3,066	13,590
Fillings in deciduous teeth	3,156	394	—	3,550
Permanent teeth filled	2,190	6,852	2,757	11,799
Deciduous teeth filled	2,858	368	—	3,226
Permanent teeth extracted	256	1,801	528	2,585
Deciduous teeth extracted	4,479	1,381	—	5,860
General anaesthetics	1,715	1,165	212	3,092
Emergencies	609	438	105	1,152
Number of Pupils X-rayed				536
Prophlaxis				3,255
Teeth otherwise conserved				680
Number of teeth root filled				8
Inlays				9
Crowns				42
Courses of treatment completed				5,393

*In addition 2,427 visits were carried out by the Dental Hygienist.

Orthodontics :	
Cases remaining from previous year	248
New cases commenced during year	276
Cases completed during year	175
Cases discontinued during year	52
No. of removable appliances fitted	363
No. of fixed appliances fitted	71
Pupils referred to Hospital Consultant	6

Prosthetics :	*5 to 9*	*10 to 14*	*15 & over*	*Total*
Pupils supplied with F.U. or F.L. (first time)	—	—	2	2
Pupils supplied with other dentures (first time)	3	28	30	61
Number of dentures supplied	9	43	48	100

Anaesthetics :	
General Anaesthetics administered by Dental Officers	299

Inspections :	
(*a*) First Inspection at school. Number of Pupils	9,819
(*b*) First Inspection at clinic. Number of Pupils	4,425
Number of (*a*) + (*b*) found to require treatment	10,646
Number of (*a*) + (*b*) offered treatment	9,804
(*c*) Pupils re-inspected at school clinic	1,160
Number of (*c*) found to require treatment	743

Sessions :	
Sessions devoted to treatment	3,504*
Sessions devoted to inspection	107
Sessions devoted to Dental Health Education	232

*This figure includes 498 treatment sessions carried out by Dental Hygientist.

Under the provisions of Section 78 of the Education Act, 1944, all the pupils (approximately 80) of Condover Hall School for the Blind were dentally examined and treatment carried out as necessary."

C. D. CLARKE, *Principal Dental Officer.*

SPEECH THERAPY

Once again the year brought the now almost inevitable changes in staffing. In July Miss C. M. Percival resigned her full-time post and resumed duty in September as Mrs. C. M. Maughan, working three sessions per week. At the end of November we were extremely sorry to lose the valuable full-time services of Miss J. Bellis who moved over the border to Denbighshire where she had been appointed Senior Speech Therapist. A series of advertisements for staff replacements were in vain and consequently there was a shrinkage in the clinical programme and in the provision of speech therapy throughout the County.

The case-load for each Therapist during the year has always remained at optimum level and the delicate choice has always to be made as to whether treatment should be given to the long-term patients with a deep-rooted speech defect or should one concentrate on a more rapid turn-over with those having less severe defects.

It will be noted from the table showing types of defect that stammering is one of the most common causes of referral. With regard to stammering, or stuttering, as some people prefer to describe it, some recent research work carried out by workers from the University of Newcastle is of interest.

This enquiry by Andrews and Harris covered all the children in the City of Newcastle-upon-Tyne in the last two years at Primary School. Of these 7,358 children 86 were discovered to be stammerers and 80 of these were paired with a control group of 80 non-stutterers of similar age, sex, background and intelligence.

Analysis of the information gained from detailed investigations showed various trends, some of which were less expected than others. Briefly, a summary of some of their findings is that :

More stammerers than non-stammerers show a family history of stammering.

Stammering is more common among children of low than high intelligence. (The fact that the patients we see in Clinics appear to be above average intelligence is probably because intelligent people are more likely to seek and to co-operate in treatment.)

There was nothing to suggest that handedness is related to stammering and none of the children interviewed was a "converted sinistral,"* Stammerers were found to be much later in learning to talk and they were also found to have a higher incidence of disorders of articulation.

More of the stammerers than the control group were the product of socially deprived homes (overcrowding, lack of stable outgoing productive family unit, mothers included more women who were unable to cope with circumstances in their lives).

Despite this the stammerers were found to be no more and no less emotionally disturbed than the control group of children ; the stammering child showed no greater liability to behaviour difficulties, fears and anxieties.

I would think that it is obvious that more research work on similar lines must be carried out in other parts of this country and abroad in order to compare these findings. It is also to be hoped that a more statistically valid number than 160 children will be investigated.

The conclusion reached by these workers is that "stammering can be regarded as the product of certain adverse environmental factors acting upon a genetic matrix."

Making a retrospective "flick" through my memory of the several child and adult stammerers I have treated in the last seventeen years I would agree with most of these findings. Certainly the difference in the so-called "pace of life" found in city and rural areas is not significant as a causative factor.

Many people still retain the idea that anywhere in this country north of Oxford is either jungle or Arctic territory. If they could dispose of the prospect of being met on arrival in Shropshire by missionaries or a sledge-team they would find that the facilities available for clinical work in Speech Therapy are extremely good.

* Left handed by nature and persuaded to be right handed by nurture.

Opportunities for interesting and rewarding work with a variety of specific speech defective children exist. For instance at the Katharine Elliot School, where a Therapist is needed in daily attendance, valuable work could be done. During the year the Principal Mr. Rabinowitz and I arranged for a machine called a "Calligraphone" to be constructed. This is a visual speech unit which displays voice sounds as distinctive patterns or roulette figures on a cathode ray tube. This apparatus should be useful as a supplementary aid to reinforcing other methods used in speech training for hard of hearing and speech defective children.

If, during the year 1966, we have an increase in staff then the full possibilities of the use of such equipment can be explored and certainly a more encouraging general report will be available.

The following table gives particulars of the conditions which necessitated attendance of 456 children who were given speech therapy during 1965 :

Condition	Cases discharged during year	On Register 31st December
Stammer	36	47
Cleft Palate	1	4
Severe Dyslalia	32	48
Nasality + or —	3	2
Dyslalia	128	86
Voice Defect	3	1
Mongolism	1	5
Non Communicating	2	2
Partially Hearing	—	5
Educational Subnormality ..	3	5
Dysarthria	2	3
Mixed Defect	8	14
Dysphasia	3	2
Mental Defect	5	4
Language Defect	—	1
TOTAL ..	227	229

*Left handed by nature and persuaded to be right handed by nurture.

These totals include 18 children from 4 neighbouring Counties, the latter paying the Shropshire Education Authority for their treatment.

At the end of 1965 Speech Therapy Clinics were being held at the following Centres :

	Monday	Tuesday	Wednesday	Thursday	Friday
Morning	No. 1 Belmont, Shrewsbury	Oswestry C.W.C.	Madeley C.W.C.	Katharine Elliot School Eye, Ear & Throat Hospital	Condover Hall
Afternoon	Eye, Ear & Throat Hospital	Oswestry C.W.C.		Dawley C.W.C. Katharine Elliot School	Market Drayton C.W.C. Whitchurch C.W.C.
Evening		Eye, Ear & Throat Hospital			

CASES TREATED

On Register 1st January	New Cases during year	Cases discharged during year	On Register 31st December
209	247	227	229

CASES DISCHARGED

Normal	Substantially Improved	Unlikely to benefit from further treatment		Left School or Ceased	Referred to Other Services	TOTAL
		Slightly Improved	Unimproved			
113	47	13	3	41	10	227

In a small number of cases, discharge is temporary and children can attend later for further treatment.

In addition :

191 children made single visits to Centres for advice.
134 visits were made to individual homes.
31 visits were made to schools to see children and discuss cases with teachers.

In all, 456 children having regular treatment in the County made a total of 3,892 attendances.

Katharine Elliot School.—This unit (referred to on page 17) gives an opportunity for the study of children with speech disorders and allows for a gradual diagnostic assessment to be made. The 40 children attending the School are divided into two classes for teaching purposes—one containing those who are able to cope with more formal teaching, and those with more severe handicaps.

At present 16 of the children are receiving regular Speech Therapy and the conditions necessitating treatment may be classified as follows :

Cerebral Palsy	9
Non-communicating :	
(*a*) Psychological	1
(*b*) Possibly neurological	3
Severe dyslalia (twins)	2
Physical abnormality	1

The number of children attending this school has risen this year, with a resultant increase in the number who would benefit from regular Speech Therapy. Unfortunately, staffing difficulties make it impossible to fulfil this extra requirement.

Regular Speech Therapy has therefore been given to the children who would derive the most benefit from this ; and the remainder are seen at intervals for re-assessment and help. As vacancies occur these patients are of course seen regularly. This system accounts for the apparently large number of children on the register.

The number of discharges during the year—4 children—appears low and this is due to the fact that the majority of the children in the school are severely handicapped. This also applies to their speech, so that most treatment is slow and long-term.

The variety of speech disorders is still very wide and the rate of progress variable, but much has been achieved over the year, and this is especially noticeable in the children's attempt to converse and make themselves understood rather than to attempt the finer aspects of speech.

Much time is required for assessment and long-term observation of these children, as an essential part of treatment, and this is facilitated in this school. Co-operation with teachers and physiotherapists is essential and is an important factor in the "whole" treatment of each child.

Conversations with parents and observation of the parent-child relationships have also helped to make an appropriate plan of treatment for each child.

E. PAULETT,

Audiologist/Senior Speech Therapist

AUDIOLOGY

In a paper on the "Early Ascertainment of Deafness in Children" read in 1960 by Dr. Mary Sheridan, then a Medical Officer at the Ministry of Health, it was said :

"Of recent years the importance of early ascertainment and treatment of deafness in young children has been increasingly recognised. This has partly been the result of more precise study and understanding of the physiological and psychological principles underlying the development of spoken language, and partly the result of availability of modern electronic hearing aids and improved methods of auditory training. If every handicapped child is to make the best use of the assets he possesses, five essential provisions must be made on his behalf : early ascertainment, full assessment, prompt medical and surgical treatment, expert training and habilitation or rehabilitation in the general community. It must never be forgotten that childhood itself is a temporary phase in progress to adulthood and if the handicapped child is to be enabled later to live a full, happy, useful life, he will need the devoted continuing attention of a team of highly trained people, each with his own indispensable part to play."

The primary methods of finding those children with an impairment of hearing are by screening tests and clinical audiometry. Obviously all these tests take time which in the opinion of many authorities, can only be found by foregoing other duties. Fortunately in this County deafness is not quite the poor relation that it was, and despite the size of present staffs of Medical Officers and Health Visitors, recognition of the problem and a realistic approach to the task of carrying out such tests has been achieved with a great amount of success.

During 1965, 4 Medical Officers and 6 Health Visitors were given courses of instruction in Shropshire by the Audiologist in the basic clinical techniques of audiological testing and ascertainment. The total staff in the Health Department audiology team now comprises :

1 Audiologist
7 Medical Officers
11 Health Visitors
2 Clerk/Sweep Frequency Testers

Infant Hearing Tests.—The number of live births in England and Wales annually averages over threequarters of a million and of the 4 million children under the age of 5 years it is expected that 1—2 per 1,000 will have an impairment of hearing serious enough to require special medical and educational treatment. As there is a wide scatter over the country of these children some ordered method of screening in order to discover them, must be used. The tests used by the specially trained Health Visitors are necessarily simple but nevertheless sensitive in their content but it is impossible to test the whole of the infant population. Certain groups of babies thought to be "at risk" of being born with, or later developing, impaired hearing are tested. These suspect babies are those who have been exposed to adverse influences in their pre-natal, peri-natal and post-natal periods or those who show some unusual symptoms in their behaviour. These risk groups are estimated to form about 20% of the infant population and amongst this 20% deafness is 14 times more common than among the remaining non-vulnerable group, but 40% of all cases of congenital deafness are still classified as of "unknown origin."

During the past year 1,548 babies (out of 5,826 live births occurring in the County) were placed on the "at risk." register. The Education Act, 1944, and School Health Services Regulation, 1953, clearly defined responsibilities for the management of deafness as beginning at the age of 2 years but the need for ascertainment at an earlier age than this is now generally recognised. Testing of these babies is usually made when they have reached the age of 8—9 months and during the year the number tested at Infant Clinics was 1,256, the results being summarised in the following table:

INFANT HEARING TESTS PERFORMED

	Tested	Passed	Failed or did not co-operate		
			For Retest	For Medical Audiology Clinic	To be seen by Audiologist
New cases ..	1,189	1,094	62	19	14
Review cases	67	49	14	3	1
TOTAL	1,256	1,143	76	22*	15†

*Of these 22 cases :

8 are to have further hearing tests ;
3 were discharged with normal hearing ;
4 are awaiting appointments to attend the Medical Audiology Clinic ;
6 subsequently attended the Hearing Assessment Clinic and the issue of hearing aids in 2 cases was recommended ; and
1 was awaiting operative treatment by the Ear, Nose and Throat Surgeon.

†Of these 15 cases :

11 were discharged with normal hearing ;
2 were referred to the Medical Audiology Clinic ;
1 is to have further hearing tests ; and
1 died.

Testing of the "at risk" babies should also be made again at 2—2½ years (the age when most normal children should be talking) and again just before school entry, but it may be several years before this ideal can be achieved in this County.

The actual tests made on these infants are quite simple and the techniques can be fairly easily acquired by most of the staff who come for training. However in order to produce reliable results there must be precise attention to detail because of the complicated developmental, acoustic and psychological principles which underly the apparently simplest of testing procedures. Because of these factors the Audiologist tries to keep under constant review the techniques employed by the field workers and to be available for discussion and follow-up of any suspect cases.

Hearing Tests of School Children.—Because of the shortage of specially qualified clerical staff the routine testing of hearing of school children in the 5 and 8 year age groups did not recommence until November and the resultant decrease in numbers, only one-fifth of the work done last year, is shown in the following table :

SWEEP FREQUENCY TESTS PERFORMED

Category	Tested	Normal	Hearing Suspect
Primary School Children	1,016	858	158
Suspected Deafness ..	5	5	—
Backwardness	5	5	—
TOTAL ..	1,026	868	158

In order to go someway to solving this problem it is proposed in 1966 to appoint an Audiometrician. This person will be initially trained by the Audiologist in testing procedure and then become responsible to him for the routine screening tests carried out in schools. It is certainly from within the group of failures found by this method that the bulk of children later referred for medical or special educational treatment are found. Again, I hope that in the future we may be able to test children of secondary school age, a group not at present screened for hearing loss.

Medical Audiology Clinics.—The failures at sweep frequency testing in schools and also other children who have been referred by School Medical Officers, Speech Therapists, Educational Psychologists, Teachers of the Deaf, Medical Practitioners and Hospital Specialists are all seen at a Medical Audiology Clinic. These clinics are staffed by one of the Medical Officers trained in this work, or the Audiologist, and one trained Health Visitor.

During 1965, a total of 247 clinics was held and 1,961 children received detailed hearing tests, with the results indicated below :

RESULTS OF TESTS AT MEDICAL AUDIOLOGY CLINICS

Referred by	Cases	Number Tested Age Groups			Discharged	Further Investigation	Hearing Defective					
							One Ear				Both Ears	
							Severe		Moderate			
		Under 5	Primary	Secondary			L.	R.	L.	R.	Severe	Moderate
Aural Surgeon ..	New	1	19	4	5	3	—	1	—	1	—	14
	Review	1	19	3	2	3	—	—	—	2	2	14
Children's Home ..	New	—	1	—	—	—	—	—	—	—	—	1
	Review	—	—	—	—	—	—	—	—	—	—	—
Deaf Teacher	New	—	72	11	47	8	—	—	6	3	2	17
	Review	—	28	3	6	4	—	1	1	3	2	14
Educational	New	—	4	—	4	—	—	—	—	—	—	—
Psychologist ..	Review	—	—	—	—	—	—	—	—	—	—	—
Family Doctor ..	New	—	19	—	10	3	—	—	—	1	—	5
	Review	—	4	—	1	3	—	—	—	—	—	—
Head Teacher	New	—	18	3	10	4	—	—	1	2	—	4
	Review	—	18	5	5	2	—	1	1	1	3	10
Health Visitor/School Nurse	New	3	16	—	7	3	—	—	—	2	1	6
	Review	1	26	2	4	4	—	—	3	4	1	13
Infant Assessment Clinic	New	15	3	—	2	6	—	—	1	2	—	7
	Review	5	13	—	2	6	—	—	2	2	1	5
School Medical Officer	New	6	240	78	148	38	1	2	19	11	18	87
	Review	—	158	63	56	28	—	2	16	8	12	99
Speech Therapist	New	3	44	2	28	9	—	1	2	1	1	7
	Review	—	15	4	7	1	—	—	3	—	1	7
Survey	New	—	4	—	2	—	—	—	—	—	—	2
	Review	—	—	—	—	—	—	—	—	—	—	—
Sweep Test	New	—	309	16	200	20	1	—	19	13	6	66
	Review	—	505	54	214	52	4	4	48	30	20	187
2 H.P. Case (E.S.N.)	New	—	14	16	24	1	—	—	—	1	1	3
	Review	—	5	11	7	1	—	—	4	2	—	2
Parent	New	7	50	8	33	11	—	—	2	2	4	13
	Review	—	22	2	5	4	—	—	1	2	1	11
Paediatrician	New	—	3	—	2	—	—	—	1	—	—	—
	Review	2	3	—	1	2	—	—	1	—	—	1
TOTALS ..		44	1,632	285	832	216*	6	12	131	93	76	595
		1,961			1,961							

*This figure includes cases where the Medical Officer was unable to diagnose definitely any permanent hearing loss. The children concerned may, at the time of examination have been suffering from such conditions as colds, catarrh, etc., or have had wax in the ears. In order not to inundate the Otologists with unnecessary referrals these children were called for further investigation before a final decision or recommendation was made.

Following attendance at the above Clinics, recommendations and referrals were made as follows :

192 children were recommended to sit in an advantageous position in class ;
92 children were notified to the Head of the School for information and guidance ;
159 children were notified to the Peripatetic Teacher of the Deaf to visit and advise in school ;
10 children were referred to the Speech Therapist ;
4 children were referred to the Educational Psychologist ;
1 child was referred to the Orthodontist ;
35 children were referred to their Family Doctors for treatment ;
29 children were referred to Ear, Nose and Throat Specialists ; and
132 children were referred to the Hearing Assessment Clinic for a final decision on operative treatment, special educational placement or the provisions of a hearing aid.

Hearing Assessment Clinics.—These are attended by Mr. E. N. Owen, F.R.C.S., Aural Surgeon at the Eye, Ear and Throat Hospital, Shrewsbury; the Audiologist; a Teacher of the Deaf; an Audiology Technician from the Hospital Group; one of the School Medical Officers and one of the specially trained Health Visitors.

Each child is thoroughly assessed by the Specialists in attendance and the parents are advised and given any help and guidance required. The family doctor is notified that the child will be attending for assessment and is always advised of the outcome, as is the Headteacher of the child's school.

During 1965 at 29 Hearing Assessment Clinics, the following recommendations were made for 152 children :

45 children were recommended for "Medresco" (N.H.S.) hearing aids ;
39 children were recommended for operative treatment ;
4 children were recommended for admission to the Partially Hearing Unit at Coleham School ;
1 child was referred to the Paediatrician ;
2 children were referred to the Child Psychiatrist ;
3 children were recommended for special home visits by the Teacher of the Deaf ;
2 children were recommended for observation in school ;
1 child was discharged, and
55 children were recommended to be recalled at a later date for review.

The Assessment Clinics are held at the Katharine Elliot School, Woodcote Way, Shrewsbury, where the facilities for this work are reasonably good but there is still a need in this County for a central, purpose built "speech and hearing" diagnostic clinic. The facilities for testing hearing accurately are poor in the Hospital or Welfare Clinic surroundings mainly because of noise interference.

This ambient noise level is normally not irritating but it can, during audiometric work, successfully mask many of the sound stimuli used. In the country as a whole there is a gradual realisation that we are living in an ever increasing noisy environment and steps are being taken to combat this annoyance. Constant exposure to some noises is of course more than an annoyance as it can result in permanent deafness. Noise, simply defined, is "any unwanted sound" and this could be a cough during a concert, a road-drill or even a boring after dinner speaker. Noise measured by a Sound Level Meter inside my own car during a recent journey registered in the region of 80 decibels which is nearly as loud as Niagara Falls. (A person with a loss of 80 decibels would require a very powerful hearing aid).

Although the Audiologist has the task of co-ordinating the audiological services it should be stressed that the Assessment Clinic is a joint clinical session and recommendations made are "team" ones.

If time could be made available it would appear that there is scope for some retrospective research into the value of the work done at these clinics. For instance, it would be interesting to know if the medical treatment prescribed was effective. Do the children issued with hearing-aids improve scholastically ? How lasting is the treatment given to the child with catarrhal deafness ?

Conductive hearing loss because of catarrh is an ever-present, and possibly increasing problem, its important feature being its variability. The pathological process in the ear may continue for weeks, months or even years and consequently hearing acuity may accordingly deteriorate or improve parallel to this.

With the presence of the Hospital Audiology Technician at Assessment Clinics we are fortunate that, by the use of new techniques, the child recommended for issue of a hearing aid is enabled to obtain this almost immediately. If the child is of school age the Peripatetic Teacher of the Deaf follows up the child in school to ensure that he is using his aid correctly and in many cases also to tell the class teacher about the value and limitations of the aid. The child under school age is visited at home by the Audiologist who undertakes a programme of parent/child training and guidance using auditory training machines. In the last term of the year a small group of these children was brought in to attend the Katharine Elliot School on one morning each week. This successful experiment was made as an interim measure prior to the admission of these children to the Nursery class of the Partially Hearing Unit at Coleham County Primary School, Shrewsbury which is due to be started in September 1966. The Principal of the Katharine Elliot School, Mr. A. I. Rabinowitz, and his staff have been most helpful and co-operative in dealing with these children and have readily made available the facilities at the school. The Calligraphone equipment, mentioned in the Speech Therapy report, has been used as have the rooms fitted with the induction loop system. The emphasis is always on the prevention oflinguistic retardation; it is essential that every effort is made before a child enters school that a satisfactory system of communication is established between the child and his parents. There is a great interest shown by the teaching staff of most of the ordinary schools attended by children with impaired hearing. It is hoped that during 1966, in co-operation with the Education Department, it may be possible to hold some form of one day course dealing with the problems of defective hearing in children specifically for teaching staff. At the other end of the scale one of the most difficult tasks which must be tackled is provision for the problems of adolescence, school leavers and job placement.

At the West Midland Agricultural Show this year a successful exhibition of the work of the Audiological services was presented. Also outside the usual work done by the Department was the audiological testing of some 100 children in the 1958 cohort being investigated by the National Child Development Study.

The work of the Audiology Section is dependent upon the clerical team backing it and I would like to thank Mr. E. R. Wakeley, Mr. R. Allen and their colleagues for their extremely helpful work and genuine interest in the children with whom they are concerned. It should also be put on record that a considerable amount of money has been saved by the intricate repairs that have been made to the very expensive electronic equipment by Mr. N. Rushworth of the School Health Section.

E. PAULETT,

Audiologist/Senior Speech Therapist

Education of Partially Hearing Children.—Miss Green, teacher of the deaf at the Partially Hearing Unit at Coleham County Primary School, Shrewsbury, gives the following account of her work :

"Following a meeting of the Shropshire Branch of the National Deaf Children's Society, the speaker, Dr. Pierre Gorman, himself born severely deaf, commented that he thought that the education of the deaf had remained static for the past 100 or more years, and that deaf children were not adequately prepared for life in a hearing world. He added that until the attitude of the general public towards the deaf person had changed, the deaf would continue to congregate in missions for the deaf after leaving the sheltered environment of their schools. After what had been a most encouraging lecture by a man whose language and achievements would outstrip those of many hearing people, one was compelled as a teacher of deaf children to take an objective look at the education of the deaf and partially hearing in one's own county.

In Shropshire, if we are really to succeed in meeting the needs of the deaf and partially hearing children then the facilities must be extended.

A teacher was seconded in September 1965 to the London University Department of Audiology and Education of the Deaf. When she returns in July 1966 there will be three qualified teachers of the deaf in the County.

In September 1965 the peripatetic services for deaf children were almost completely suspended when the one extra class for partially hearing children was set up. Accommodation was limited and the two classes had to share a room, but this was felt to be preferable to leaving partially hearing children in normal schools where they were failing educationally, socially and emotionally, or alternatively leaving pre-school partially hearing children at home where they and their parents were becoming more and more frustrated. Cramped conditions, however, limited the number of pre-school children admitted to two.

There are in these two classes 21 children from all over Shropshire with ages ranging from 4—11 years, all with varying degrees of hearing loss.

Dr. Gorman's criticism that deaf children were not adequately prepared for life in a hearing world after attending schools for the deaf can be largely met by educating these deaf and partially hearing children as we do here in units attached to schools for hearing children.

Socially they become more mature through observing the behaviour of the hearing children. When watching children at play one cannot distinguish the partially hearing and deaf children from the hearing children apart from the outward sign of deafness—the hearing aid.

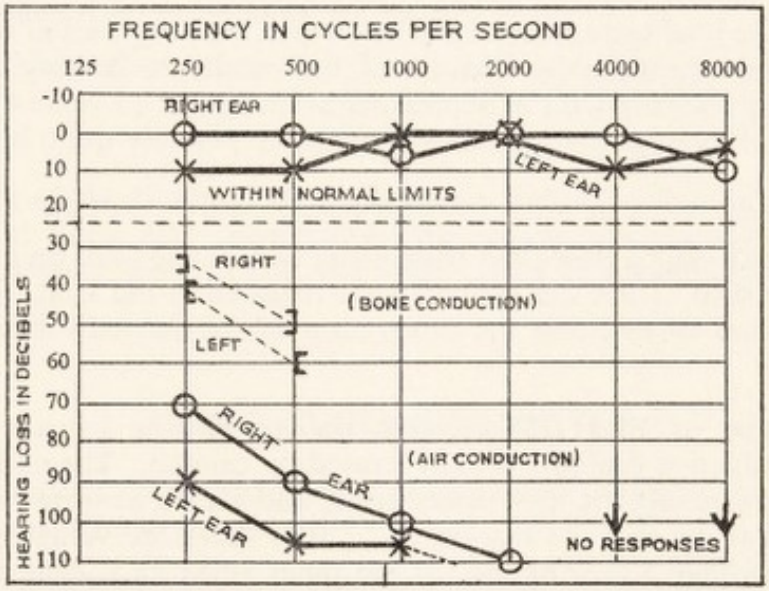
The deaf children are never prevented from using any method of communication to convey an idea. It would be quite wrong to stop a child communicating by natural gesture, drawing or writing when he does not have spoken language. However, at the Coleham Partially Hearing Unit, apart from the young deaf child who uses natural gesture accompanied by vocalisation, one does not see the use of hands in communication and there is little sign of the gross facial movement which one often sees when deaf persons are talking. Even before their spoken language is fully intelligible, they are expected to take messages to teachers, dinner helpers and kitchen staff in the hearing school, and to go on expeditions to the local shops where they not only learn money values, but have additional opportunities to communicate with people in the hearing world. They also go on educational visits with an infant class from another school ; they visited R.A.F. Station, Shawbury, Father Christmas, cafes, supermarkets and frequently go to local shops. These visits are not only excellent for teaching new language, but provide opportunities for learning how to behave in a public place. When visiting one cafe, a child with a severe high frequency hearing loss whose language and speech were practically nil 5 years ago, confidently gave the order without any prompting from the teacher, and was easily understood by the waitress.

At Coleham Partially Hearing Unit, even children who would be termed profoundly deaf are admitted. The results of audiometric testing are only the beginning of the story. Failure to appreciate the need for auditory training may later lead some parents and teachers to feel that a hearing aid is of no benefit to the child. The situation is comparable to that of interpreting an unknown foreign language, there is a need for a multi-sensory stimulation of the receptor centres before language can be remembered, interpreted, and when necessary, expressed as thought to solve abstract problems through speech or written language.

It takes a hearing baby a year of vocalisation of sounds, babbling, and listening, before he utters the first words which are then only approximations.

If a hearing child needs this time to learn to identify the code of language through an unimpaired hearing mechanism, then one must be prepared to allow more time for the deaf child to pass through similar stages.

One child when admitted at the age of 6½ years gave no response to the Pure Tone Audiometer. After two months of auditory training two responses were recorded—one at 100 decibels at 500 cycles per second, and the other at 110 decibels at 1,000 cycles per second. Now after two years of auditory training, she has hearing as shown in the audiogram sketched below, and she can identify many words and phrases through hearing alone. (A decibel is the unit of measurement of sound intensity).



A child's residual hearing is of great value if he is carefully trained to listen, and he will ultimately realise that these faint sounds can be meaningful and important. This does not mean that the handicap of deafness can be removed by training, but it does mean that the child is not left to learn language solely through observing movements of the speaker's lips.

The hearing losses of children in the Unit (i.e. average loss *better* ear of the 3 frequencies 500, 1000 and 2000 cycles per second) are as follows :

Average Loss	30/40 db	40/50 db	50/60 db	60/70 db	70/80 db	80/90 db	90/100 db
No. of Children	2	4	2	3	4	4	2

From this table it can be seen that as well as the profoundly deaf children in the unit there are also children whose hearing loss would appear not to warrant special full-time education.

Every child is an individual, and emotional and intellectual factors may be just as important in planning the child's future as the decibel loss on an audiogram.

It was interesting to observe that one of the two children with the least hearing loss in the better ear was able only to hear correctly one-third of a word list spoken to him in normal conversational voice at a distance of three feet in good listening conditions. He was in a class of 48 children and had not started to read at the age of 6½ years. He had no number concept and could not even count in sequence to 10. The Headmistress of the school he attended was surprised when she learned that the boy had been recommended to attend the Partially Hearing Unit for a short period of time, she had considered that the best placement was in a class for children retarded by lack of mental ability. The boy has since been assessed as being of high average range of intelligence. On a Schonell Arithmetic test his arithmetic age exceeded his chronological age by 7 months after a year in the Partially Hearing Unit. Reading by the traditional method reminded him of the failure he had experienced in the hearing school and, therefore, last July he commenced reading by using the initial teaching alphabet. He is now reading confidently in the initial teaching alphabet but is not yet ready to try again the orthographic method.

One girl, despite the intelligent interest shown by the teaching staff at her school realised she was failing socially and educationally because of her moderate hearing loss. This child was admitted to the Partially Hearing Unit in September at the age of 11 years 4 months and has since been discovered to be of average ability and with a future possibly quite bright.

School Visits.—Until September 1965 these visits were carried out on a full-time basis by one qualified teacher of the deaf ; then her services were required in the Unit. The main work of the peripatetic teacher is that of assisting the integration of the partially hearing child within the hearing school.

A large precentage of the 1,358 children on the visiting list are handicapped by the fluctuating type of conductive deafness usually caused by catarrh. The child with the fluctuating type of hearing loss is probably the least understood, and even a hearing loss of 10/20 decibels is sufficient for the child to be thought disobedient. It is therefore valuable for the child with a variable hearing loss to have a hearing aid for the times when he is deaf or, at any rate, for his teachers to be made aware of his handicap by the visiting teacher.

At present there is no Partially Hearing Unit for children above Junior School age and there are many children who have still not overcome their handicap by that time. However, if their hearing loss is only moderate and their speech and language good, they are transferred to the Secondary Modern School in their area. In these cases also the peripatetic teacher can give some remedial help, and auditory training. Numbers do not permit the help to be more than spasmodic and many of these children are found to be functioning much below their potential. This is sometimes partly due to the fact that many adolescents who had previously accepted their aids, refuse to wear them in the new environment because they feel conspicuous.

It is interesting to note that it is seldom difficult to persuade a child in a Secondary Grammar School to wear his aid.

The following is a statistical summary of the work carried out during the year by peripatetic teachers of the deaf (1964 figures in brackets) :

No. of schools visited in 1965	197	(160)
Visits to schools	309	(769)
No. of visits to children at school	898	(624)
No. of visits to children at home	11	(27)
No. of school age children on visiting list on 31st Dec., 1965	1,358	(653)

Of these 1,358 children :

81 need a termly visit plus auditory training. (10 of these 81 children need full-time education in a Partially Hearing Unit)

1,277 need an annual check up

Home Visits.—Training of pre-school children and their parents had been undertaken by the Audiologist.

Home visits are still made by teachers of the deaf to parents of children of school age in order to give them guidance on how best they can help their child, and this service has been usefully supplemented by the formation of the local Branch of the National Deaf Children's Society.

Home visits are also made in the vacations by the Audiologist and the teachers of the deaf to the children on holiday from out-county Residential Schools.

Two of these children were taken to a Youth Centre where they met some hearing contemporaries.

Shropshire Branch of the National Deaf Children's Society.—Throughout the year meetings were held in the Unit at which many interesting lectures were given by a variety of speakers. The discussions between parents, teachers and other specialists following these talks appear to have been of very great value.

CHILD GUIDANCE SERVICE

Dr. Benady, Consultant Child Psychiatrist, gives the following account of the work carried out by the Child Guidance Service during 1965 :

"I have pleasure in paying tribute to the work carried out by Mr. J. L. Green, the County Psychologist, and his staff during the first nine months of 1965. As can be seen from the figures below, this work has not diminished in any way and each case was dealt with as fully as possible without medical direction. The Clinic remains short of Psychiatric Social Workers, but will be increasing its Psychological staff as well as its clerical staff in the near future.

The most pressing problem is the provision of adequate services for disturbed adolescent boys who, for one reason or another, are unable to attend normally at school. In this context, it has been suggested that the Authority should consider the possibility of a Hostel for them.

Regular weekly Clinics are now held in Shrewsbury and Wellington, and monthly Clinics in Oswestry, Ludlow and Bridgnorth. The services at Market Drayton will be developed as necessary.

We are continuing with the policy of a diagnostic assessment as soon after referral as possible, but this may mean a treatment waiting list.

With regard to treatment, the close links that we have with Shelton Hospital remain and have been increased by the allocation of four beds for child psychiatric purposes, although, of course. the ideal would be a specialised in-patient Child Psychiatric Unit.

A full range of clinical cases is being referred to the Clinic by all the various agencies, and we are hoping to be able to work in closer contact with the referring agency than hitherto.

The future of the Child Guidance Clinic in general is held to be primarily a Consultative Clinic for all Social Agencies dealing with children and young people. We cannot, however, forget the individual and his family and their needs for psycho-therapy, be it individual or group, and we hope to be able to continue both in spite of the increased demands made on our time."

Summary of work done during 1965 (figures for 1964 in brackets) :

Total number of new referrals	258	(263)
Total number of new cases seen	228	(219)
Unco-operative	10	(12)
Awaiting appointments	20	(32)
Old cases still requiring help	45	(48)

Sources of referral :

Head Teachers	21%	(28%)
Private Doctors	17%	(15%)
County Medical Officer of Health	37%	(32%)
Parents	6%	(12%)
Probation Officers	2%	(5%)
Miscellaneous, e.g. Children's Department, Psychiatric Hospitals, Education Welfare Officers, Speech Therapists, N.S.P.C.C., Health Visitors	17%	(8%)

Reasons for referral :

Behaviour difficulties such as aggressive behaviour, severe temper tantrums, truancy, pilfering	31%	(35%)
Nervous conditions such as night terrors, anxiety conditions, stammering and timidity	25.5%	(25%)
Physical disorders, e.g. day or night enuresis, soiling, failure to eat or sleep normally	26.5%	(24%)
Failure in school. Difficulties either in specific subjects, general behaviour or general attitude to work	13.5%	(13%)
Miscellaneous reasons: vocational guidance, advice re adoptions, reports to Magistrates	3.5%	(3%)
Number of cases seen by Psychiatrist	78	(7)
Number recommended for admission to Schools for Maladjusted Children	17	(20)

B.C.G. VACCINATION OF SCHOOL CHILDREN

B.C.G. vaccination against Tuberculosis is available, with parental consent, to :

(*a*) school children in the year preceding their fourteenth birthday ;

(*b*) children of 14 years and upwards who are still at school and students at universities, teacher training colleges, technical colleges and other establishments for further education; and

(*c*) whole school classes, which may include a few children under 13 years, for convenience.

The following are particulars of schools visited for B.C.G. vaccination purposes during 1965, with comparative figures for 1964 :

	Maintained and Grant-aided Schools		Independent Schools		Total	
	1965	1964	1965	1964	1965	1964
Schools visited	34	54	17	23	51	77
Children tested	2,248	3,089	276	454	2,524	3,543
Reactors—positive	145	222	28	58	173	280
—negative	1,963	2,751	242	394	2,205	3,145
Not read	140	116	6	2	146	118
Children vaccinated	1,925	2,714	232	385	2,157	3,099
Negative reactors not vaccinated	38	37	10	9	48	46

The acceptance rate for B.C.G. vaccination for 1965 was 93 per cent.

Special surveys were made at two schools where children had been in contact with known cases of Tuberculosis :

	Tested	*Positive Reactors*	*Negative Reactors*	*Not Read*	*Negative Reactors Vaccinated*
Children (all ages) ..	513	44	428	41	—

N.B.—These figures are not included in the table above.

The majority of the negative reactors were pupils under 13 years of age and therefore too young for vaccination ; they will be retested and vaccinated where necessary when they reach 13 years of age.

Mass Radiography.—Appointments for chest x-ray by Mass Radiography are offered to all positive reactors and also to their home contacts. In addition, since February 1964, arrangements have been made for those pupils who have had large Mantoux positive reactions (induration 15 mms. and above) to have follow-up x-rays four months and sixteen months after their initial chest x-ray.

The table below summarises the results of all cases investigated by the Stoke-on-Trent and Wolverhampton Mass Radiography Units.

	Pupils	*Home Contacts*	*Staff*
Cases investigated	723	180	76
Recalled for large film examination ..	11	3	2
Cases of tuberculosis discovered ..	—	1	—

(Included in the above figures are 536 children and 76 staff, from the schools at which special surveys were made. 9 children and 2 members of staff were recalled for large film examination).

DIPHTHERIA IMMUNISATION

Routine Medical Examination Sessions in school give the School Medical Officers opportunity to check on the children's state of protection against Diphtheria, to urge the importance of immunisation and to get parental consent to its promotion and maintenance. School Nurses, Health Visitors and District Nurses, who in the course of their duties discover school children who have missed immunisation, also endeavour to obtain the necessary parental "consents." Propaganda methods, including the display of posters, are also used from time to time to remind the public of the importance of immunisation.

During 1965, the total number of children *of school age* who were primarily immunised was 314; of this number 188 were treated by School Medical Officers and 126 by general medical practitioners.

Children immunised against Diphtheria in infancy should have a reinforcing injection after an interval of three or four years and School Medical Officers at routine medical inspections advise this in appropriate cases.

Unfortunately, due to the demand for poliomyelitis vaccination between 1957 and 1962 and to the demand for smallpox vaccination in 1962, there was a decline in the numbers of children receiving booster doses against diphtheria. In order to rectify this, a new procedure was started during the Autumn Term, 1963. Under this scheme consent forms have been issued to parents of 5 and 11 year olds at the time when preliminary arrangements are being made for the school medical inspection. In addition to protection against diphtheria, primary immunisation or boosters against tetanus and poliomyelitis were offered to 5 year olds. Children aged 11 years were offered booster or primary immunisation against diphtheria and tetanus, and re-vaccination against smallpox : parents have the choice of their children being given the necessary doses either at school or by their family doctors.

Of 4,806 school children given "booster" doses in 1965, some 3,628 were dealt with by the School Medical Officers and 1,178 by general medical practitioners.

The effects of the immunisation campaign are demonstrated by the following table showing the incidence of, and deaths from, Diphtheria among persons of all ages in the County during the past twenty years.

		1946—50	1951—55	1956—60	1961—65
Notifications ..	Total	35	1	—	1
	Annual average	7	0.2	—	0.2
Deaths ..	Total	5	1*	—	—
	Annual average	1	0.2	—	—

*Death of elderly women, assigned by Registrar-General ; C. diphtheria not found.

VACCINATION AGAINST SMALLPOX

During the year, 167 children between the ages of 5 and 14 years were vaccinated against Smallpox. Of this number, 74 vaccinations were performed by School Medical Officers and 93 by general medical practitioners.

In addition, 350 children were re-vaccinated, 227 by School Medical Officers and 123 by general practitioners.

VACCINATION AGAINST POLIOMYELITIS

Both Sabin (oral) and Salk (injection) vaccines continued to be available, but the former was the more widely used almost to the exclusion of the latter.

Some 480 children between the ages of 5 and 15 years received primary vaccination during the year and, of these, 305 were dealt with by County Council Medical Officers while the remaining 175 received their doses from General Practitioners.

In addition, a further 3,612 children in the same age group were given fourth (or booster) doses, 2,408 by County Council Medical Officers and 1,204 by General Practitioners.

IMMUNISATION AGAINST TETANUS

Of the 2,610 children who received primary immunisation against tetanus, 2,098 were dealt with by School Medical Officers and the remaining 512 by general practitioners. Of a further 4,701 children who received booster doses of tetanus antigen mainly in conjunction with diphtheria boosters by means of combined vaccines, 3,170 were immunised by School Medical Officers and 1,531 by Practitioners.

HEALTH EDUCATION

Health Education covers a wide field, some sections being more specialised than others. Schools promote physical and mental health by teaching games and physical education, and academic and practical subjects in classroom and workshop, and by extra-curricular activities. Within this educational framework there is a place for the medical and dental educational services which the Health Department try to fill as opportunity arises.

During the year in the course of their normal duties, School Medical Officers, Dental Officers and Health Visitors visit schools in the County and give talks on health subjects. We are receiving more and more requests for talks to be given in Schools and the Department's Officers are prepared to tackle special needs on current problems in the course of these talks. Visual aids, films, filmstrips, slides and flannelgraphs together with leaflets and posters or display panels are available. This applies to all schools, whether or not they are equipped with projection equipment.

The scope of the talks has extended from general health and hygiene, nutrition, grooming, care of person, teeth, feet, food hygiene, to more specialist subjects such as parentcraft, smoking, venereal disease and safety in the home.

There is a growing demand for guidance for adolescents in regard to personal relationships between the sexes, and during the year the Health Education section of the Salop County Health Department has offered to Secondary Schools a course for young people on the problems of adolescence and emergence into the complexities of modern life.

Where Heads of Secondary Schools have requested sex education programmes, the courses are arranged by Mrs. Jean Owen, who is a professional teacher recruited to the staff of the County Health Department for this purpose and who contributes the following report on her activities during the year :

"The first complete year's programme from September, 1964, to July, 1965, has seen the completion of 61 courses consisting of an average of 3 visits on each course. Thirty-four secondary schools or colleges have participated and an extremely successful course was asked for and supplied to one Junior School.

Some secondary schools are now asking for this course to be done in the first year and this, in our experience, is very successful and to be recommended. The boys and girls of eleven and twelve years old are not emotionally involved with problems of adolescence and like to have information of a simple factual nature. This first year course should be followed up by a more advanced course involving the personal relationships of adolescence, at some point before they leave school.

The course is, therefore, adapted to the requirements of each individual Head of school, and his group's needs, and is essentially seen as an adjunct to each school's programme.

Mrs. Owen is aided by Mr. H. Harris who has charge of any visual aids which may be required for the programme and can also call upon a Medical Officer for one of the three meetings, if requested.

The first meeting is introduced by the showing of a modern film "Learning to Live" produced by the London Foundation for Marriage Education. This is a most useful and sensitive film, greatly appredíated by both boys and girls, which gives not only the biological facts of reproduction but also touches upon aspects of personal relationships, responsibility and questions of morality.

Questions submitted by the pupils at this first meeting form the basis for the succeeding meetings which are best conducted in smaller groups as free discussion is a most valuable part of this course. In fact, one of the conclusions which one formulates as the scheme progresses, is that these young people find discussion in their own age group, under an outside chairman, a most helpful measure—their individual problems and those of their friends when brought out and discussed seem to help them to get life's complexities into focus.

The pressures of the adult world, relentlessly applied through the mass media, bring to these young people the necessity of resolving their personal patterns of behaviour at an earlier age than, perhaps, ever before.

One finds that these boys and girls have few inhibitions in discussing problems of sexual behaviour, and modern morality, provided that the adult in charge is prepared to meet them with an equally straightforward approach.

Another welcome development of this work is the increasing interest shown by Parent-Teacher Associations. Heads of schools are asked to inform the parents of pupils who are to receive these lectures so that if they so wish, pupils may be withdrawn. Such withdrawals have been approximately 9 in about 3,000 pupils involved. Interested parents have seen the film "Learning to Live" and had an opportunity to discuss the programme with Mrs. Owen on ten occasions.

In presenting this course to the Secondary Schools of Shropshire, we hope that we are able to help the teachers to open a window on this adult world and its problems, to help the boys and girls to solve some of their own and to achieve the emotional maturity which we all need for a happy life, before and after we leave school."

Smoking and Health.—Research and all the available statistical evidence indicates that there is a definite correlation between the smoking of cigarettes and the incidence of lung cancer, and on grounds of general health we do all that is possible by personal example and by the giving of information to discourage the formation of the smoking habit in youth and to curtail it in the addicted among the older generation.

Some Heads of Schools have felt that talks devoted entirely to smoking were undesirable because they tended to give undue emphasis to the practice and might well stimulate interest and experiment among those in whom the reverse reaction was intended but School Medical Officers are nevertheless expected to take every opportunity of pointing out to children the ill-effects of indulging in habits which are calculated to undermine good health.

In this County we have supported the Ministry of Health's anti-smoking campaign :

(*a*) by a programme of talks and the showing of films and slides in schools, available on request ;

(*b*) by displaying posters in clinics, council premises and elsewhere by distributing leaflets ;

(*c*) by offering talks to organised groups.

PHYSICAL EDUCATION

The following report has been provided by Mr. J. W. Beswick, Physical Education Adviser :

Shropshire Schools' Field Centre.—The Shropshire Schools' Field and Adventure Centre at Arthog again was in use from April to October last year. Again more pupils and staff attended the centre for both educational pursuits in field work and adventure activities including canoeing, sailing and mountain work and investigations in the mountains. The total numbers attending were some 900 children and 100 staff exclusive of the Children's Department who took their usual fortnight in the middle of August.

All the children attending the Summer Camp at Arthog are examined before departure to camp by a School Medical Officer—and must be certified free from infection and verminous infestation before being allowed to proceed.

Arrangements are made with a local medical practitioner to provide medical services at the camp when needed.

Swimming.—Again swimming is on the increase and new baths are being used each year. We hope to have at least three new ones in use by this next Summer season. Local Education Authority awards increased by 50%, the A.S.A. Survival Awards by 40% and the Royal Life-saving Society Awards increased by 40%.

The elite clinic for the better swimmers of the county who are being trained for competitive swimming continues to flourish in both Shrewsbury and Wellington.

Duke of Edinburgh's Award.—With the advent of a new Assistant Physical Education Adviser the Duke of Edinburgh's Award Scheme has been put on a different footing and he has been able to increase the scope considerably and change the pattern of work. Many more boys and girls are now involved and much more adventurous work is being tackled. Some seventeen boys and two girls attended the gold award presentation at Buckingham Palace in 1965.

Shropshire Schools' Sports and Athletics Association.—The numbers of sports and games held at area, county, inter-county, national and international level under the jurisdiction of this Association have now increased to twenty-one and it seems very likely that in 1966 four more activities under the National Council of School Sport will be added. This will mean now that some hundreds of children are able to compete at this very high level in National and International Competition.

Physical Education.—Again with the acquisition of new halls in new primary schools there is more opportunity for real physical education to take place both in and outdoors and many more children are able to change their clothing and footwear fully to take part in this activity. Barefoot work is becoming much more popular despite a few criticisms but the beneficial effects for the mobility of the feet is proving its worth.

SCHOOL CANTEENS

Medical Examination of Staff.—In order to ensure as far as possible that those engaged in the School Meals Service are not suffering from, or carriers of, infectious diseases liable to be transmitted by contamination of the food served in the canteens, the medical examination of canteen staffs is carried out at least once a year, and new entrants to the service are examined as soon as possible and also given chest X-ray examinations. They should be examined *before* commencing employment; often the worker's services are urgently required and prior examination is not considered possible, but this is potentially dangerous practice.

These medical examinations are directed towards establishing the cleanliness of the person, clothing and hands of those employed in the preparation or handling of food; and the absence of infectious conditions such as septic skin lesions, discharging ears and chronic catarrh and other conditions such as eczema or other forms of dermatitis.

If on initial examination an employee is found to have a history or shows symptoms of intestinal disorder, arrangements are made for specimens of faeces, and if necessary urine, to be submitted to the Public Health Laboratory, Shrewsbury, for investigation.

The following particulars give some indication of this work during the year :

KITCHENS AND SCHOOL CANTEENS

Premises		Personnel Employed				
		Supervisors	Cooks	Helpers	Others	Total
Central Kitchens ..	11	10	29	82	13	134
Self-contained Canteens	144	2	189	558	254	1,003
Canteens for dining only	154	—	—	327	220	547
TOTAL ..	309	12	218	967	487	1,684

During 1965 a total of 1,580 examinations of canteen personnel (326 initial and 1,254 re-examinations) was carried out.

In eight cases it was necessary to arrange for special chest x-ray examinations and the results in all these cases were satisfactory. X-ray examinations are made when the Mass Radiography Unit is in the area, or can be arranged specially at the request of the Medical Officer.

An employee suffering from dermatitis resigned from her appointment but in four further cases—one with a mild skin condition and three others suffering from a discharge from the ears—the canteen helpers were subsequently allowed to resume duty after having been treated successfully.

A further employee was found to have defective vision and it was recommended that she should not be employed in the canteen kitchen or on any task which would endanger herself or other employees.

This scheme has been extended to include personnel engaged in the preparation and handling of food stuffs at the Boarding Schools and Hostels in the County, and during the year, 63 such examinations were carried out by the School Medical Officers.

NATIONAL CHILD DEVELOPMENT STUDY

In 1958 a Perinatal Mortality Survey was carried out throughout the country under the auspices of the National Birthday Trust Fund, and Domiciliary Midwives and Midwives practising in private nursing homes were asked to complete a form of questionnaire in respect of every child born between 3rd and 9th March, 1958, of whom there were 91 in the County of Shropshire.

In order to carry out a National Survey of the educational and physical, development of these same children an organisation known as the National Child Development Study (1958 Cohort) was set up for this purpose in collaboration with the Society of Medical Officers of Health, the Association of Chief Education Officers and the Association of Directors of Education in Scotland.

The aims of the Survey were to relate certain factors associated with pregnancy, labour and the early neonatal period which appear to place children "at risk," to the physical, psychological, social and educational development of the children ; to obtain data on these facets of development for the whole cohort of children; and to identify further "vulnerable" groups as well as children with known handicaps, at seven years of age, in order to follow closely their development.

The Survey involved the completion of the following documents :

Parental Questionnaire

This form, designed for completion by the Health Visitor/School Nurse during an interview with the child's mother, covered aspects of the child's general development over the past seven years, school and pre-school experience, social class of the parents, accommodation occupied by the household and a detailed medical history.

Medical Questionnaire

This form covered the special senses, height, weight, laterality and speech as well as a general medical examination.

Audiogram

This form was completed by the Council's Audiologist.

Approximately 100 children in this County were enrolled in this survey and parental and medical questionnaires and audiograms were completed in each case during the early part of the year.

CHILD HEALTH SURVEY

In 1946 a Joint Committee representative of the Institute of Child Health and the Population Investigation Committee of the London School of Economics was set up to conduct an enquiry into questions relating to health, growth and development. The number of children enrolled in the survey was 6,000 and in order to ensure that the children whom it covered were representative of all social classes in Great Britain, Medical Officers of Health of certain selected Local Health Authorities, of whom Salop County Council were one, were asked to notify all children born in

a particular week in March, 1946, and to submit each year, beginning with 1946, a report on the medical examination and on the home circumstances of each child included in the enquiry.

The Survey is still being continued by the Joint Committee and during 1965 School Nurses were asked to visit the homes of the 20 Shropshire young persons concerned, to obtain confidential reports on their health and occupations.

SANITARY CIRCUMSTANCES OF THE SCHOOLS

In 1954 School Medical Officers completed comprehensive inspection reports on all the school premises in the county making notes on the sanitary arrangements, water supply, washing accommodation, canteens, heating, lighting and ventilation. On the occasion of each annual routine medical inspection the premises are re-inspected and matters which require attention or investigation are referred to the Chief Education Officer with a view to their being dealt with by the Education Works Committee.

GENERAL

Meals.—School canteen meals are available at 1/- per head (free in necessitous cases) for one hundred per cent of children attending school; 74.7 per cent were having school dinners at a census taken in September, 1965 ; in September, 1964, the figure was 69.9 per cent.

Milk.—Milk is supplied free of charge in all schools and a census taken in September, 1965, showed that 74.5 per cent of the children were drinking it.

Quality of Milk Supplies.—As far as possible only Pasteurised Milks are supplied ; of a total of 288 departments in maintained schools, 287 had pasteurised supplies and 1 an untreated supply in 1965.

Investigation of Milk Supplies.—The County Public Health Inspectors are responsible for the supervision of school milk supplies and samples for testing are obtained by Sampling Officers of the County Health Department. Methylene Blue colour tests to determine the keeping quality and, in the case of Pasteurised milk, Phosphatase tests to determine whether the milk has been properly processed, are carried out on milk from each supplier at regular intervals.

The table below gives the results of the examination of samples taken during 1965 :

Grade of Milk	Samples taken	Methylene Blue Test			Phosphatase Test	
		Satisfactory	Unsatis.*	Void†	Satisfactory	Unsatis.‡
Pasteurised	126	100	23	3	124	2
Untreated	5	5	—	—	—	—
TOTAL ..	131	105	23	3	124	2

*In the cases of the samples failing the Methylene Blue Test follow up samples were taken, and these proved to be satisfactory.

†Methylene Blue tests are declared void when the atmospheric shade temperature exceeds 65°F. during storage in the laboratory.

‡Following the phosphatase failures, investigations were carried out at the pasteurising plants concerned. Follow up samples proved to be satisfactory.

Medical Examination of Prospective Teachers.—During 1965, the medical staff of the School Health Service examined 320 candidates for entry to the teaching profession.

STATISTICAL TABLES

(i. e. as submitted to the Department of Education and Science on Form 8.M)

TABLE I (A) PERIODIC MEDICAL INSPECTIONS

Age Groups Inspected (By year of birth)	Number of Pupils Inspected	Physical Condition of pupils inspected (nutrition)		Pupils found to require treatment (excluding dental diseases and infestation with vermin)		
		Satisfactory	Unsatisfactory	For defective vision (excluding squint)	For any other condition recorded at Part II	Total Individual pupils
		No.	No.			
(1)	(2)	(3)	(4)	(5)	(6)	(7)
1961 and later ..	29	29	—	—	—	—
1960	1,828	1,828	—	16	50	63
1959	2,187	2,187	—	23	80	100
1958	488	487	1	10	20	27
1957	251	251	—	5	14	15
1956	174	174	—	2	11	13
1955	170	170	—	5	5	10
1954	921	921	—	34	29	63
1953	2,174	2,174	—	90	76	158
1952	1,404	1,404	—	36	61	92
1951	1,949	1,949	—	84	95	172
1950 and earlier ..	3,055	3,055	—	138	118	238
TOTAL ..	14,630	14,629	1	443	559	951

NOTE : (i) Routine medical examinations are normally carried out on entry to school, at 11 years of age and again at 14 years.

(ii) Columns 5, 6 and 7, relate to individual pupils and not to defects. Consequently the total in column (7) is not necessarily the sum of columns (5) and (6).

(B) OTHER INSPECTIONS

Special Inspections	1,364
Re-inspections	11,741
	13,105*

*In addition to those inspected a total of 2,297 pupils in 1957, i.e. 8 year old group, were given Vision tests. Of this total, 14 were recommended for treatment and 93 for observation.

Also approximately 1,000 visits per annum are made by School Medical Officers to the homes of handicapped pupils for special examination, re-examination and parent guidance purposes, etc.

(C) INFESTATION WITH VERMIN

(1) Total number of examinations in the schools by the School Nurses or other authorised persons ..	94,450
(2) Total number of individual pupils found to be infested	1,218
(3) Number of individual pupils in respect of whom cleansing notices were issued (Section 54(2), Education Act, 1944)	24
(4) Number of individual pupils in respect of whom cleansing orders were issued (Section 54(3), Education Act, 1944)	9

TABLE II

RETURN OF DEFECTS FOUND BY MEDICAL INSPECTIONS IN THE YEAR ENDED 31st DECEMBER, 1965
PERIODIC AND SPECIAL INSPECTIONS

Defect Code No.	Defect or Disease	Entrants		Leavers		Others		Total		Special inspections	
		Requiring :		Requiring:		Requiring :		Requiring :		Requiring :	
		Treatment	Observation	Treatment	Observation	Treatment	Observation	Treatment	Observation	Treatment	Observation
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
4	Skin	20	161	76	198	79	188	175	547	69	8
5	Eyes (*a*) Vision	49	602	222	980	172	636	443	2,218	9	77
	(*b*) Squint	17	120	10	50	17	89	44	259	2	15
	(*c*) Other	1	22	2	23	1	51	4	96	—	9
6	Ears (*a*) Hearing	18	264	3	78	8	125	29	467	—	40
	(*b*) Otitis Media ..	5	213	9	57	4	95	18	365	2	21
	(*c*) Other	—	50	2	24	—	29	2	103	1	7
7	Nose or Throat	37	633	20	213	29	338	86	1,184	6	76
8	Speech	16	151	2	27	5	42	23	220	—	50
9	Lymphatic Glands ..	1	153	—	28	1	75	2	256	—	17
10	Heart	1	101	4	89	1	78	6	268	—	13
11	Lungs	3	227	4	85	8	119	15	431	1	17
12	Development :										
	(*a*) Hernia	5	25	1	4	1	9	7	38	—	2
	(*b*) Other	1	121	10	29	5	78	16	228	1	14
13	Orthopaedic :										
	(*a*) Posture	1	22	3	75	2	67	6	164	—	9
	(*b*) Feet	7	238	4	144	9	172	20	554	1	27
	(*c*) Other	5	129	18	168	8	98	31	395	1	18
14	Nervous System :										
	(*a*) Epilepsy	2	16	3	17	2	15	7	48	2	3
	(*b*) Other	1	32	2	10	1	22	4	64	1	11
15	Psychological :										
	(*a*) Development ..	—	58	2	62	3	117	5	237	—	58
	(*b*) Stability	3	157	5	95	7	114	15	366	1	68
16	Abdomen	2	66	5	58	5	78	12	202	1	8
17	Other	4	41	27	108	10	95	41	244	1	18

TABLE III

(A) EYE DISEASES, DEFECTIVE VISION AND SQUINT

	Number of cases dealt with
External and other, excluding errors of refraction and squint	23
Errors of refraction (including squint)	3,893
TOTAL ..	3,916
Number of pupils for whom spectacles were prescribed	3,845

(B) DISEASES AND DEFECTS OF EAR, NOSE AND THROAT

	Number of cases dealt with
Received operative treatment :	
(*a*) for diseases of the ear	37
(*b*) for adenoids and chronic tonsillitis ..	453
(*c*) for other nose and throat conditions ..	128
Received other forms of treatment	16
TOTAL ..	634
Total number of pupils in schools who are known to have been provided with hearing aids: (*a*) in 1965	49
(*b*) in previous years	.. 100

(C) ORTHOPAEDIC AND POSTURAL DEFECTS

	Number of cases dealt with
Number of pupils known to have been treated at clinics or out-patients departments ..	128
Number of pupils treated at school for postural defects	47
TOTAL ..	175

(D) DISEASES OF THE SKIN (excluding Uncleanliness, for which see Part C of Table I)

	Number of defects treated or under treatment during year
Ringworm : (i) Scalp	2
(ii) Body	11
Scabies	1
Impetigo	32
Other skin diseases	15
TOTAL ..	61

(E) CHILD GUIDANCE TREATMENT

Number of pupils treated at Child Guidance Clinics under arrangements made by the Authority ..	273

(F) SPEECH THERAPY

Number of pupils treated by Speech Therapists	456

(G) OTHER TREATMENT GIVEN

	Number of cases dealt with
(*a*) Miscellaneous Minor Ailments	54
(*b*) Pupils who received convalescent treatment under School Health Service arrangements	18
(*c*) Pupils who received B.C.G. Vaccination ..	1,925
(*d*) Other treatment given :	
Appendicitis	7
Arthritis	1
Asthma	5
Bronchitis	2
Cardiac Conditions	13
Diabetes	3
Epilepsy	7
Hernia	7
Meningitis	1
Nephritis	1
Pneumonia	1
Rheumatism / Rheumatic Fever	4
Tubercular Conditions	11*
Miscellaneous	30
TOTAL (*a*) — (*d*) ..	2,090

*9 of this total were attendances at Chest Clinics for "check-up."

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