[Report 1953] / Medical Officer of Health and School Medical Officer of Health, West Riding of Yorkshire County Council.

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COUNTY COUNCIL OF THE WEST RIDING OF YORKSHIRE

Sixty-fifth

ANNUAL REPORT

OF THE

COUNTY MEDICAL OFFICER

AND

Forty-sixth

ANNUAL REPORT

OF THE

PRINCIPAL SCHOOL MEDICAL OFFICER

YEAR 1953

WEST RIDING HEALTH COMMITTEE

(as at 1.11.54).

Chairman

County Alderman J. W. Trickett

Vice-Chairman

County Alderman N. Carter

County Aldermen

Bambridge, H. J., O.B.E.
Bednall, A.
Collier, J. H.
(Vice-Chairman of the County Council).
Mellor, J. W.
Roberts, B.
Runton, Mrs. Ryder, C.B.E.
Sutcliffe, H.
Tomlinson, Sir Thomas, B.E.M.
(Chairman of the County Council).
Whittock, M.

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Barnes, Mrs. M. L.
Baynham, T.
Blackburn, J., O.B.E.
Carradice, P.
Cheetham, T.
Clarney, H.
Cockroft, H.
Crockatt, D. A.
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Dawson, T. S.
Denton, Mrs. N.
Guy, H.
Hanson, G. M.
Hardy, J.
Harrison, A.
Hibbert, J.
Holt, R. B.
Hunter, Major J. C., M.C.
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Miles, H.
Morris, W. A.
Newsome, T. A., B.E.M.
Oldham, J. F.
Pickersgill, A.
Rankin, H.
Smith, Mrs. E. E.
Tennant, J. S., M.A.
Thackray, C., B.A.
Thompson, M.
Waddilove, G.
Whitehead, H.
Whiteley, A. E.
Wilkinson, H. S.
Yorke, J.

WEST RIDING EDUCATION COMMITTEE

(as at 1.11.54).

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County Alderman W. M. Hyman

Vice-Chairman

County Councillor J. Fuller Smith

Representative Members:—

County Aldermen

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(Vice-Chairman of the County Council).
Cornthwaite, F. J.
Creighton, M.
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Lane, J. W., B.E.M.
Runton, Mrs. Ryder, C.B.E.
Smith, Mrs. J.
Taylor, E., M.B.E.
Tomlinson, Sir Thomas, B.E.M.
(Chairman of the County Council).
Turner, W. H.

County Councillors

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Bennett, H. V.
Boland, C. W.
Bowes, J. E.
Broughton, C. T.
Craven, H. J.
Crowther, A. C.
Fitzpatrick, Mrs. L. I.
Geldard, Col. N., D.S.O., M.C.
Greenald, Mrs. D.
Lawton, J. A., M.A., B.Sc., M.Ed.
Mason, G. S., B.Sc.
Medcalf, G. T.
Morton, F.
Nicholson, G. H.
Payne, J. E.
Rastall, Mrs. A.
Ratcliffe, Mrs. E.
Richardson, B., M.A.
Smith, Mrs. E. E.
Stott, S.
Thackray, C., B.A.
Thackray, H. E., M.A.
Warren, R. A. D., B.A.
Whiteley, A. E.
Wright, G., M.B.E.

Added Members:—

Adshead, H. J.
Green, Mrs. H. E., B.A.
Hardaker, Mrs. L.
Hepworth, B.
Martin, Mrs. M., LL.B.
Morris, Sir Charles, M.A.
Potter, Mrs. M. G.
Semmens, Mrs. H. W.
Sowden, P.
Whittaker, Dr. J. M., F.R.S.

STANDING SUB-COMMITTEES OF THE WEST RIDING HEALTH COMMITTEE

Ambulance Sub-Committee.—All matters relating to the County Ambulance Service.

Public Health Sub-Committee.—Matters relating to the Milk (Special Designation) (Pasteurised and Sterilised Milk) Regulations, 1949, Venereal Diseases, Vaccination and Immunisation, Rural Water Supplies and Sewerage, Housing Acts, Public Health Propaganda, Food and Drugs, Shops Acts, Nurses' Acts, 1943-45, and all other powers and duties of the Health Authority not delegated to another Standing Sub-Committee.

Mental Health Sub-Committee.—All matters relating to the duties of Local Health Authorities under the Lunacy and Mental Treatment Acts and the Mental Deficiency Acts, and the care of persons suffering from mental defectiveness. (Sections 22, 28 and 51, National Health Service Act, 1946.)

Welfare Sub-Committee.—Arrangements for the prevention of illness, the care of persons suffering from illness, or the after-care of such persons. (Section 28, National Health Service Act, 1946.)

Arrangements for promoting the welfare of persons who are blind, deaf or dumb and other persons who are substantially and permanently handicapped by illness, injury, or congenital deformity, or such other disabilities as may be prescribed by the Ministry of Health, and arrangements with Voluntary Organisations therefor. (Sections 29-31, National Assistance Act, 1948.)

Arrangements for the protection of property of persons admitted to hospitals, etc. (Section 48, National Assistance Act, 1948.)

The recovery of charges and expenses where permissible in respect of all services provided by the Health Committee.

The West Riding Distress Fund.

Welfare Accommodation Sub-Committee.—The provision and management of residential accommodation for persons who, by reason of age, infirmity or any other circumstances, are in need of care and attention which is not otherwise available to them. (Sections 21-24, National Assistance Act, 1948.)

Arrangements with Voluntary Organisations and other Local Authorities for the provision of accommodation in property maintained by them. (Section 26, National Assistance Act, 1948.)

The registration of disabled persons or aged persons homes. (Sections 37-39, National Assistance Act, 1948.)

Registration of charities for disabled persons. (Section 41, National Assistance Act, 1948.)

Provision of a meals service for aged persons.

The provision of aged persons clubs.

Care of Mothers and Young Children and Nursing Services Sub-Committee.—The duties of the County Council under Sections 22, 23, 24, 25 and 29 of the National Health Service Act, 1946, namely, the care of mothers and young children, midwifery, health visiting, home nursing and domestic help.

Divisional, School Health and Dental Services Sub-Committee.—All matters appertaining to the Divisional Health Administration, Health Centres, and the School Health and County Dental Services.

SUMMARY OF CONTENTS

Note: A detailed index to the contents of the report is given on pages 126 and 127.

INTRODUCTION

For the third consecutive year I have the honour to present the annual report on the public health and preventive medical services in the West Riding Administrative Area. I was appointed County Medical Officer and Principal School Medical Officer as from 5th April, 1954, and although not in the senior position during the year under review I am taking the liberty of presenting the report under my new designation.

This year the Minister of Health has not asked for a Special Survey Report and the report therefore follows the general lines of previous ones with a few additional items on which brief comment has been made.

It is always pleasing to announce records but there must come a year or years when no records have been broken, yet the volume of work and endeavour has equalled or even surpassed that of years in which records have been established. It is therefore with this restraining thought in mind that I record that the infant mortality rate is again the lowest for the Administrative County, being 29.3 compared with 30 in 1952. The maternal mortality figure is also the lowest ever recorded and is 0.5 per 1,000 live and stillbirths compared with 0.8 for the previous year. The death rate from tuberculosis of the lungs is 0.16, the same as last year and therefore equals the lowest recorded.

During the year there was an outbreak of virulent smallpox affecting Todmorden mainly in the administrative county but also associated with county boroughs in Yorkshire and Lancashire. There were 14 cases with the diagnosis confirmed in the county and of these 6 died. A full account of the outbreak will be found in the Report. It shows the painstaking work undertaken by Dr. Lyons, Medical Officer of Health, Todmorden, in dealing with the outbreak. Thanks are due to Dr. C. W. Dixon, a Consultant on smallpox for the Ministry of Health, for the great assistance he gave throughout the outbreak: to the Medical Officers of the Ministry of Health for their valuable advice: and to the medical officers and health visitors not only of the Todmorden Division but of other county divisions who willingly volunteered to take part in the work of vaccination, tracing and supervision of contacts.

What a remarkable thing it is to report that during the year there were many more cases of smallpox than there were of diphtheria. One case of diphtheria, which recovered, was confirmed during the year. Twenty years ago there were 1,652 cases and 122 deaths. The scheme for diphtheria immunisation with reinforcing injections continues and must be maintained to ensure a continuation of this freedom from a once deadly disease. There must be no slacking off in our efforts to control diphtheria and a high level of immunisation must be our aim.

Whooping cough continues to be prevalent. There were 5,821 confirmed cases compared with 5,865 in 1952. Immunisation against this disease, which affects the youngest age groups, was available from 1st June, 1952, and from then to the end of 1952 3,509 children had been protected. During the full year 1953 the number of immunisations was 8,520. It would be most helpful if the Medical Research Council trials into the efficacy of whooping cough immunisation could come to a speedy conclusion and a clear cut policy result.

In November, 1953, the Ministry of Health issued Circular 22/53 relating to B.C.G. vaccination. The Authority made application for the amendment of their scheme under Section 28 of the National Health Service Act in order that this form of preventive action against tuberculosis could be offered to school children between their thirteenth and fourteenth birthdays. Approval has been received and the scheme has started at the time of writing.

The scheme for the Divisional Administration of the Preventive Medical Services continues in its original basic form but as opportunity arises consideration is given to the reduction of the number of divisions. During the year the number was reduced from 31 to 30 by the amalgamation of two divisions and consideration was given to two further amalgamations. Approval was subsequently obtained from the Ministry of Health so that at a future date the number of divisions in the administrative county will be 28.

Provision of accommodation for mental defectives is still a problem. At the end of 1952 the number awaiting admission to institutions was 214; at the end of 1953 the number on the waiting list was 274. Institutional accommodation for mental defectives is a function of the Regional Hospital Boards but the Local Health Authority is responsible for the defectives remaining at home and who do not require institutional care. Occupation and training is necessary for mental defectives at home, particularly those children reported by the Local Education Authority to the Health Committee as ineducable. During the year steps have been taken to increase the number of occupation centres provided by the Authority and there has also been an increase in the number of group classes established.

An innovation during the year was the provision of a mobile clinic for maternal and child welfare services, operating in the more sparsely populated parts of the northern portion of the county. This has proved successful and it is intended to obtain a similar unit for the southern portion of the county. Details, including a photograph, will be found in the Report.

The Home Help service continues to provide most useful aid for the well-being and comfort of patients in their homes. Particularly is this so in the case of the chronic sick, aged and infirm, who received 72.3% of the total number of hours worked by home helps.

In conclusion, I should like to record my indebtedness to all members of the staff of the County Health Department for their loyal co-operation and their helpful assistance to me at all times.

I am,

Yours faithfully,

J. WOOD-WILSON.

County Medical Officer.

PART I

VITAL STATISTICS

Area and Population

	Municipal Boroughs and Urban Districts	Rural Districts	Administrative County
Area (acres) — See note below	380,334	1,229,425	1,609,759
Population:			
Census, 1931	1,128,519	375,538	1,504,057
Census, 1951	1,161,588	427,530	1,589,118
Estimated (Mid-1953)	1,158,200	434,400	1,592,600

Small changes in the boundaries of the Bentley-with-Arksey U.D. and the Doncaster R.D. took place on 1st April, 1954, the nett effect of which reduced the acreage of Municipal Boroughs and Urban Districts to 380,328 and increased that of Rural Districts to 1,229,431; also a population of 6, as at the 1951 Census, was transferred from Rural Districts to Municipal Boroughs and Urban Districts. The acreage of the Administrative County remained unchanged.

Number of Municipal Boroughs, 10; Urban Districts, 58; Rural Districts, 21; Total 89.

Summary for 1953

The live birth rate was 15.7; the stillbirth rate per 1,000 live and still births 25; the live premature birth rate per 100 live births 6.7. The death rate from all causes was 11.6; diphtheria nil; whooping cough 0.01; measles 0.01; meningococcal infections (cerebro-spinal or spotted fever, etc.) 0.01; acute poliomyelitis (infantile paralysis) 0.01; tuberculosis of the lungs (respiratory system) 0.16; other forms of tuberculosis 0.02; respiratory diseases 1.20; cancer 1.88; heart and circulatory diseases 4.26. Infant mortality was 29, and maternal mortality per 1,000 live and still births 0.51.

A comparison with the figures for the past 64 years is given in the following table:—

Year	Live Birth Rate	Death Rate All Causes	Zymotic Death Rate	Tuberculosis of lungs Death Rate	Other Tuberculous Diseases Death Rate	Respiratory Diseases Death Rate	Cancer Death Rate	Stillbirths per 1,000 total births	Maternal Mortality per 1,000 live births	Infant Mortality
1890–1909	28.9	16.7	1.89	1.19	0.52*	3.20	0.77*	†	†	147
1910–1919	22.5	14.5	1.26	0.84	0.41	2.58	0.98	†	4.81	112
1920	25.1	12.6	0.94	0.71	0.28	2.26	1.07	†	5.26	92
1921	23.3	12.6	0.78	0.74	0.29	2.20	1.11	†	5.04	97
1922	20.9	12.2	0.58	0.68	0.30	2.07	1.15	†	4.16	81
1923	20.6	12.2	0.53	0.71	0.28	2.11	1.16	†	4.32	81
1924	20.4	12.8	0.48	0.70	0.25	2.43	1.19	†	4.57	83
1925	20.1	12.3	0.53	0.70	0.26	2.15	1.22	†	5.12	81
1926	19.4	11.6	0.46	0.62	0.22	1.78	1.24	†	4.82	73
1927	17.7	12.6	0.51	0.65	0.21	2.12	1.28	†	5.18	79
1928	17.7	11.5	0.28	0.61	0.22	1.46	1.29	†	5.45	62
1929	16.7	13.6	0.54	0.66	0.21	2.22	1.28	47	5.24	89
1930	16.9	11.4	0.33	0.57	0.20	1.35	1.33	45	6.25	65
1931	16.1	12.4	0.38	0.57	0.16	1.64	1.32	45	5.82	74
1932	15.8	12.1	0.39	0.52	0.17	1.33	1.46	48	5.22	70
1933	15.0	12.2	0.30	0.49	0.14	1.36	1.42	47	6.24	70
1934	15.2	11.7	0.41	0.44	0.12	1.16	1.44	48	5.81	58
1935	15.0	11.9	0.28	0.48	0.10	1.13	1.48	47	4.55	58
1936	15.1	12.3	0.29	0.44	0.12	1.25	1.51	45	4.35	63
1937	15.2	12.7	0.21	0.46	0.11	1.23	1.60	45	3.92	60
1938	15.5	11.6	0.23	0.38	0.11	0.99	1.55	44	3.74	51
1939	15.2	12.2	0.18	0.41	0.10	1.01	1.52	42	3.05	54
1940	15.3	13.4	0.18	0.42	0.11	1.94	1.58	40	3.26	56
1941	15.4	12.3	0.22	0.42	0.12	1.43	1.68	39	2.72	57
1942	17.0	11.7	0.18	0.42	0.12	1.26	1.65	36	3.36	49
1943	17.8	12.7	0.19	0.43	0.12	1.63	1.72	34	2.48	50
1944	20.2	12.1	0.12	0.37	0.09	1.32	1.79	31	1.98	44
1945	17.9	12.3	0.19	0.38	0.09	1.36	1.80	30	1.78	51
1946	19.7	11.9	0.13	0.36	0.08	1.31	1.72	29	1.86	44
1947	21.5	12.3	0.16	0.39	0.09	1.37	1.80	26	1.31	45
1948	18.5	11.3	0.12	0.37	0.07	1.29	1.74	24	1.17	39
1949	17.2	12.1	0.08	0.32	0.05	1.44	1.81	24	0.85	38
1950	16.3	11.8	0.10	0.25	0.04	1.18	1.83	24	1.00	35
1951	15.8	12.7	0.10	0.24	0.04	1.48	1.80	26	0.96	32
1952	15.4	11.5	0.07	0.16	0.03	1.11	1.92	25	0.82	30
1953	15.7	11.6	0.08	0.16	0.02	1.20	1.88	25	0.52	29

* This rate is for the 10 years 1900—1909.
† Figures not available.

In the above table, the birth and death rates are per 1,000 estimated population; the stillbirth rates are per 1,000 total births (i.e., per 1,000 live plus stillbirths); the maternal mortality rates and the infant mortality rates are per 1,000 live births.

The incidence of, and the mortality from smallpox, enteric fever including paratyphoid fever, scarlet fever, diphtheria, measles, whooping cough, and diarrhoea in infants under two years of age was formerly considerably more than those of other infectious diseases. They were thus classified as the seven principal zymotic or infectious diseases, and it was customary to give a combined death rate therefrom denominated the "zymotic diseases death rate", or the "zymotic death rate". The zymotic death rates shown above are on this basis up to and including that for the year 1949. The mortality from all of these seven diseases has declined considerably and in some cases is now below that of some infectious diseases not included in the classification. Therefore, the combined mortality from the zymotic or infectious diseases is now best shown by a combined death rate from infective and parasitic diseases excluding tuberculosis, influenza, acute primary and influenzal pneumonia, enteritis and certain localised infections. The rates from and including 1950 are shown on this new basis.

The respiratory diseases death rate is the combined death rate from bronchitis, pneumonia, and other respiratory diseases excluding tuberculosis and influenza.

The maternal mortality rate is stated in two ways (a) per 1,000 live births, and (b) per 1,000 live and stillbirths. The latter is obviously the more correct way, but the number of stillbirths has been available only from the year 1929, and in order to provide a statistical comparison between the size of the rates from 1929 with those for previous years, the rates in the foregoing table are per 1,000 live births. The maternal mortality rates from 1929, per 1,000 live and stillbirths, are shown on page 10.

Births and Infant Mortality

The live births relating to the Administrative County numbered 25,026 (13,026 males, 12,000 females) in 1953, the crude birth rate per thousand of the population being 15.7 compared with 15.4 for 1952. There is no reason to suppose that this slight increase in 1953 over 1952 presages a halt in the downward trend in the birth rate which has been experienced since 1947.

There were 633 stillbirths in 1953, the stillbirth rate per thousand live and stillbirths being 24.7 compared with 24.6 for 1952.

Illegitimate live births numbered 950 which is at the rate of 38 per thousand of the total number of live births.

The deaths of infants under one year of age numbered 733, being at the rate of 29.3 per 1,000 live births, the lowest rate ever recorded for the Administrative County.

The mortality of infants at various periods in the first year of life is shown below: —

	Number of Deaths							Deaths per 1,000 Live Births						
	1947	1948	1949	1950	1951	1952	1953	1947	1948	1949	1950	1951	1952	1953
Male Infants														
Under 4 weeks	450	339	323	319	297	285	265	26.7	22.9	23.1	23.8	22.8	22.6	20.3
4 weeks—3 months ...	147	112	94	88	72	46	62	8.7	7.6	6.7	6.6	5.5	3.6	4.8
3—6 months	130	99	94	76	61	47	56	7.7	6.7	6.7	5.7	4.7	3.7	4.3
6—12 months	117	80	73	48	53	38	43	7.0	5.4	5.2	3.6	4.1	3.0	3.3
Total under 1 year	844	630	584	531	483	416	426	50.1	42.6	41.7	39.7	37.1	32.9	32.7
Female Infants														
Under 4 weeks	353	266	259	203	176	205	200	22.2	18.8	19.7	16.2	14.6	17.2	16.7
4 weeks—3 months ...	82	84	68	57	51	45	43	5.1	5.9	5.2	4.6	4.2	3.8	3.6
3—6 months	103	85	61	69	54	36	27	6.5	6.0	4.6	5.5	4.5	3.0	2.2
6—12 months	80	64	65	44	34	34	37	5.0	4.5	4.9	3.5	2.8	2.9	3.1
Total under 1 year	618	499	453	373	315	320	307	38.8	35.2	34.4	29.8	26.1	26.9	25.6
All Infants														
Under 4 weeks	803	605	582	522	473	490	465	24.5	20.9	21.4	20.2	18.8	20.0	18.6
4 weeks—3 months ...	229	196	162	145	123	91	105	7.0	6.8	6.0	5.6	4.9	3.7	4.2
3—6 months	233	184	155	145	115	83	83	7.1	6.3	5.7	5.6	4.6	3.4	3.3
6—12 months	197	144	138	92	87	72	80	6.0	5.0	5.1	3.5	3.5	2.9	3.2
Total under 1 year	1462	1129	1037	904	798	736	733	44.6	39.0	38.2	34.9	31.8	30.0	29.3

The table below gives a more detailed analysis of the mortality in infants (male and female) under 4 weeks of age in the years 1947 to 1952; the figures for 1953 are not yet available:—

	Number of Deaths						Deaths per 1,000 Live Births					
	1947	1948	1949	1950	1951	1952	1947	1948	1949	1950	1951	1952
Under 1 day	254	209	237	193	176	229	7.7	7.2	8.7	7.5	7.0	9.3
1—7 days	297	236	203	218	221	183	9.1	8.2	7.5	8.4	8.8	7.5
1—4 weeks	252	160	142	111	76	78	7.7	5.5	5.2	4.3	3.0	3.2
Total under 4 weeks ...	803	605	582	522	473	490	24.5	20.9	21.4	20.2	18.8	20.0

It will be observed from the figures in the above two Tables that although the total infant mortality rate has decreased considerably since 1947, the rate of mortality among infants in the first seven days of life has remained almost static. The death rate among infants in the first day of life varies from approximately 7.0 to 9.0 per thousand live births. About 75 per cent. of these deaths in the first day of life are due to immaturity, post-natal asphyxia and atelectasis, and birth injury; congenital malformations account for a further 10 per cent.

Deaths

Deaths in 1953 numbered 18,504 (9,799 males, 8,705 females) compared with 18,272 (9,567 males, 8,705 females) in 1952. The crude death rates per 1,000 of the estimated population were 11.6 in 1953, 11.5 in 1952, 12.7 in 1951 and 11.8 in 1950.

To make a proper comparison with the death rates for England and Wales, the crude death rates for the Administrative County must be adjusted to allow for differences in the age and sex constitution of the population. The rates shown below for the aggregates of Boroughs and Urban Districts, Rural Districts and for the Administrative County as a whole, have been so adjusted:—

Year	Boroughs and Urban Districts	Rural Districts	Administrative County	England and Wales
1950	12.6	11.1	12.3	11.6
1951	13.6	11.9	13.2	12.5
1952	12.3	10.8	12.0	11.3
1953	12.6	10.4	12.1	11.4

The following table shows the number of deaths in 1953 relating to the Administrative County, classified according to age and cause:—

Cause of Death	Age at Death								
	Under 1 year	1 and under 5	5 and under 15	15 and under 25	25 and under 45	45 and under 65	65 and under 75	75 and over	Total
1. Tuberculosis, respiratory	2	—	2	11	68	109	50	12	254
2. Tuberculosis, other	2	10	5	2	4	4	2	2	31
3. Syphilitic disease	—	—	—	—	3	20	16	6	45
4. Diphtheria	—	—	—	—	—	—	—	—	—
5. Whooping cough	6	6	1	—	—	—	—	—	13
6. Meningococcal infections	6	4	1	—	1	—	—	—	12
7. Acute poliomyelitis	—	4	2	3	2	—	—	—	11
8. Measles	2	4	3	—	—	—	—	—	9
9. Other infective and parasitic diseases	3	2	4	6	6	6	6	7	40
Total—Infective and Parasitic Diseases, exc. Tub.	*17*	*20*	*11*	*9*	*12*	*26*	*22*	*13*	*130*
10. Malignant neoplasm, stomach	—	—	—	—	14	179	183	164	540
11. Malignant neoplasm, lung, bronchus	—	—	1	—	19	256	129	39	444
12. Malignant neoplasm, breast	—	—	—	—	40	115	77	56	288
13. Malignant neoplasm, uterus	—	—	—	—	16	68	44	28	156
14. Other malignant and lymphatic neoplasms	1	4	4	12	72	473	484	441	1,491
15. Leukaemia, aleukaemia	1	4	6	5	12	28	10	5	71
Total—All forms of Cancer	*2*	*8*	*11*	*17*	*173*	*1,119*	*927*	*733*	*2,990*
16. Diabetes	—	—	1	2	4	33	53	37	130
17. Vascular lesions of nervous system	—	1	—	2	38	484	925	1,356	2,806
18. Coronary disease, angina	—	—	—	—	45	778	860	681	2,364
19. Hypertension with heart disease	—	—	—	—	6	87	162	149	404
20. Other heart disease	1	1	1	17	101	406	827	1,976	3,330
21. Other circulatory disease	—	—	—	3	11	98	183	389	684
Total—Heart and Circulatory Diseases	*1*	*1*	*1*	*20*	*163*	*1,369*	*2,032*	*3,195*	*6,782*
22. Influenza	8	3	—	5	6	24	61	54	161
23. Pneumonia	117	8	4	4	27	121	140	180	601
24. Bronchitis	30	8	2	—	15	275	361	455	1,146
25. Other diseases of respiratory system	4	—	—	5	12	60	40	44	165
Total—Diseases of the Respiratory System incl. Influenza and excl. Tuberculosis	*159*	*19*	*6*	*14*	*60*	*480*	*602*	*733*	*2,073*
26. Ulcer of stomach and duodenum	1	—	—	—	10	65	57	36	169
27. Gastritis, enteritis and diarrhoea	34	5	—	6	7	19	11	16	98
28. Nephritis and nephrosis	2	1	3	10	32	83	55	59	245
29. Hyperplasia of prostate	—	—	—	—	—	6	47	88	141
30. Pregnancy, childbirth, abortion	—	—	—	5	8	—	—	—	13
31. Congenital malformations	107	10	4	2	11	16	3	1	154
32. Other defined and ill-defined diseases	385	22	25	23	110	307	282	506	1,660
33. Motor vehicle accidents	1	7	14	39	32	42	18	18	171
34. All other accidents	20	16	20	18	65	91	75	176	481
35. Suicide	—	—	1	4	36	94	25	9	169
36. Homicide and operations of war	—	—	—	1	2	2	2	—	7
Total—Accidents, Suicide and Violence	*21*	*23*	*35*	*62*	*135*	*229*	*120*	*203*	*828*
Total—All Causes	733	120	104	185	835	4,349	5,188	6,990	18,504

Certain groups of diseases account for about three-quarters of the death rate from all causes for the Administrative County. This feature is not peculiar to the Administrative County. It could be said of the death rates for most, if not all, other areas and that of the country as a whole. The relevant statistics for the Administrative County are shown below:—

	Death rates per 1,000 population			
	1950	1951	1952	1953
Vascular Lesions of the nervous system	1.59	1.72	1.74	1.76
Heart and circulatory diseases	4.39	4.72	4.35	4.26
Bronchitis and Pneumonia	1.07	1.35	1.01	1.10
Cancer	1.83	1.80	1.92	1.88
Totals of above	8.88	9.59	9.02	9.00
Death rate— all causes	11.8	12.7	11.5	11.6

Child Mortality

The deaths of children between the ages of 1 and 5 years numbered 120 in 1953, a reduction of 3 on the number in 1952. The enormous reduction which has taken place in the past forty years in mortality among toddlers is shown by the statistics below. Apart from the effect, economic and sociological, on the community of the saving of so much infant life, one can envisage in perusing these figures the family tragedies which have been averted.

Number of deaths of children aged 1-5 years from the various causes — West Riding Administrative County.

Cause of Death	Annual Averages for Quinquennia				1945	1946	1947	1948	1949	1950	1951	1952	1953
	1911-15	1927-31	1935-39	1940-44									
Measles	439	107	27	18	22	2	16	6	6	3	8	2	4
Whooping cough	167	67	29	20	12	13	16	8	4	3	10	5	6
Diphtheria	110	47	51	32	10	6	—	4	3	1	—	—	—
Other infective and parasitic diseases, excl. tuberculosis	54	45	18	13	4	4	14	8	7	13	12	2	10
Tuberculosis, respiratory	47	13	5	4	8	1	2	7	2	1	3	—	—
Tuberculosis, other	201	82	37	39	33	20	42	28	24	15	16	13	10
Cancer	3	5	4	6	3	4	6	3	5	8	12	8	8
Heart and circulatory diseases	4	3	2	1	2	1	—	2	2	—	—	1	1
Influenza	6	43	10	11	3	7	4	1	4	2	2	2	3
Pneumonia	457	321	121	85	56	40	36	40	39	24	22	27	8
Bronchitis	150	42	10	17	11	7	11	9	7	2	8	4	8
Other diseases of respiratory system	49	15	6	5	4	2	1	6	4	6	1	2	—
Diarrhoea and other digestive diseases	248	45	38	23	21	18	16	18	13	3	3	2	5
Congenital debility, malformations, premature births, etc.	12	9	7	10	8	16	8	14	15	9	21	10	10
Accidents	82	54	50	47	52	31	36	31	37	39	29	28	23
Other Causes	323	119	52	45	43	32	34	21	19	32	28	17	24
All causes	2,352	1,017	467	376	292	204	242	206	191	161	175	123	120

The outstanding feature of the above table is the tremendous decline in the mortality from the so-called common infectious diseases; tuberculosis; bronchitis; pneumonia and other diseases of the respiratory system and diarrhoea and other digestive diseases. It will also be noted that there is a decline in the number dying from accidents.

The death rates of children between the ages of 1 to 5 years per 1,000 living in that age-group in the Administrative County are shown below:—

	Rate
5 years 1911-15	17.13
5 years 1927-31	10.62
Year 1951	1.52
Year 1952	1.15
Year 1953	1.17

The rates for 1911-15 and 1927-31 are based on the census populations for 1911 and 1931 respectively. Those for 1951, 1952 and 1953 are based on estimated populations.

Maternal Mortality

The number of deaths of mothers ascribed to complications of pregnancy, childbirth and abortion was 13 in 1953, the mortality rate per 1,000 live and stillbirths being 0.51 compared with 0.76 for England and Wales. The rate of 0.51 for the Administrative County is the lowest recorded and shows a considerable decrease on that for 1952 (0.80). It is noteworthy that the rate for England and Wales increased from 0.72 in 1952 to 0.76 in 1953. In 1953, 78 of the 89 County Districts in the County had no maternal death.

The number of maternal deaths and the average maternal mortality rate for the two quinquennial periods 1944-48 and 1949-53 in each of the Public Health Divisional Areas are shown in the following table:—

Division	5 years 1944-48			5 years 1949-53			Percentage decrease in rate for 1949-53 on that for 1944-48
	Total Live and Stillbirths	Maternal Deaths	Maternal Mortality Rate per 1,000 Live and Stillbirths	Total Live and Stillbirths	Maternal Deaths	Maternal Mortality Rate per 1,000 Live and Stillbirths	
1	4,814	11	2.29	4,277	4	0.94	58.95
2	1,948	6	3.08	1,685	1	0.59	80.84
3	5,043	13	2.58	4,318	4	0.93	63.95
4	5,859	13	2.22	5,105	2	0.39	82.43
5	6,016	7	1.16	5,141	2	0.39	66.38
6	2,791	1	0.36	2,420	—	—	100.00
7	1,885	6	3.18	1,788	—	—	100.00
8	5,867	6	1.02	4,985	1	0.20	80.39
9	4,037	7	1.73	3,502	3	0.86	50.29
10	4,408	3	0.68	3,879	2	0.52	23.53
11	6,449	13	2.02	5,345	6	1.12	44.55
12	5,742	6	1.04	5,048	4	0.79	24.04
13	4,312	2	0.46	3,483	5	1.44	‡*213.04*
14	3,886	3	0.77	3,228	3	0.93	‡*20.78*
15	4,633	9	1.94	4,114	1	0.24	87.63
16	5,098	6	1.18	4,060	4	0.99	16.10
17	4,302	3	0.70	3,680	2	0.54	22.86
18	5,099	7	1.37	4,347	3	0.69	49.64
19	4,902	8	1.63	4,244	1	0.24	85.28
20†	7,498	13	1.73	6,223	8	1.29	25.43
22	6,953	13	1.87	6,700	5	0.75	59.89
23	7,110	15	2.11	6,316	7	1.11	47.39
24	3,307	3	0.91	2,873	2	0.70	23.08
25	4,674	6	1.28	3,975	4	1.01	21.09
26	4,530	4	0.88	4,060	3	0.74	15.91
27	4,474	9	2.01	3,586	3	0.84	58.21
28	6,102	15	2.46	5,270	7	1.33	45.93
29	3,787	8	2.11	3,672	3	0.82	61.14
30	6,695	7	1.05	5,824	7	1.20	‡*14.29*
31	8,418	13	1.54	7,793	9	1.15	25.32
Total Admin. County	150,639	236	1.57	130,941	106	0.81	48.41

† Division No. 21 was abolished as from 1st October, 1953, and the single County District comprising it was included in Division No. 20 as from that date. The statistics shown above for Division No. 20 are for the Division as so enlarged.

‡ Percentage increase.

The above Table is similar to that given in the Annual Report for 1952, and is repeated because it appears to have some value, with reservations, for the purpose of comparison. In perusing the figures shown therein, it should be borne in mind that the mortality rates given are in most cases based on a small number of deaths and a small deviation in the number of deaths would have a very appreciable effect on the rate, for instance, in those cases where there are only one or two deaths, an additional one or two deaths would double the rate. The percentage increase in the rates for 1949-53 in Divisions 13, 14 and 30 should not be taken too seriously. Nevertheless, the figures do show which areas of the County have contributed to the decrease in the County rate from 1.57 in 1944-48 to 0.81 in 1949-53 and what areas may have conditions to be overcome to bring about a decrease in mortality.

The table below shows the number of deaths and the mortality rate for the past 25 years for the Administrative County: —

Year	No. of deaths from			Mortality Rate per 1,000 live and stillbirths		
	Puerperal and post abortive sepsis	Other maternal causes	Total	Puerperal and post abortive sepsis	Other maternal causes	Total
1929	58	76	134	2.16	2.83	4.99
1930	63	99	162	2.32	3.64	5.96
1931	57	88	145	2.19	3.37	5.56
1932	50	77	127	1.96	3.01	4.97
1933	48	96	144	1.98	3.96	5.94
1934	54	82	136	2.20	3.33	5.53
1935	43	62	105	1.78	2.56	4.34
1936	39	61	100	1.62	2.54	4.16
1937	21	69	90	0.87	2.87	3.74
1938	25	62	87	1.03	2.55	3.58
1939	19	51	70	0.79	2.13	2.92
1940	22	53	75	0.92	2.21	3.13
1941	17	48	65	0.68	1.93	2.61
1942	25	59	84	0.96	2.27	3.23
1943	18	46	64	0.68	1.72	2.40
1944	18	40	58	0.60	1.32	1.92
1945	14	32	46	0.53	1.20	1.73
1946	14	41	55	0.46	1.34	1.80
1947	7	36	43	0.21	1.07	1.28
1948	3	31	34	0.10	1.05	1.15
1949	4	19	23	0.15	0.68	0.83
1950	*	*	26	*	*	0.98
1951	*	*	24	*	*	0.93
1952	*	*	20	*	*	0.80
1953	*	*	13	*	*	0.51

*Deaths from puerperal and post abortive sepsis are no longer given separately.

A revised international classification of deaths was adopted from the commencement of the year 1950. The table below shows the maternal death rates, per thousand live and stillbirths, based on this revised classification.

Cause of Death	1950		1951		1952		1953	
	W.R. Admin. County	England & Wales	W.R. Admin. County	England & Wales	W.R. Admin. County	England & Wales	W.R. Admin. County	England & Wales
Maternal Sepsis (not associated with abortion)	0.15	0.12	0.12	0.10	—	0.09	0.08	0.10
Toxæmias of pregnancy and puerperium (not associated with abortion)	0.30	0.26	0.12	0.24	0.32	0.21	0.16	0.24
Abortion with or without mention of sepsis or toxæmia	0.23	0.15	0.23	0.16	0.12	0.13	0.04	0.11
Other complications of pregnancy, child-birth and the puerperium	0.30	0.34	0.46	0.32	0.36	0.29	0.23	0.31
Total Maternal mortality	0.98	0.87	0.93	0.82	0.80	0.72	0.51	0.76

It will be observed that in 1953 the maternal death rate for the Administrative County from all the various causes was less than that for England and Wales. The maternal death rate for the Administrative County is now less than a tenth of what it was twenty years ago.

PART II

EPIDEMIOLOGY

Incidence and Notification of Infectious Disease

Smallpox, cholera, diphtheria, membranous croup, erysipelas, scarlet fever, and the fevers known by any of the following names, *typhus, typhoid, enteric,* or *relapsing,* are compulsorily notifiable under Section 144 of the Public Health Act, 1936; *chickenpox* is notifiable under Section 147 of the same Act in some West Riding County Districts; *food poisoning* under Section 17 of the Food and Drugs Act, 1938. The following communicable diseases are compulsorily notifiable under the regulations stated in brackets—*measles and whooping cough* (Measles and Whooping Cough Regulations, 1940); *meningococcal infection, acute poliomyelitis—paralytic and non-paralytic, and acute encephalitis—infective and post infectious* (Acute Poliomyelitis, Acute Encephalitis and Meningococcal Infection Regulations, 1949); *ophthalmia neonatorum* (Ophthalmia Neonatorum Regulations, 1926, 1928 and 1937); *puerperal pyrexia* (Puerperal Pyrexia Regulations, 1951); *tuberculosis* (Tuberculosis Regulations, 1952); *malaria, dysentery and acute primary and influenzal pneumonia* (Infectious Diseases Regulations, 1927); *plague* (Notification of Case of Plague (General) Regulations, 1900). The contagious diseases of syphilis, gonorrhoea and soft chancre (classed under the term venereal diseases) and scabies are not compulsorily notifiable.

With the exception of food poisoning, which is dealt with on Page 25, the following table shows the number of cases in 1953 of each "notifiable" disease, being the numbers of cases originally notified and the final numbers after corrections subsequently made by the notifying medical practitioner or by the medical superintendent of the infectious diseases hospital, because of revised diagnosis as a result of bacteriological reports or further observation of cases since notification: —

AGE GROUP	Scarlet Fever		Whooping Cough		Acute Poliomyelitis (Paralytic)		Acute Poliomyelitis (Non-paralytic)		Measles		Diphtheria	
	M	F	M	F	M	F	M	F	M	F	M	F
Numbers originally notified (All Ages)	1,475	1,554	2,846	2,991	63	55	19	8	10,044	9,836	10	12
	3,029		5,837		118		27		19,880		22	
Final numbers after correction												
Under 1 year ...	4	3	254	243	1	5	—	—	356	339	—	—
1—2 years ...	129	108	696	716	12	7	2	—	2,273	2,168	—	—
3—4 „ ...	355	363	857	934	7	6	3	1	3,053	2,983	—	—
5—9 „ ...	804	849	983	998	12	10	4	3	4,023	3,945	—	1
10—14 „ ...	114	152	25	32	5	1	4	2	193	205	—	—
15—24 „ ...	37	41	2	12	9	10	2	2	71	95	—	—
25 and over ...	13	12	14	38	7	9	—	2	42	73	—	—
Age unknown...	4	3	6	11	—	—	—	—	20	14	—	—
Totals (all ages)	1,460	1,531	2,837	2,984	53	48	15	10	10,031	9,822	—	1
	2,991		5,821		101		25		19,853		1	

AGE GROUP	Acute Pneumonia		Acute Encephalitis		Dysentery		Typhoid and Paratyphoid Fever		Erysipelas		Meningococcal Infection	
	M	F	M	F	M	F	M	F	M	F	M	F
Numbers originally notified (All Ages)	861	725	7	3	230	250	5	9	140	164	34	23
	1,586		10		480		14		304		57	
Final numbers after correction												
Under 5 years...	141	150	3	—	86	69	1	—	2	1	15	12
5—14 years ...	111	92	3	2	84	78	—	3	3	4	2	2
15—44 „ ...	201	182	1	1	34	56	1	3	35	33	3	2
45—64 „ ...	251	142	—	—	10	17	2	2	60	87	1	—
65 and over ...	150	153	—	—	4	15	—	—	38	34	—	—
Age unknown...	7	5	—	—	2	—	—	—	1	4	—	—
Totals (all ages)	861	724	7	3	220	235	4	8	139	163	21	16
	1,585		10		455		12		302		37	

	Numbers Originally Notified	*Numbers After Correction*
Smallpox	16	14
Puerperal Pyrexia	141	141
Ophthalmia Neonatorum	20	20
Chicken Pox	739†	not corrected
Malaria	14	14

† Chicken Pox is compulsorily notifiable only in certain County Districts.

The table belows affords a comparison with the preceding eight years:—

Disease	Number of corrected notifications (Chicken Pox not corrected)								
	1945	1946	1947	1948	1949	1950	1951	1952	1953
Scarlet Fever	3,109	2,369	2,764	3,863	3,191	2,506	1,792	2,176	2,991
Whooping Cough	2,844	4,451	3,424	6,201	3,947	7,669	6,933	5,865	5,821
Diphtheria	862	551	221	153	66	32	10	4	1
Measles	24,904	1,883	21,739	16,545	16,489	15,763	25,194	13,938	19,853
Acute Pneumonia (primary or influenzal)	1,347	1,324	1,188	1,308	1,456	1,207	1,739	1,366	1,585
*Meningococcal Infection	*67*	*71*	*78*	*56*	*60*	55	57	50	37
Acute Poliomyelitis (paralytic)	8	1	351	46	224	150	90	103	101
Acute Poliomyelitis (non-paralytic)						41	58	28	25
*Acute Encephalitis (infective)	*3*	*2*	*2*	*1*	*2*	6	5	6	7
*Acute Encephalitis (post infectious)	—	—	—	—	—	3	14	1	3
Dysentery	411	127	108	208	73	1,117	837	370	455
Ophthalmia Neonatorum	46	46	82	51	37	39	29	23	20
Puerperal Pyrexia	81	104	85	98	98	125	128	151	141
Smallpox	—	—	—	—	—	—	—	—	14
Enteric or Typhoid Fever (excluding Paratyphoid)	9	14	9	18	3	9	—	2	2
Paratyphoid Fevers	7	50	16	10	11	4	62	4	10
Erysipelas	383	366	347	409	429	405	312	273	302
†Chicken Pox	310	443	550	432	827	465	797	1,350	739
§Malaria	36	28	11	6	2	1	2	5	14
‡Food Poisoning	‡	‡	‡	‡	329	346	138	192	329
Tuberculosis:—									
Respiratory	1,271	1,204	1,233	1,246	1,478	1,297	1,296	1,337	1,223
Other Forms	479	432	389	407	431	348	285	296	247
Total (Tuberculosis)	1,750	1,636	1,622	1,653	1,909	1,645	1,581	1,633	1,470

* These terms replace others in use before 1st January, 1950, for certain groups of diseases and are consistent with the international standard classification of diseases which was brought into general use on 1st January, 1950. More or less, the term "meningococcal infection" covers the same disease as the former term "cerebro-spinal fever", but also covers a somewhat wider group of diseases; "acute encephalitis (infective)" replaces the former term "encephalitis lethargica"; "acute encephalitis (post infectious)" covers the forms of encephalitis occasionally following or associated with certain well defined infections, e.g., chickenpox, measles, mumps and vaccinia and is to bring about the notification of cases showing late effects of acute encephalitis (infective). The figures in italics in the above table show the number of cases notified under the former terms.

† Chickenpox is compulsorily notifiable only in certain County Districts, and the figures given do not, therefore, represent the full number of cases occurring in the Administrative County.

§ All the cases of malaria shown in the above table were believed to be contracted abroad except for one in 1947.

‡ Notification of cases of food poisoning, or suspected food poisoning, only became generally in operation as from 1st January, 1949.

Scarlet Fever

The number of cases of scarlet fever (2,991) was 815 more than in 1952, and was the highest number since 1949 when there were 3,191. The figure of 2,991 represents a case rate of 1.88 per 1,000 estimated population (compared with 1.39 for England and Wales). As is usual with this disease, the greatest number of cases occurred in the first and fourth quarters of the year, and in children in the age group 3 to 9 years. The Districts in the County with the highest case rates (i.e. number of cases per 1,000 estimated population) were:— Barnoldswick U.D. 4.80; Brighouse B. 3.65; Castleford U.D. 3.62; Dearne U.D. 3.05; Denholme U.D. 7.68; Garforth U.D. 4.28; Harrogate B. 4.46; Heckmondwike U.D. 3.26; Hemsworth U.D. 3.37; Mexborough U.D. 3.48; Penistone U.D. 3.69; Queensbury and Shelf U.D. 3.71; Royston U.D. 4.66; Wath-upon-Dearne U.D. 3.28; Wombwell U.D. 3.46; Settle R.D. 3.18.

Whooping Cough

In 1953, 5,821 cases of whooping cough were recorded compared with 5,865 in 1952. The case rate in 1953 per 1,000 of the estimated population was 3.66 in the Administrative County and 3.58 for England and Wales; the corresponding rates for 1952 were 3.69 and 2.61. A characteristic of the incidence of whooping cough is its biennial or triennial periodicity, that is a year of low incidence alternates with one or two successive years of much higher incidence. It is noticeable, however, that the annual numbers of cases notified in the Administrative County have remained at the higher level during the past four years. Whether this reflects an actual increase in incidence is problematical. In the past, many cases of the disease have escaped notification because the parents did not call in the doctor on account of the cost, especially where the "whoop" was absent as so often occurs with mild cases. Now, it may be, that a larger proportion of cases is being notified because medical attention is being sought more frequently in mild cases due to the fact that under the National Health Service a doctor's bill is not incurred by the parents. Whooping cough attacks mainly infants and children under ten years of age, and medical attention is necessary because of the risk, even in mild cases, of complications of a nature, which in young children and infants particularly, can have serious consequences such as permanently impaired respiratory function; also some deaths in children ascribed to convulsions, bronchopneumonia and other respiratory illnesses have their origin in mild attacks of whooping cough. It is a matter for satisfaction, therefore, if medical attention is being sought more frequently.

Of the County Districts, the following had in 1953 the highest number of cases per 1,000 of the estimated population:— Barnoldswick U.D. 7.74; Denholme U.D. 6.53; Earby U.D. 9.86; Featherstone U.D. 8.25; Goole B. 7.08; Otley U.D. 6.27; Pontefract B. 8.71; Rothwell U.D. 8.25; Sowerby Bridge U.D. 7.88; Stocksbridge U.D. 6.07; Tickhill U.D. 12.06; Bowland R.D. 6.45; Wetherby R.D. 6.30; Wharfedale R.D. 8.05.

Whooping Cough Immunisation.—As part of the Authority's arrangements under Section 26 of the National Health Service Act, 1946, immunisation against whooping cough is given when requested by parents in clinics or by general medical practitioners who take part in the scheme.

The Ministry of Health still decline to express any firm opinion as to the effectiveness or otherwise of any of the combined diphtheria-pertussis vaccines and the use of a single pertussis vaccine has been continued. As a result of this policy there is little doubt that an increasing number of general practitioners are using a combined vaccine with the obvious advantage of fewer injections, and as no payment is made to general practitioners for the record of whooping cough immunisation unless the Authority's vaccine has been used, many immunisations undertaken by the general practitioners may be unknown to the Authority. In approving the Authority's proposals the Ministry made a requirement that records should be maintained to assess the value, or otherwise, of whooping cough immunisation. Such records as are being kept will prove of little value if numerous children, unknown to the Authority, are being immunised successfully by the general practitioners using a combined vaccine. It is to be hoped that the Ministry will give an early decision on the use of combined vaccines as the present position can only be regarded as unsatisfactory.

Since the scheme commenced in June, 1952, 12,029 children under 4 years of age have been immunised.

Diphtheria

The rapid decline since the War in the incidence of diphtheria in the County can only be regarded as dramatic, the number of notifications having fallen from 862 in 1945 to only one in 1953. For the last three years there have been no deaths from diphtheria, and in 1950 there was only one death in a total of 32 notified cases of the disease.

It is not surprising that with the virtual disappearance of diphtheria as a killing disease in infancy and childhood it is becoming difficult to persuade many modern parents that a recurrence of the disease amongst the child population can only be prevented by a maintenance of a high state of immunisation. The problem is not made any easier by the fact that few, if any, of the parents of today's children have ever seen a case of diphtheria or appreciate the degree of suffering that the disease can cause.

Although the display of posters on advertisement hoardings and the issue of leaflets to the parents must continue to play a part in any campaign to achieve the immunisation of the young child, our strongest weapon in the fight to overcome parental apathy is still the health visitor. The health visitor more than anyone else is in a position to talk to the parents and convince them that immunisation against diphtheria is still worth-while and necessary. Much remains to be done when it is considered that less than 50% of West Riding children are immunised before reaching compulsory school age. Primary immunisation of 75% of all children reaching the age of one year should still be our aim.

The number of children who received immunisation during 1953, together with figures for previous years, are shown in the following table:—

Year	No. of children who completed a full course of immunisation			No. of children who were given a reinforcing injection
	Under 5	5-14	Total	
1948	20,958	6,220	27,178	19,274
1949	20,728	7,162	27,890	18,071
1950	14,836	3,961	18,797	13,929
1951	16,606	5,567	22,173	17,092
1952	15,798	5,298	21,096	23,390
1953	13,768	4,893	18,661	22,614

The immunisation state of the child population in the Administrative County as at the 31st December each year for the years 1948 to 1953 is given in the following table:—

NUMBER IMMUNISED

Year	Under 5	% of population 0-4	5-14	% of population 5-14	Total under 15	% of population 0-14
1948	59,795	44.1	139,194	65.0	198,989	56.9
1949	64,811	46.7	143,966	65.8	208,777	58.4
1950	66,484	47.9	150,179	67.1	216,663	59.7
1951	66,077	47.4	150,177	70.1	216,254	61.5
1952	60,885	46.4	177,875	74.8	238,760	64.7
1953	54,304	42.9	198,151	81.4	252,455	68.2

Measles

The number of cases per 1,000 of the population was 12.47 for the Administrative County, almost the same as the rate for England and Wales, namely 12.36. The chief complication of measles is bronchopneumonia; among other risks attendant on even a mild attack of measles are "middle ear disease" and damage to the eyes. As with whooping cough, many deaths of children classed to bronchopneumonia, convulsions and other respiratory affections had their origin in an attack of measles.

The West Riding County Districts with the highest number of cases in 1953 per 1,000 of the population were:— Adwick-le-Street U.D. 17.11; Batley B. 20.01; Colne Valley U.D. 18.46; Denholme U.D. 35.33; Earby U.D. 22.61; Featherstone U.D. 19.06; Goole B. 40.86; Heckmondwike U.D. 25.36; Horbury U.D. 17.52; Hoyland Nether U.D. 26.77; Knottingley U.D. 20.37; Maltby U.D. 18.24; Mexborough U.D. 18.04; Otley U.D. 22.42; Pontefract B. 17.55; Royston U.D. 19.87; Skipton U.D. 25.71; Spenborough U.D. 20.92; Stocksbridge U.D. 27.10; Wath-upon-Dearne U.D. 19.23; Wombwell U.D. 24.93; Worsborough U.D. 18.69; Hemsworth R.D. 17.62; Kiveton Park R.D. 24.94; Rotherham R.D. 17.49; Sedbergh R.D. 53.62.

Meningococcal Infection

(Cerebro-Spinal Fever)

There were 37 confirmed cases of meningococcal infection notified in 1953 compared with 50 in 1952. The incidence in 1953 was the lowest for a number of years. As in previous recent years the cases were scattered over the County in ones and twos and the majority were in children under 5 years of age.

Acute Poliomyelitis

(Infantile Paralysis)

The number of confirmed cases notified in 1953 (101 paralytic, 25 non-paralytic) shows little variation on that for 1952 (103 paralytic, 28 non-paralytic). The case-incidence in 1953 in the Administrative County per 1,000 of the population did not vary much from that for the country as a whole, in fact it was slightly lower. The relevant figures are given below:—

Case rate per 1,000 population—year 1953

Poliomyelitis	*Administrative County*	*England and Wales*
Paralytic.	0.06	0.07
Non-Paralytic.	0.02	0.04

In the Administrative County the age incidence of the cases notified in 1953 was very similar to that for 1952, and does not vary significantly from year to year; the number of deaths was 11 in 1953 and 11 in 1952. The cases notified in 1953 were distributed throughout the Administrative County, and no District had more than five. Although the causal agent, a filterable virus is known, knowledge of the mode of transmission of the disease is still very incomplete but it is realised that isolation of patients and control of contacts are important preventive measures. A vast amount of research is proceeding in a number of countries, particularly the United States where the disease is and has been far more prevalent than in this country, and a number of significant factors have been brought to light. There is promise that it may be possible to formulate more effective preventive measures in the not too far distant future. Trials of vaccines to protect against poliomyelitis are proceeding in the United States on a large scale, but it will be some considerable time, probably some years, before these trials reach a stage when the results can be finally evaluated.

Acute Encephalitis

There was no significant change in 1953 in the incidence in the County of infective encephalitis. Ten confirmed cases (7 infective, 3 post-infectious) were notified, these being distributed in ones in widely separated Districts. The post-infectious form is a serious complication of illness from one of the common infectious diseases, usually measles, mumps or chickenpox.

Dysentery

There were 455 cases of dysentery notified in 1953 compared with 370 in 1952; 70 per cent. of the cases in 1953 and 75 per cent. in 1952 were in children under 15 years of age. These figures do not by any means represent the true incidence. Many mild cases are never seen by a doctor and consequently are not notified. Dysentery is a bowel infection; flies, lack of cleanliness and defective personal hygiene, particularly in food handlers are largely responsible for its spread. It is not the aesthetic aspect that the Medical Officer of Health has so much in mind in his request to "Now wash your hands, please" but the far more serious one of the spread of the bowel infections such as dysentery, some forms of food poisoning and the typhoid fevers through the neglect of this elementary precaution.

Ophthalmia Neonatorum

This is a purulent discharge from the eyes within twenty-one days of birth, and could lead to impaired vision or even blindness unless prompt and skilled treatment is given. Twenty cases of ophthalmia neonatorum were notified in 1953 and received treatment. In none was vision impaired.

Puerperal Pyrexia

A modification in the definition of "puerperal pyrexia" for the purpose of notification, brought about as from the 1st August, 1951, by The Puerperal Pyrexia Regulations, 1951, to meet changed conditions due to advances in medical treatment, accounts for the increase in the number of notifications of puerperal pyrexia since 1951. "Puerperal Pyrexia" — to quote the Regulations — means "any febrile condition occurring in a woman in whom a temperature of 100.4° F. or more has occurred within 14 days after childbirth or miscarriage." A rise in temperature under these conditions could presage some serious complication, such as puerperal sepsis which twenty years ago was the cause of over a third of the maternal deaths in the Administrative County. The purpose of notification is to ensure that treatment is provided at an early stage when there is more likelihood of prevention of serious developments.

Smallpox

There were 14 cases of the virulent type of smallpox (variola major) in the Administrative County in 1953, all believed to be part of one outbreak.

Two types of smallpox are recognised (a) the virulent variola major, attacks from which can be severe with a high rate of fatality, and (b) the less fatal variola minor, cases of which are usually mild, though not always. Cases of variola minor, the mild form of smallpox, were few in number in this country before 1921 when the disease suddenly began to be widely prevalent. The teeming population of the West Riding Administrative County did not escape its visitations and commencing with that year the incidence in the County gradually increased and reached epidemic proportions in the four years 1926-29 when 5,918 cases were notified, representing an average of nearly 1,500 cases per year. In 1930 there were 617 cases and, with 146 cases in 1931, the epidemic died out almost as suddenly as it had arisen. The course of the illness was mild in the great majority of cases, and among the whole of the 7,523 cases which occurred in 1921-31, only 20 were fatal, of which 7 were babies and 2 young school children. It can be assumed that if the cases had been variola major, the deaths would have numbered somewhere between 1,000 and 1,400. In the 7 years 1932 to 1938 only 7 cases of smallpox were notified, in 4 of which there were strong grounds for believing that the infection had been contracted abroad. In the 14 years after 1938 there was not a single recorded case of either type of smallpox in the Administrative County until 1953 when the outbreak of 14 cases of the virulent variola major occurred in March to May. Apart from 4 sporadic cases, the last previous outbreak of variola major in the Administrative County was one of 13 cases in 1919, the infection having been brought in by a soldier from the Middle East.

Sixteen cases in the Administrative County were notified in connection with the 1953 outbreak as under:—

	Week ended:—									
	March			April				May		
	14th	21st	28th	4th	11th	18th	25th	2nd	9th	Total
Todmorden B.	1	5	5	2	-	-	-	-	-	13
Colne Valley U.D.	-	-	-	-	-	1	-	-	-	1
Morley B.	-	-	-	-	-	1	-	-	-	1
Baildon U.D.	-	-	-	-	-	-	-	-	1	1
	1	5	5	2	-	2	-	-	1	16

Two of the cases notified from Todmorden B. were not confirmed as smallpox. The outbreak was not confined to the Administrative County, there being one or more cases in the Lancashire towns of Bacup B., Oldham C.B. and Bury C.B. also in the West Riding in Halifax C.B. and Leeds C.B. All these cases are believed to have been interconnected.

The history of the outbreak is set out in the following extracts from the combined report of Dr. J. Lyons, Medical Officer of Health for the Borough of Todmorden (and Divisional Medical Officer in that area and adjacent Districts for the County Council), and Dr. C. W. Dixon, Consultant on the list of practitioners designated by the Ministry of Health to assist Medical Officers of Health in the diagnosis of smallpox. It should be stated that the combined report appeared in "The Medical Officer" in December, 1953.

The outbreak was first recognised in the Todmorden area although the origin of the first case in the country is not, and never will be, known. The Todmorden cases also comprised a number of connected infections, whereas those occurring in neighbouring districts were isolated single cases with no verified connection with the primary focus.

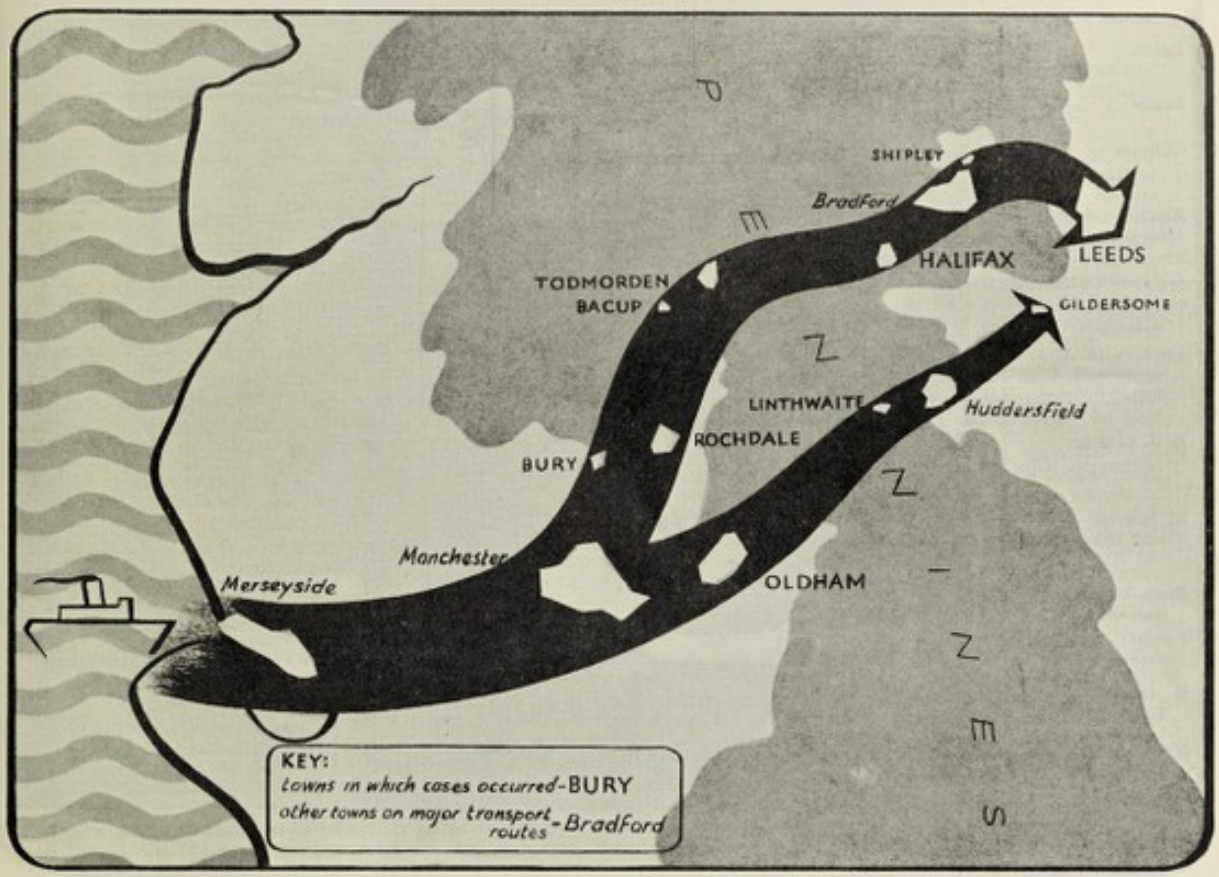
Todmorden is a town of 19,000 inhabitants situated at the confluence of three Pennine valleys. Although within the West Riding administrative area it bears a Lancashire postal address and shares its main industry, the spinning and weaving of cotton, with the neighbouring Lancashire towns of Bacup, Rochdale and Burnley. Raw cotton, shipped to Merseyside from every major growing area in the world, is transported to Todmorden by road. Many of the lorry crews reside in the Merseyside area. There is much traffic by road across the Pennines from Liverpool through Todmorden connecting with Halifax, Huddersfield, Bradford and Leeds.

The map (Fig. 1) shows the principal towns in the area, those concerned in this outbreak and the chief road transport routes across the country. Fig. 2 shows the epidemiological pattern for this outbreak. The diagram is drawn so that the shaded markings have a periodicity of 13 days. This shows the relationship of cases described in the text, the order in which they were diagnosed, and the division of the outbreak into the period before and after the first case became known.

The last recorded death from smallpox in Todmorden prior to this outbreak was in 1893, and there had been no notified cases since the 1920s. The Rochdale outbreak of variola minor in 1952 had not given rise to any known cases in Todmorden and only a relatively small number of Todmorden residents were vaccinated at that time.

FIG. 1

Smallpox in the Industrial Pennines, 1953
Transport Routes



The case shown in above diagram as arising in Shipley actually occurred in Baildon, near Shipley

The vaccinal state of the population at the beginning of 1952 was low. During the period 1947-52 inclusive, the percentage of infants vaccinated was approximately 20, and it has been estimated that about 50 per cent. of the adult population had had a successful primary vaccination at some time previously, mostly during infancy or early childhood. It is interesting to note that in 1947, the last complete year of so called "compulsory" vaccination, 101 infants were vaccinated representing 40 per cent. of the 0—1 population. In 1948 the figure had fallen to 35 (14 per cent.). Vaccination in contiguous areas also shows a low level. The infant vaccination level given by Conybeare (1950) for the West Riding was 6 per cent., Halifax 4.8 per cent., Huddersfield 6.9 per cent., Bradford 3.2 per cent., Leeds 14.4 per cent., Oldham 8.8 per cent., Bury 5 per cent. Although these estimates are shown by Blackley (1950) to be too low even if they are doubled, the level is insufficient to produce any significant herd immunity.

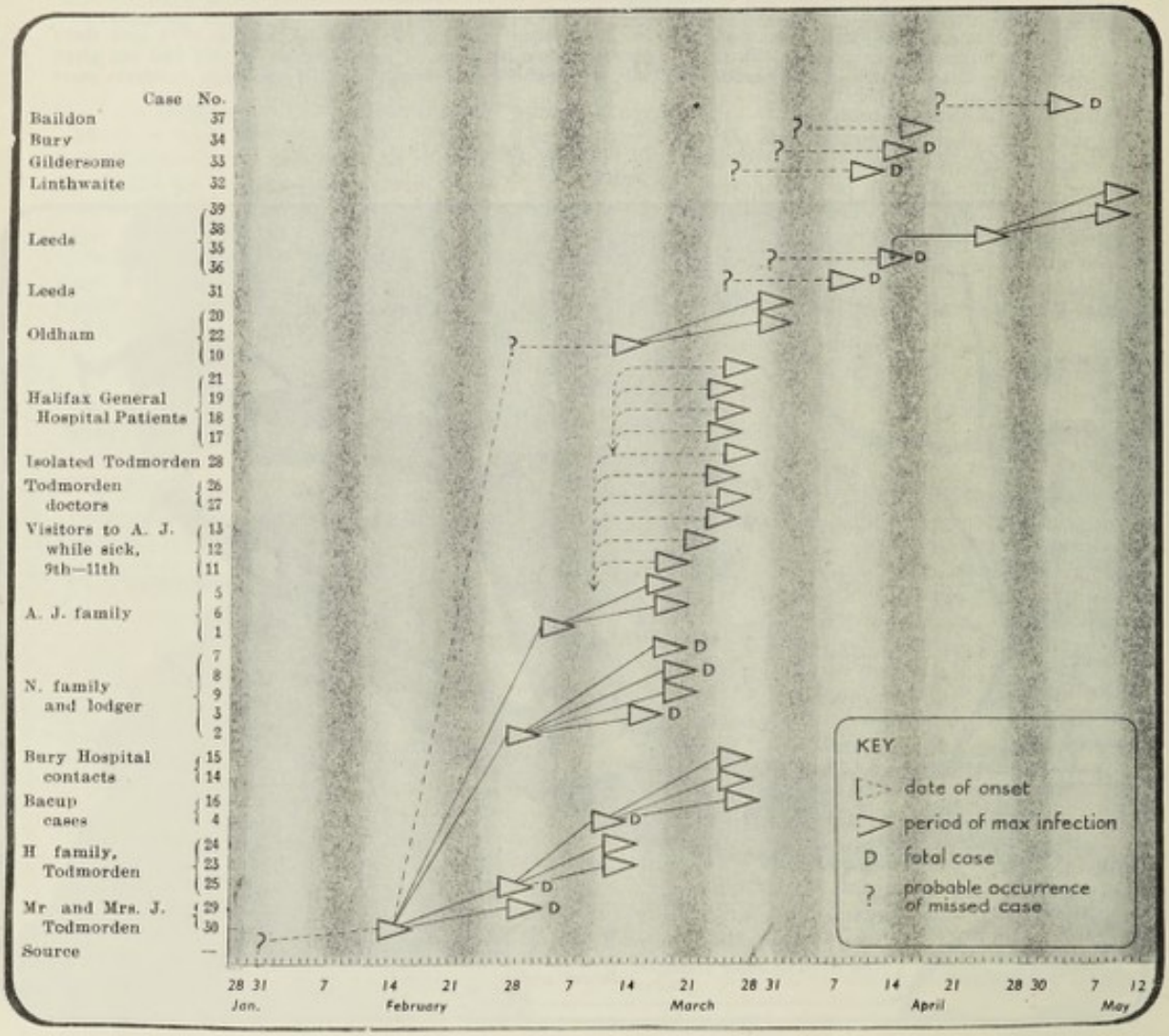
The Todmorden Health Department first became aware of the existence of smallpox in the town on Thursday afternoon 12th March, 1953, when the M.O.H. received a telephone message from one of us (C.W.D.) to the effect that a Todmorden patient, in the Halifax General Infirmary, whom he had been invited to see, was in his opinion a typical benign confluent variola major. There had been no recorded variola major in Britain since the Brighton outbreak and one did not expect it suddenly to appear in an inland town. This was nevertheless an "administrative" smallpox backed by a confident clinical diagnosis and action had to be taken with the minimum of delay. To have awaited the results of laboratory tests would have been the height of folly.

The first move of the M.O.H. was to order an initial supply of vaccine lymph from the Public Health Laboratory in order to vaccinate contacts. The director of the laboratory was at the same time advised of the possibility of much larger supplies being required during the next few days. The West Riding Deputy County Medical Officer of Health and all medical officers of health of neighbouring sanitary authorities (both in Yorkshire and Lancashire) were advised of the situation by telephone and a circular letter was sent to all local general practitioners. The latter were requested to notify the M.O.H. of any suspicious cases encountered, including any adult or atypical cases of chickenpox.

The long and arduous task of contact-tracing was begun on the same day with a visit to the home of the patient A. J. (case 1 in Fig.2), a man aged 45 years employed as an undercarder in one of the largest cotton spinning mills in Todmorden. He had been vaccinated in infancy, but not since. The family consisted of the man's wife aged 42 years, and a daughter aged 13 years who attended a local secondary school. The wife had been successfully vaccinated in infancy; the daughter was unvaccinated. Information from the wife and also from the family doctor revealed that the patient had had a "cold" on the 2nd March, but that he did not feel very ill and continued to work up to and including the 5th March. On this day he became much worse, complaining of severe malaise, frontal headache and feverishness, and took to his bed.

FIG. 2

Smallpox in the Industrial Pennines, 1953
Cases and Dates of Onset



A typical herpetic lesion was observed on the upper lip by his wife, but no general eruption appeared until two days later (7th March) when "red pimples" were noted on the face and lower arms. There was vomiting at this stage, the vomit being described as "mixed with blood." The development of the eruption during the ensuing few days caused the general practitioner to consider the possibility of smallpox—he had in his younger days been a resident physician in a smallpox hospital—but two features persuaded him to dismiss the possibility from his mind. Firstly, the initial lesion appeared to have been a typical herpetic "spot" and, secondly, the general rash did not appear until 5—6 days after the earliest symptoms.

In the light of subsequent developments it is almost certain that the man's early symptoms were in fact due to a common cold with labial herpes and that the first day of illness due to variola was on the 5th March when he became much worse and was compelled to give up work, the rash appearing two days later. The doctor did not unfortunately convey his transient suspicion to the M.O.H., but on the 11th March he called in a consultant dermatologist. The latter made a provisional diagnosis of generalised herpes and arranged for the man to be admitted to the Halifax General Hospital. Consultation between the dermatologist and Dr. T. H. Flewett of the University Department of Bacteriology about the possibility of culture for herpes virus resulted in one of us (C.W.D.) being invited to see this interesting case on the day of admission. This fortunately prevented the patient from being in the General Hospital for more than a few hours. The repercussions in Halifax will be related later. The man was removed to Oakwell Smallpox Hospital in the evening of the same day; he had been in the general ward for several hours in fairly close contact with other patients as well as medical and nursing staff. Appropriate precautions to limit infection in the hospital were taken by the medical officer of health of Halifax, Dr. G. C. F. Roe.

The late diagnosis of A. J. (Case 1) resulted in there being a large number of contacts. The possibility of infectivity on and after the 5th March had to be reckoned with and, since he was at work on this day, exhaustive inquiries had to be made at the mill so as to list as contacts for vaccination and surveillance all those who worked in close proximity in addition to any persons who had stopped to talk to him. Persons who had walked past him on the 5th March without stopping and who did not work in the same room were not classed as close contacts. Other contacts included relatives and friends who had visited the patient at his home between the 5th and 12th March, 1953, and also the ambulance staff who removed him to the Halifax General Hospital.

The multiplicity of contacts and the probability of still more being added to our lists during the next week or so influenced the decision to grade the contacts into roughly three categories according to the degree of closeness:—

Class 1.—"Inner ring" contacts, e.g. members of the same household, persons working in close proximity during the early stages of illness, visitors who had actually entered the patient's bedroom, ambulance men and persons conveyed in the same ambulance as case 1 before recognition of the case and before disinfection of the ambulance and its contents.

Class 2.—"Outer ring" contacts, e.g. persons working in the same room at the mill but never within close proximity (10 ft.), visitors to the patient's home who did not enter the bedroom.

Class 3.—Remote and doubtful contacts, e.g. workers in the mill other than those in categories 1 and 2, persons who called at the patient's home during the period of infectivity but did not enter the door, e.g. grocery assistant, newsvendor, etc.

As it was obviously desirable to reduce alarm and industrial dislocation to a minimum the precautionary measures adopted were also graded. The action taken may be summarised as follows:—

A. *Vaccination.*—All contacts were offered vaccination, priority being given to class 1 contacts, all of whom were vaccinated within 24 hours of the clinical diagnosis of A.J. (case 1). The only contacts to refuse vaccination throughout the entire outbreak were three or four class 3 contacts. Members of class 1 contacts' households (secondary contacts) were also vaccinated at the same time so as to produce a ring of immunes around all potential secondary cases. (Dixon, 1948.) In theory it is not necessary to vaccinate contacts of contacts, but the possibility of unsuccessful vaccination made it advisable to start as early as possible if one were to ensure that all family secondary contacts were successfully vaccinated before the primary contacts reached the end of their presumptive incubation periods.

As an example of what may occur, one of the secondary contacts of A. J. (case 1) was vaccinated at the same time as her husband who was a primary contact. The husband's vaccination (three days after contact) was successful and he developed a modified variola nine days later. His wife's vaccination failed, as did a second and third attempt performed by a different doctor with a different technique. A fourth attempt at vaccination was made on the first day of her husband's illness and there was considerable anxiety until an accelerated vesicular reaction became evident three or four days later. But even this successful vaccination on the first day of exposure to infection did not preclude the possibility of the lady developing a highly modified infection. Her subsequent free passage through the quarantine period may have been due as much to good fortune as good management, but it is clear that the position would have been worse if the initial attempt at vaccination had been postponed a few days. Repeated failure to vaccinate successfully proved to be rare, but it was noted that approximately 10 per cent. of contacts required a second attempt. Unsuccessful efforts were not related to any particular doctor or any particular technique, nor was there any reason to suspect the quality of the lymph. Fewer "no-takes" might possibly have resulted from giving two insertions instead of one, especially if done on different arms.

B. *Surveillance.*.—All class 1 and 2 contacts were placed under daily surveillance up to and including the 16th day after contact. The class 3 contacts were told to take to bed if there were any illness, feverishness or rash, and to arrange for the Health Department and their own doctor to be notified. In the absence of symptoms arrangements were made for them to be examined on the 16th day.

The examination of all contacts on the 16th day was carried out very thoroughly so as to ensure that a highly modified case was not being missed. The contacts were examined unclothed and special attention was paid to the face and extremities and in particular to pressure points so that isolated lesions should not be missed. The history of dates of contact was also carefully checked to ensure that the quarantine period was in fact terminated. The daily surveillance was in the early stages carried out by medical staff, but, as the number of contacts grew, the task was partly delegated to health visitors and sanitary inspectors, who covered the first nine or ten days of the contacts' quarantine period, thus allowing the medical staff to concentrate on the crucial latter part.

In the later stages of the outbreak the sanitary inspectors were completely occupied with disinfection and epidemiological inquiries and the health visitors were given the entire responsibility of surveillance during the first nine or ten days of the quarantine period. Fortunately many of them had had experience in vaccination in their training in the University of Leeds, and they were able to check and revaccinate where necessary. They were also qualified to deal with the social problems that frequently arose among the quarantined contacts. Class 1 contacts were, in addition to daily surveillance, *requested* to stay off work and avoid mixing with other persons as much as possible. All contacts off work were offered National Insurance Certificates entitling them to sickness benefit for the period of exclusion. The National Insurance Office was, however, reluctant to handle certificates or deal with callers from homes which might at any time be infected, and it was decided to send the certificates *en masse* directly from the Medical Centre to the Insurance Office. This arrangement worked well.

It should be emphasised that in no case were close contacts *ordered* to stay off work. There is no statutory power to enable this to be done, nor could any compensation be paid for loss of earnings. This had to be explained to them in every case so as to avoid as far as possible any misunderstanding or any subsequent claim for compensation or damages. No such claims have so far come to light nor was there a single deliberate refusal to adopt the advice of the M.O.H. The attitude of the public throughout the outbreak was remarkable. All precautionary measures, although lacking the force of law, were accepted with extraordinary readiness. Indeed one was constantly being requested to consider the imposition of more stringent precautions. Many responsible citizens were quite prepared to have places of assembly closed, and a travelling fair which was about to visit the town was stopped by the Markets Committee although advised that such action was unnecessary. Many firms inquired as to the safety of allowing certain contacts to continue at work. Many of these were, in fact, secondary contacts and the position had to be carefully and painstakingly explained to each inquirer. Requests to undertake mass vaccination in factories and schools were also received and had to be reassuringly warded-off. Individual queries came in their hundreds, e.g. "Am I a contact?" "Can I go to the football match?" "Should I cancel my holidays?" "Should I allow my child to return from boarding school?" and many more.

The "confirmation" of the diagnosis of case 1 raised two new issues, viz., mass vaccination and press publicity. The M.O.H. had not up to that time given any public statement to the press and the newspapers of Britain now began to direct their long-range artillery on the Medical Centre's two telephone lines, often blocking them for important calls. The local telephone exchange was extremely helpful in keeping out apparently unimportant calls, but the situation was not completely satisfactory and it was decided to appoint the editor of the local paper as publicity agent and give prepared statements to him for distribution to newspapers. With one or two exceptions this arrangement worked well and helped to spare both the M.O.H. and the telephone for more urgent work.

There was now evidence of strong public demand for vaccination and it was equally clear that the public looked to the M.O.H. to provide facilities at the centrally situated and well-appointed Medical Centre. Mass vaccination was considered to be neither desirable nor necessary and included in the first press report was the following:—

> "Dr. Lyons said full precautions were being taken. The Health Department was concentrating on the vaccination and supervision of persons who had been in direct contact with the patients, but the Medical Officer stressed that there was no urgent need for other people to be vaccinated."

In spite of this assurance queues began to form at the Medical Centre and additional medical and nursing staff had to be borrowed from neighbouring areas to cope with the rush. The doctors and nurses engaged in this large-scale vaccination were instructed to avoid wherever possible the vaccination of pregnant women or persons suffering from eczema or diabetes unless they were contacts.

Among those advised against vaccination was an eczematous school-boy. The advice was accepted by the boy's mother, but his sister was later vaccinated by the family doctor and during the course of play at home the boy's skin was infected by the girl's primary vesicle. He developed a generalised vaccinia, but fortunately recovered. It is interesting to note that the eczema almost cleared during the course of the illness.

The first week-end of the outbreak saw further intriguing developments. The early notification of neighbouring medical officers of health bore fruit. Dr. T. O'Grady, medical officer of health of the adjacent Lancashire town of Bacup, telephoned on the evening of the 14th March to inform us that a Bacup man (Mr. T. B.) employed at the same mill as case 1 had felt ill when last at work on the 9th March and three days later was sent by his doctor to an infectious disease hospital as a "severe scarlet fever" with skin petechiæ. His condition deteriorated very rapidly and he died about twenty-four hours after admission, on 13th March.

In the light of the news from Todmorden the possibility of this man having died from fulminating smallpox had now to be considered. The blood count had suggested an acute virus infection and specimens of heart blood and a piece of skin were sent by the hospital pathologist to the virus laboratory. On the 18th March Professor A. W. Downie reported that the blood had given a strongly positive test for variola antigen and virus had been recovered on a culture. But before the receipt of this report the circumstances were regarded as sufficiently suspicious to merit the tracing of contacts. These consisted—in Todmorden—of mill contacts on the 9th March, the first day of illness, in addition to a few persons who sat close to him on a bus on that date. Some of this number had already been vaccinated as possible contacts of case 1; the remainder were vaccinated on the 15th and 16th March and all were placed under surveillance. It was not considered desirable to publicise the fact that the patient had travelled on a Corporation bus on his first day of illness. Such publicity would certainly have ensured that all bus contacts would be known and vaccinated, but it would also have caused considerable alarm. The possible effect on transport workers had to be considered too. Discreet inquiries enabled us to discover those persons who had been sitting in close proximity to the patient; the risk to the others on the bus was thought to be minimal and we felt justified for once in adopting a policy of "masterly inactivity."

No secondary cases from the Bacup man (case 4) occurred in Todmorden, but his wife (case 16) had a moderately severe attack, and two children (cases 14 and 15) who were with this man in hospital on the 12th March developed mild attacks. The wife's onset of illness was on the 25th March so that, assuming the incubation period to be not longer than thirteen days, it would appear she did not become infected until the fourth day of her husband's illness.

The second interesting development in the early days of the outbreak arose out of the request to general practitioners to report any adult or atypical cases of chickenpox.

One such patient was a man, J.N. (case 2), employed at the same cotton mill as the previous cases. He was sixty years of age and had been vaccinated in infancy and during the 1914-18 war. He gave a history of severe malaise and feverishness beginning on Saturday the 28th February when he was at work. He took to bed on the following day and called in the family doctor. A rash was first noticed by the patient on the 4th March; it was said to have extended over the forehead, chest and arms. When seen by us on Sunday the 15th March the man said he had recovered and was hoping to return to work on the following day. On examination, however, there was evidence of a past modified eruption. The peripheral distribution of suspicious scars together with the existence of four minute "seeds" on the hands were strong indications of variola and a clinical diagnosis was made. As this was the 16th day of disease the man was questioned about the health of his family. He said that his wife had been ill in bed since the previous day, but that she was "often like this." Mrs. N. who was 57 and had been vaccinated in infancy was nevertheless examined. She was toxic, very pale and restless, and complained of headache, backache and vomiting; there was no rash. This picture fitted perfectly the initial stage of smallpox and it was therefore decided to admit Mrs. N. (case 3) as clinical smallpox along with her husband. The latter had largely recovered, but he was theoretically still infective. Mrs. N. developed an erythematous rash within twenty-four hours of removal to hospital; she was true type 1, fulminating *purpura variolosa* and died.

The family contacts of Mr. and Mrs. N. consisted of two unvaccinated sons (ages 19 and 14 years), an unvaccinated middle-aged lodger (Mrs. S.), and the son of Mrs. S. an R.A.F. youth on leave who had been successfully vaccinated only two months previously. In view of the very late diagnosis of Mr. N. it was not considered that vaccination of his family contacts would be likely to afford any appreciable degree of protection—they had already been exposed to infection for a fortnight—but the vaccinations were nevertheless performed within an hour of Mr. and Mrs. N. being admitted to hospital. Vaccinations late in the quarantine period have, of course, an administrative advantage in that if the vaccinated contact subsequently becomes a suspect one need not hesitate to admit to a smallpox hospital.

The mill contacts of Mr. N. (case 2) were already out of quarantine by the time they were traced on the 16th March, since the man had not been at work since the 28th February, but they were all examined to exclude the possibility of mild modified infections and all were found to be clear. Two relatives who had stayed overnight on the 28th February—1st March and who were therefore close contacts on the first day of illness also reached the end of their quarantine period uneventfully.

The other family contacts did not fare so well. Out of a household of six persons the only one to escape infection was the recently vaccinated R.A.F. youth. Of the five infected one was Mrs. N. (case 2) with type 1, fulminating, *purpura variolosa;* one son (case 8) who closely resembled his mother in looks and physical development died from type 2, malignant confluent; while the other son (case 9) apparently equally exposed and equally vaccinated late in the incubation period developed an unmodified discrete attack. The lodger (case 7), no relation, developed a malignant semi-confluent attack and died. (Types are Dixon's classification (from "The Diagnosis of Smallpox," H. Grayshon Lumby, Leeds), 1951.)

The fate of the contacts of case 1 showed a similar pattern, but with less severe results. None of the mill workers in contact with case 1 on the first day of illness developed the disease. All class 2 contacts remained free of infection, but several of the class 1 contacts were infected. These included the other members of his family, viz., his wife (case 6), and daughter (case 5), and three of the persons who had visited him on the 10th or 11th March and had been inside his bedroom (cases 11, 12 and 13). One of the latter (case 11) insists that he was in the bedroom for not more than two or three minutes, but it must be supposed that on the 11th March the condition of case 1 was such that the concentration of virus in the bedroom would have been very high. The most probable source of virus would be dust from the bedding, infected from the respiratory tract of the patient during the early stages of the disease.

Case 1's short stay in the Halifax General Hospital (he was in the ward for seven hours) produced a batch of four secondary cases (17, 18, 19 and 20) among patients, three in nearby beds, the other patient being ambulant. All four were highly modified by successful vaccination performed immediately after contact.

In addition to the contacts already mentioned were two Todmorden general practitioners who had attended both case 2 and case 1, between the 2nd and 11th March.

Both doctors subsequently developed influenza-like symptoms; one on the 22nd March the other on the 23rd March. They at first attributed their illness to the after-effects of revaccination performed on the 14th March and they carried on with their duties until the 24th March, a well-marked vesicular reaction then

being present. Both had been vaccinated several times before, but the last occasion was thought to have been about twenty years ago. The persistence of symptoms on the 24th March induced them to notify the M.O.H. (J. L.) who examined them and, unable to satisfy himself about the diagnosis, he called in the smallpox consultant (C. W. D.). We were able to demonstrate three small macules on the forehead and hands of one of the doctors (case 27) whose pyrexia had in fact commenced exactly 12 days following the one contact with case 1. The other doctor (case 26) had no skin lesions, but the first vaccination attempt had failed and only the second one, done on the fifth to sixth day of the presumptive incubation period, was positive and, being of a primary type, suggested that immunity at the time of exposure might well have been low. Though not pathognomonic it was agreed that the existence of these macules in characteristic sites was sufficient to warrant a provisional diagnosis of variola and the precautionary removal of both doctors to a smallpox hospital was advised. It is to the credit of the two doctors that they readily consented to this course of action being taken although fully aware of the unwelcome publicity that was bound to follow.

This unfortunate turn of events was a heavy blow to the Health Department. Every one of the hundreds of patients examined by the two general practitioners since the morning of the 22nd March was now a potential new case. The general practitioners' normally busy practice had moreover been swollen by queues of people wishing to be vaccinated and, although it was possible to obtain lists of patients visited in their own homes, the only way of effectively tracing all the surgery contacts was by an appeal to the public. It was of course recognised that the risk to these contacts was small, but not small enough to be ignored. A statement was carefully prepared by the M.O.H. being designed to achieve the impossible task of tracing the contacts without alarming the public; it read as follows:—

"Doctors . . . and . . . are today being admitted to hospital for investigation. They had both been in contact with the first two cases of smallpox before diagnosis had been established. They are showing only mild symptoms, but in view of the nature of their work and in order to avoid the possibility of spread of infection, they have agreed to be placed in isolation in hospital.

"There is no cause for alarm but, as a precautionary measure, all persons who have been seen by either of these two doctors since Sunday morning last, the 22nd March, are advised to attend the Medical Centre, Todmorden, this evening between 6 and 8 p.m., so that arrangements can be made for vaccination, examination, and supervision where necessary.

"There is no necessity for special action in respect of patients last seen by either doctor before last Sunday.

"Persons unable to attend should try to notify the Health Department through a friend or neighbour."

The statement was placed on notice boards outside the Medical Centre and in other prominent sites in the town and was also broadcast by the local radio relay service. A slightly amended version leaving out the names of the doctors was broadcast on the 6.15 p.m. B.B.C. News from the North.

A questionnaire was rapidly prepared and duplicated so that it would be possible for clerks to obtain all the relevant information, e.g. name, age, address, date and duration of contact, date of any recent vaccination (if any), etc. Vaccination sessions for the general public were suspended for that evening so that the staff could concentrate on this work. Over 200 persons attended. After preliminary interview by clerks, each contact, armed with his or her completed questionnaire, was referred to a doctor. Where there was a history of recent vaccination the lesion was examined. If the reaction was *clearly* positive and if the vaccination had been done three or more days before contact the person was advised that no further precautions were necessary. Where the reaction was doubtful or negative or where there was no evidence of successful vaccination within the last two years, vaccination was performed then and there. He or she was also advised as to the arrangements for surveillance. Where the enquiries revealed contact of a transient nature, e.g. persons who had been "in and out" of the surgery in a matter of a minute or so, they were regarded as class 3 contacts and were not placed under surveillance, but were told to report any illness, feverishness or rash.

The evening's work went off with remarkable smoothness. The doctors, nurses and clerks, all of whom had been requested to be as reassuring and cheerful as possible in their approach, achieved the required result with a complete absence of friction or alarm. Not a single contact rejected the advice offered and, as a result of the enquiries, approximately one-third of the persons interviewed were placed under surveillance.

The subsequent progress in hospital of the two doctors was interesting. The pyrexia subsided within a day or two and the rash failed to develop. The macules noted at the initial examination disappeared; one which had been scraped failed to grow any virus on chicken embryo—a result of doubtful significance. Complement fixation test on the serum could not be done because of the recent vaccination. The appearance and subsequent abortion of the few macules supported a diagnosis of *variola sine eruptione* but the hospital consultant, who had not seen the macules, was unable to concur and was in favour of discharging the two doctors forthwith. This situation was discussed with Dr. W. H. Bradley of the Ministry of Health at a meeting when three of the panel of smallpox consultants were present. It was not agreed by all that the two doctors had had smallpox although one of us (C.W.D.) maintained that they were both *variola sine eruptione* and notified them as such to the M.O.H. No one, however, would affirm that these two patients could not have had such attacks. It was, however, agreed that after seven days they were not infectious. All their contacts reached the end of the quarantine period uneventfully.

Investigations into the source of the outbreak led to some fascinating, if rather grim, discoveries. The fact that the first three cases were men working at one cotton spinning mill naturally focused attention on raw cotton which is imported from a number of areas where smallpox is endemic. Two of the men, cases 1 and 2, worked in the carding room and cotton-chamber respectively, in both of which rooms the density of raw cotton dust in the atmosphere is very high, but case 4 was a cop-packer, handling spun cotton (yarn) only, a much cleaner job. The date of onset of case 4 (9th March) was ten days after that of case 2 and five days after that of case 1. He could not, therefore, have been secondary to case 1 and it was unlikely that he was secondary to case 2. It seemed more probable that he acquired his infection from a "missed" case belonging to the same generation as cases 1 and 2. As will be seen later this supposition was almost certainly correct.

The hypothesis in favour of raw cotton as the source of infection appeared to be given fresh support by the appearance of a case of smallpox in the Oldham area. The patient, case 10, was a man employed in the "blowing" room of a spinning mill. His onset of illness was on the 13th March, twelve days after the onset of the earliest Todmorden case then known, but no direct link could be established with any person in Todmorden. There was, however, one factor of possible significance, namely that raw cotton from the same consignment was being used at both mills at the material times and few (if any) of the other mills in the area were at that time using cotton from this consignment.

The weight of circumstantial evidence incriminating raw cotton was now far from negligible and investigations had to be made over a wide area of Lancashire. Individual medical officers of health were naturally handicapped when attempting a regional "check-up" outside their own boundaries. Dr. C. G. S. Nicol and Dr. Thomson of the Ministry of Health carried this out with much energy and enthusiasm. They advised the holding of the suspected consignment of raw cotton and of cotton waste from the Todmorden mill. This was readily acceded to by the cotton industry. No restrictions were placed on the movement of yarn (spun cotton) which was considered to be innocuous. The M.O.H. nevertheless received a long succession of anxious inquiries from firms in various parts of the country who had had recent deliveries of yarn from Todmorden. All were given the appropriate reassuring advice.

A new line of inquiry leading to more concrete results arose indirectly out of the fatal Bacup case (No. 4). One had been impressed by the virulence of the infection leading to a fulminating viræmia with no characteristic eruption and, therefore, no clinical diagnosis. Mrs. N. (case 3) was somewhat similar and, had her illness occurred a week earlier, she too would probably have gone undiagnosed. Were there others? Inquiries at the mill revealed that one of the older employees, a Mr. H. (case 25), had not been at work since the 26th February and was said to have died from pnuemonia on the 3rd March. There was in fact a history of chest trouble and the Registrar's returns confirmed that the certified cause of death was broncho-pneumonia. Furthermore, the man had been cremated and one could assume, therefore, that he had been examined by at least two doctors, one of the examinations consisting of a *post-mortem* inspection. There seemed little ground for suspicion, but further investigation was considered worthwhile especially after a clerk in the Health Department reported that a rumour was prevalent in the neighbourhood to the effect that the man had died from smallpox.

Mr. H.'s married son was sought. He gave a history of his father feeling ill after returning from work on the 26th February. He became much worse during the following two days and complained of headache, backache and vomiting. He normally lived alone, but the son and also a married daughter decided to stay with him throughout this week-end (28th February—2nd March). On the 2nd March a blotchy red rash was observed on the arms and body. His doctor saw him on this day and also observed the rash—later described to the M.O.H. as patchy and scarletiniform—and took it to be a toxic rash arising out of his acute pyrexial chest condition, a very fair assumption especially since the existence of smallpox in the town was not then known. Mr. H. died on the 3rd March. The rash was still evident after death, being noticed both by the doctor giving the second cremation certificate and also by the undertaker, but neither considered it of any significance at the time.

As our interview with Mr. H. junior took place nearly three weeks after his father's death we asked whether he or his sister had since developed any illness. He replied that both had had a sharp attack of influenza beginning on the 11th March, fourteen days after the onset of his father's illness. They were both now recovered.

A careful clinical examination did not reveal any lesions other than one single small "scab" over the son's *tendo Achilles*. This was scraped and sent to the Liverpool Laboratory, but no virus was grown from it. Blood specimens were also sent for C.F.T. and Professor Downie reported that the results, for both the son and daughter, were strongly suggestive of either recent variola or recent vaccination. The daughter (case 23) had not been vaccinated since infancy thirty-three years ago and the son (case 24) was last vaccinated in 1946. A diagnosis of *variola sine eruptione* in both was clearly justified, the father's illness being a fulminating smallpox. This also solved the problem of the Bacup man's source of infection. Mr. H.'s work brought him into frequent contact with the Bacup man (case 4) and they were also friendly outside the mill; the time interval between their respective dates of illness was approximately eleven to twelve days. Neither the doctor who treated the patient, the second doctor who saw the body, the undertaker, or any of the neighbours who visited Mr. H. contracted the disease although their vaccination states did not suggest immunity. The contacts of Mr. H. junior and his sister during the first four days of their illness were vaccinated, although very late, and placed under daily surveillance but no further cases arose.

Further inquiries at the mill led to the discovery of two more "missed" cases including yet another death. On the 2nd March, two days before the onset of case 1, at 11 p.m. a Mrs. J. (case 29), the wife of a cotton waste bagger at the mill, was admitted to a hospital in Halifax with a three-day history of toxæmia, pyrexia, anorexia and vomiting, and abdominal discomfort. Intestinal obstruction was suspected and a laparotomy performed, but the patient died four hours after admission. At *post-mortem* examination an erythematous eruption was observed on the chest. The only other positive finding was some congestion of the jejunum and death was certified as being caused by "toxæmia due to acute enteritis." We interviewed Mr. J. approximately three weeks after his wife's death. On being questioned about his own health he stated that he had had a rash on his forehead and arms about a fortnight before his wife took ill, but that he did not consult a doctor. He had been vaccinated in infancy, re-vaccinated in 1906 and again during the 1914—18 war. He consented to examination and a dozen or more small recent pink scars about ¼ in. in diameter were observed chiefly on the arms and legs. The appearance of the individual lesions was not pathognomonic but their number and distribution were highly suggestive. A specimen of blood was sent for C.F.T. and the report supported a diagnosis of recent variola.

Mr. J. (case 30) had intermittent contact at work with cases 1, 2 and 25 and the dates of onset of illness are consistent with him being the source of infection of the other three. As direct human-to-human spread of infection is always more likely than through the agency of fomites, it can, we consider, be safely assumed that the other three cases did in fact acquire their infection from Mr. J. and not from raw cotton. The dusty conditions in that part of the mill may well have encouraged this infection without the need for very close contact. Furthermore it is extremely unlikely that Mr. J. himself was infected by cotton for, although he was the first known case in the mill, his job as a bagger of cotton waste was such that he was actually the *last* worker in the mill to handle raw cotton.

The exact source of Mr. J.'s infection unfortunately remains unsolved. Investigations were hampered by the lapse of time between early February when Mr. J. acquired his infection, and late March when the inquiries were first instituted. Mr. J. co-operated to the best of his limited ability but, not unexpectedly, it was impossible to obtain a consistent and reliable account of his movements and contacts at the material time. From the jig-saw of information received from relatives, friends, workmates and Mr. J. himself it seemed that the most likely contact with the outside world was through lorry drivers unloading cotton and collecting cotton-waste at the mill. (It will be remembered that Mr. J.'s job consisted largely of the bagging of cotton waste for despatch to a depot in Lancashire.) It was known that several of the drivers were in the habit every now and then of spending an hour or two at the mill but their inability to remember specific instances after six or seven weeks was understandable. Some of the drivers resided in or near Merseyside and inquiries were made through the respective medical officers of health as to whether there was any history or clinical evidence of missed modified infection and whether any gave a history of contact at or near the ports with persons recently arrived from Asiatic countries. It had been supposed that the peregrinations of lorry drivers would extend to dockside cafés, public houses, and other depots of social intercourse, but they were remarkably reticent about their recreational habits and no information of a positive nature was obtained. Indeed, the accounts of movements given by contacts in general throughout the outbreak indicated a level of social and moral rectitude which would delight our religious brethren and disappoint the Sunday newspapers. The probing of private lives is distasteful and often impracticable, but we are firmly of the opinion that, had it not been for this gap in our knowledge, we should have obtained valuable clues to the genesis, not only of the Todmorden outbreak, but of the apparently isolated cases which occurred subsequently in other parts of the West Riding.

The back-dating of the onset of the first known Todmorden case to approximately the 15th February by the discovery of cases 30 and 29 now provided a possible link between Todmorden and the Oldham case (No. 10) whose onset was the 13th March. The interval of twenty-six days between the two left just enough room for an intermediate missed case about the 1st-3rd March. The two men were unknown to one another, but Dr. Thomson of the Ministry of Health did well to unearth two persons who were likely to have had contact with both. On closer investigations, however (including sampling of blood for C.F.T.), he had to exonerate the two suspects and the missing link was never found.

To complete the picture in Todmorden it is necessary to mention one further person, case 28. On the 27th March we saw this woman who had an early maculo-papular rash on the face and arms and a few on the legs, following a history of headache, malaise, vomiting, commencing three days previously on the 24th March, an epidemiologically significant date. Vaccination with a successful outcome had been performed five days before the commencement of symptoms, but there was no known contact with smallpox. Clinically this case had to be regarded as a "probable" smallpox and admitted to hospital; contacts were immediately vaccinated and other precautions taken. In hospital the rash did not develop, but aborted leaving very minute scabs the size of a pinhead. Some were removed and sent to the laboratory for examination for virus. Because of the recent successful vaccination serological tests were of no value. The first laboratory report after three days gave one virus colony grown—significance doubtful. After a further three days a second report was negative. At the end of six days therefore all that could be said was a diagnosis of "P.U.O."; it could or could not have been smallpox. Administratively, however, it had been treated as smallpox and no secondary cases occurred.

The Todmorden outbreak proceeded to its conclusion "according to plan." There were no solitary, unconnected cases and no further contacts under surveillance developed the disease. A cautiously worded "all clear" was issued to the press on Monday the 13th April.

Turning to the other repercussions of this outbreak, the Oldham case (case 10) already referred to, although having had many contacts of a rather distant nature, only gave rise to two secondary cases—a girl aged 17 (case 22) who had visited the house and the mother aged 55 (case 20).

The situation in Halifax was likely to give trouble. Case 1 had been admitted to the general ward containing 30 general medical and dermatological cases. He was in the ward for three hours before the diagnosis of smallpox was made and some ambulant patients spoke to him. Following the diagnosis the medical officer of health of Halifax was immediately informed and vaccination of patients in the ward and the remainder of the staff and patients of the hospital was done under his direction. Four patients in the ward contracted smallpox, all very mildly. Points of great interest were firstly, the limited time of contact and secondly, that of the 30 patients in the ward three of the nearest were infected. Vaccination performed on the day of contact within eight hours and undoubtedly positive in three of them failed to prevent an attack although considerable vaccinio-modification was seen.

One of the patients (case 18) suffered from constitutional eczema, the second (case 19) from sclerosing lipogranuloma affecting the legs, the third (case 17) was convalescent from acute hepatitis, and the fourth (case 21) was convalescent from pneumonia. These cases were under close observation and it was thought that the pyrexial onset was on the 19th which gives rather a short incubation period. The rashes, however, were seen by one of us (C.W.D.) on the 26th and early vesicular lesions were present. In view of the vaccinio-modification these need not have been present for more than 24 hours so that the incubation period seems more likely to have been ten or eleven days. A further complication was present in one of the patients in that he had suffered from some secondary vaccinal lesions around the primary lesion and it was at first thought that his whole condition was generalised vaccinia. It was possible, however, to see that the age of the vaccinal lesions and those of the variola were quite different.

On the 27th March a woman in another Halifax hospital was thought to have a suspicious rash. She was examined by one of us (C.W.D.) and it was found that, after a mild pyrexial attack three days before, a few macular lesions had appeared on the arms and face. The patient was not very co-operative, the history was rather doubtful and the lesions not very typical. The patient, however, had been in hospital a few days and had come from Todmorden during the time when unknown cases of smallpox were present. The patient was regarded as a suspect smallpox, admitted to the smallpox hospital and the inmates of the institution for chronic sick were vaccinated. The diagnosis ultimately turned out to be wrong.

Another doubtful case was admitted by the acting medical officer of Halifax (Dr. R. A. W. Procter). This was a man who after a pyrexial attack showed a profuse maculo-papular eruption on the lower arms, hands and neck. He had been recently vaccinated but might possibly have been a contact as he was a gas fitter and had been engaged in the hospital where case 1 was admitted. Unfortunately he had the habit of washing his face, neck and hands in a strong disinfectant and this apparently set up a local dermatitis. However, the trauma to these sites could have caused a local profusion of smallpox lesions, so this again was the sort of case that had to be admitted for observation. The man had attended a football match in the Lancashire area during a pyrexial attack and this led to the advice being given that all who had been at the football match, some 11,000, ought to be vaccinated. This was the type of case where 24 hours clinical observation could quite easily disprove the diagnosis of smallpox.

The next surprise in this outbreak was the diagnosis of smallpox in a boy aged 8 years (case 31) in Leeds. He had been sent to Seacroft Fever Hospital by ambulance with a diagnosis of measles and fortunately was examined before admission and diverted to the smallpox hospital. This child had lived in an overcrowded part of Leeds close to the cattle market. There were family and other contacts, but fortunately the schools were closed. Vaccination of contacts was done straight away but at this late stage, 6th or 7th day, the outlook was not very hopeful. No secondary cases, however, occurred. Four days later a boy of 16 living in Linthwaite near Huddersfield (case 32) was diagnosed as smallpox and removed to hospital. He was a lorry driver's mate and travelled in the Huddersfield, Halifax and Leeds areas. He had no known contacts with Todmorden. There were four members of the family who were isolated in the smallpox hospital as a precautionary measure from the 10th day of the presumptive incubation period. Three other close contacts were isolated because of slight pyrexia. No secondary cases occurred from this focus.

Two days later a fulminating case was diagnosed in Gildersome on the outskirts of Morley not far from Leeds. This man (case 33) worked at a clay pit and was concerned with the loading of lorries. He had a small cabin to which he is believed not infrequently to have invited lorry drivers. In spite of extensive inquiries by the medical officer of health of Morley, Dr. F. G. E. Hill, no contact could be traced with any of the known cases.

The next case reported was a woman of 69 in Bury (case 34) who was sent into hospital as a case of uræmia. This case was not seen by either of the writers, but as far as is known no source of infection could be discovered.

On the 2nd May a *post-mortem* porter (case 35) who worked in the City of Leeds Public Mortuary was seen by one of us (C.W.D.) and diagnosed as modified smallpox.

He had had a febrile attack followed by a rash which was confidently thought to be chickenpox. On investigation it was found that he had pricked his finger when attending to a body at the mortuary some nine days prior to the onset. This resulted in a "septic" finger affecting the pulp, but, although untreated, it never suppurated and only produced a rather deep nodular lesion. It seems almost certain that this was an inoculation with variola virus and accounted for the nine-day incubation period. Investigation of the *post-mortem* records showed that the source of infection, Mrs. B., a woman of 40 years of age (case 36), was suddenly taken ill two days before death with violent headache, backache, vomiting, accompanied by a moderate pyrexia. She died without any signs to suggest the cause of death. The post-mortem at the coroner's request revealed nothing abnormal beyond small hæmorrhages in the larynx and under the pericardium. A blood film showed cells entirely consistent with a diagnosis of acute leukæmia and a death certificate to that effect was given.

The repercussions from this were considerable. The mortuary, although a public mortuary of the city, was situated in the grounds of a large general hospital and there was sufficient contact of staff to necessitate control measures being taken there. One pathologist who had never been vaccinated was in contact with the mortuary porter during his pre-eruptive febrile attack when he had remained on duty. The pathologist was vaccinated late, on the 10th day, and was given a dose of vaccinia gamma globulin on the 12th day. The vaccination was successful and the pathologist escaped an attack; the two events were not necessarily connected. A second pathologist who did the autopsy on Mrs. B. was taken ill some seven days after and had no eruption, but did have a number of febrile attacks over a period of ten days.

He was fully investigated in the teaching hospital, but no diagnosis was arrived at. When his previous contact with smallpox came to light a specimen of blood was examined for the presence of anti-bodies and a titre of 1 in 20 obtained. This was first reported as diagnostic of smallpox, but was later changed to indicating contact with smallpox virus, a fact already known. The picture was complicated by the fact that although no vaccination had been done for about four years, the individual had been vaccinated many times in the army and had served in Burma and the Far East. Although patients who recovered from quite severe smallpox were perfectly well within a few weeks and back at work quite soon after their attack, this individual had recurrent fever and malaise some six weeks later and was not fully recovered for some three months. There seems little doubt that this infection was not due to the variola virus.

Our experience in the interpretation of serological findings in individuals who have been vaccinated many times is not sufficiently great to be certain that some individuals may not have a more lasting immunity than usually supposed, or that other virus infections might not produce an anamnestic reaction.

The last isolated case in this outbreak (No. 37) occurred in a miner of 19 from Baildon, near Shipley. He visited football matches and cinemas and possibly other forms of recreation to a considerable extent, but no known contact could be found between him and the other cases, or any known contacts. Diagnosis was made early on the 4th day and contacts vaccinated promptly. No secondary cases occurred.

The final episode was the occurrence of smallpox in the son (case 39) and daughter (case 38) of the mortuary attendant. They were vaccinated when the diagnosis was made in their father on the 8th day of their incubation period. The bitter irony of life showed itself in the boy having a very mild attack, type 7, with virtually no residual scarring, while the girl of 18 years of age and a hairdresser, had a full discrete attack with severe scarring. These cases had been under surveillance and no secondary cases arose from them.

This outbreak showed most of the features to be expected in smallpox. After entry into the country from an unknown source, a number of missed cases occurred, particularly of the fulminating type, before a case was diagnosed. In spite of many opportunities the spread of infection was more limited than is usually assumed. High attack rates only occurred in very close contacts, in the family, amongst personal friends, or close contacts at work. It is to be noted however that, conversely, in spite of apparently close contact and late vaccination, many family contacts remained free particularly where the original case was of a fulminating kind. It seems that the cases of moderate severity, for a variety of reasons, prove to be the most potent sources of infection to others.

Beyond this essentially "family infection" there were at least five known cases where infection occurred in individuals who in spite of most heroic investigations could be found to have no known connection with any other case. These five individuals, however, were not just caught in a random scatter of infection in some mysterious way. One was a lorry driver's mate; one a miner bent on pleasure; another a middle-aged woman who lived in a slum district where lorries were frequently parked for the night. A small boy lived close to the cattle market and the street he lived in was frequently used to park lorries and he was known to play in and out of the drivers' cabs. The man at the clay works had considerable dealings with lorry drivers who visited the works. There is a common element amongst all these people; they are drawn from one social class and for reasons best known to themselves are a little secretive of their movements. Many in the road transport industry will be ex-service men whose immunity following service vaccinaton will have waned sufficiently for an "influenza with spots" but probably nothing more.

In spite of the many authorities involved on the Yorkshire side one ambulance was maintained by the West Riding County Council for moving smallpox patients and was available on the usual cost basis to any other local authorities that wished to use it. This was an advantage in the disinfection of ambulances and crews at the hospital and reduced the number of individuals handling cases. It was used for all the movements from the Yorkshire side except those from the City of Leeds.

It should be emphasised that the source of this outbreak could not be traced in spite of extensive and systematic enquiries. It might have been infected raw cotton, but it could have been some other vehicle of infection. This is not the first time that the importation of smallpox into this country through the medium of raw cotton has been suspected. The reason for this is that smallpox is prevalent, often endemic, in some areas where cotton is grown. Consequently there is liability of the cotton becoming infected, and there is a history of outbreaks of the disease in England where a definite source of infection could not be traced, but the first cases were reported among workers in cotton mills. The risk of infection is decreased as the raw cotton is processed, and is regarded as probably negligible after the carding stage. There is no known means of disinfecting cotton—short of destructive measures—and Medical Officers of the Ministry of Health have recommended that the only safeguard which can be recommended confidently is the vaccination, at regular intervals of say two years, or as circumstances require, of those workers in the cotton industry who handle raw cotton and cotton waste up to and including the carding stage.

It was, therefore, decided to recommend that the County Council's Vaccination Scheme under the National Health Service Act which provided for the vaccination of adults, only in the event of an outbreak of smallpox, should be amended so that periodical vaccination could be offered, as part of the Local Health Authority Services, to appropriate cotton mill workers, and workers in other industries where risks of infection might arise. The County Council agreed, in October, 1953, to the appropriate amendment of the Scheme by the addition of the following paragraph thereto:—

"Other Persons

Arrangements will also be made for the vaccination or re-vaccination of other persons, as may be decided by the Authority, either in individual cases by medical practitioners or at sessions."

This amendment has received the approval of the Ministry of Health.

Vaccination against Smallpox.—Vaccination is offered to the parents or guardians of all young children during the first month of life and is carried out either at the Infant Welfare Clinics or by the family doctor.

The number of vaccinations performed during 1953 was much greater than in what may be termed a normal year due to the cases of smallpox in Todmorden and other areas of the West Riding, as will be seen from the statistics in the table below showing the number of vaccinations and re-vaccinations performed during the years 1950-1953. Despite this fact, the figures are still unsatisfactory, particularly in the age group "under 1".

Year	Vaccinations						Re-Vaccinations					
	Under 1	1	2-4	5-14	15 or over	Total	Under 1	1	2-4	5-14	15 or over	Total
1950	3,259	3,701		4,345	5,763	17,058*	11	178		1,068	6,338	7,595*
1951	3,531	1,857	719	496	961	7,564	25	23	56	160	2,038	2,302
1952	3,803	1,368	479	373	1,042	7,065	25	7	23	136	1,273	1,464
1953	6,556	2,901	6,770	24,611	29,166	70,004¶	32	58	842	8,680	36,266	45,878¶

* Three cases of suspected smallpox were reported during the year.
¶ Excluding 11,375 unclassified cases.

Two cases of generalised vaccinia were reported during the year. There were no complications and both recovered.

Enteric (Typhoid) Fever

Of the 2 cases of enteric fever, one was in Aireborough U.D. and the other in the adjoining Ilkley U.D. There appeared to be little doubt in the Ilkley case that the infection was contracted during a visit to France.

Paratyphoid Fever

Of the 10 cases of paratyphoid fever, 3 were single cases in widely separated Districts, 2 were institutional cases, 2 were in a family where there was a chronic carrier, and 3 were in children of one family where extensive enquiries failed to reveal the source of infection.

Food Poisoning

The notified confirmed cases numbered 329 and there are records of 37 other cases having been ascertained in the course of investigation into outbreaks, a total of 366 recorded cases. The recorded total for 1952 was 697. These figures do not represent the total incidence of cases because for many mild cases, particularly in private households, medical advice is not sought and the cases thus escape notification, but the value of even incomplete notification should not be underestimated. The investigations into the circumstances of notified cases have in some instances enabled measures to be taken limiting the spread of foci of infection into wider spread outbreaks. The large number of cases shows that need still exists for better standards of hygiene in all matters connected with the handling and preparation of food.

Twenty-nine outbreaks are recorded for 1953 in the Administrative County, and in 16 of these, the causal agent was identified; 178 sporadic cases, apparently not connected with an outbreak, were also recorded, in 70 of which the causal agent was identified. The relevant statistics are given in the table overleaf:—

Division No.	Food Poisoning Notifications returned to R.G. (Corrected)					Number of outbreaks due to Identified Agents						Outbreaks of Undiscovered Cause		Single Cases		
	Quarter of Year				Total	Chemical Poisoning	Salmonella Organisms	Staphylococci (inc. Toxin)	Cl. botulinum	Other bacteria	Total Cases	No. of outbreaks	No. of Cases	Agent Identified	Unknown Cause	Total
	1st	2nd	3rd	4th												
1	—	—	1	—	1	—	—	—	—	—	—	—	—	—	1	1
2	—	—	8	—	8	—	2	—	—	—	*12	—	—	—	—	—
3	—	3	16	1	20	—	—	—	—	—	—	—	—	—	20	20
4	—	1	4	1	6	—	—	—	—	1	†20	—	—	2	4	6
5	—	1	6	2	9	—	1	—	—	—	3	—	—	2	4	6
6	—	1	26	24	51	—	2	—	—	—	‡25	—	—	—	34	34
7	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
8	—	1	12	—	13	—	—	1	—	—	8	—	—	5	—	5
9	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
10	—	—	6	—	6	—	—	—	—	—	—	1	5	—	1	1
11	—	—	4	—	4	—	1	—	—	—	4	—	—	—	—	—
12	2	48	10	1	61	—	—	2	—	—	48	—	—	12	1	13
13	—	—	17	—	17	—	3	—	—	—	¶15	1	5	—	1	1
14	—	—	3	—	3	—	—	—	—	—	—	—	—	—	3	3
15	1	—	5	1	7	—	—	—	—	—	—	—	—	7	—	7
16	—	—	24	1	25	—	—	—	—	—	—	1	14	9	2	11
17	—	2	14	—	16	—	—	—	—	—	—	—	—	—	16	16
18	3	3	1	1	8	—	—	—	—	—	—	—	—	—	8	8
19	—	—	6	—	6	—	—	—	—	—	—	—	—	2	4	6
20	—	—	1	—	1	—	—	—	—	—	—	—	—	1	—	1
22	3	4	11	3	21	—	2	—	—	—	4	5	10	3	4	7
23	—	1	8	2	11	—	1	—	—	—	2	1	3	5	1	6
24	1	1	5	2	9	—	—	—	—	—	—	1	3	5	1	6
25	—	1	4	—	5	—	—	—	—	—	—	—	—	4	1	5
26	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
27	—	—	4	2	6	—	—	—	—	—	—	2	§4	2	1	3
28	—	—	1	—	1	—	—	—	—	—	—	—	—	1	—	1
29	—	—	5	—	5	—	—	—	—	—	—	1	3	2	—	2
30	—	1	3	—	4	—	—	—	—	—	—	—	—	4	—	4
31	—	—	2	3	5	—	—	—	—	—	—	—	—	4	1	5
	10	68	207	44	329	—	12	3	—	1	141	13	47	70	108	178

* Includes 4 cases ascertained during the course of investigations.
† Cases not notified, but ascertained.
‡ Includes 8 cases ascertained during the course of investigations.
¶ Includes 4 cases ascertained during the course of investigations.
§ Includes 1 case ascertained during the course of investigations.

Venereal Diseases

New Cases (compared with previous years). Table A.

Year	Syphilis	Gonorrhoea	Total of new cases of Syphilis and Gonorrhoea	Other Conditions	Total of new patients
1938	346	650	996	503	1,499
1939	403	678	1,081	593	1,674
1940	299	499	798	497	1,205
1941	331	552	883	587	1,470
1942	423	479	902	735	1,637
1943	487	654	1,141	1,344	2,485
1944	413	560	973	1,383	2,356
1945	473	767	1,240	1,419	2,659
1946	723	1,140	1,863	1,859	3,722
1947	573	729	1,302	1,511	2,813
1948	463	550	1,013	1,403	2,416
1949	435	383	818	1,360	2,178
1950	357	304	661	1,447	2,108
1951	247	171	418	1,212	1,630
1952	219	211	430	1,275	1,705
1953	214	182	396	1,228	1,624

New Cases (Quarterly and stage of disease). Table B.

Quarter ended	Acquired Syphilis				Congenital Syphilis				Gonorrhoea		Other Conditions	
	Early		Late		Under 1 yr.		Over 1 yr.					
	1952	1953	1952	1953	1952	1953	1952	1953	1952	1953	1952	1953
31st March ...	6	4	45	37	—	—	10	13	48	44	324	326
30th June ...	2	4	50	33	—	—	11	13	74	49	310	287
30th September ...	5	1	43	42	1	—	4	9	36	50	300	286
31st December ...	6	—	25	43	—	1	11	14	53	39	341	329
Total ...	19	9	163	155	1	1	36	49	211	182	1,275	1,228

New Cases (Treatment Centres). Table C.

Name of Special Treatment Centre	Syphilis	Gonorrhoea	Other Conditions	Total
Barnsley Clinic, Queen's Road	15	20	106	141
Bradford St. Luke's Hospital	17	15	87	119
Burnley Victoria Hospital	1	1	7	9
Dewsbury General Hospital	14	8	62	84
Doncaster Royal Infirmary	21	36	155	212
Goole Bartholomew Hospital	10	3	21	34
Halifax Royal Infirmary	16	7	73	96
Harrogate General Hospital	15	4	66	85
Huddersfield Royal Infirmary	4	12	52	68
Keighley Victoria Hospital	16	6	65	87
Leeds General Infirmary	26	18	163	207
Oldham Boundary Park General Hospital	2	—	7	9
Rotherham, 12, Frederick Street	10	10	75	95
Sheffield Jessop Hospital	1	—	4	5
Sheffield Royal Hospital	2	8	17	27
Sheffield Royal Infirmary	7	1	15	23
Sheffield City General Hospital	—	—	2	2
Wakefield Clayton Hospital	34	32	238	304
York County Hospital	3	1	13	17
	214	182	1,228	1,624

The total number of new cases from the Administrative County attending Special Treatment Centres during 1953 was 1,624, a decrease of 81 compared with the previous year. Syphilis, gonorrhoea and other conditions shared in this reduction.

New cases of Syphilis were only 5 less than in 1952, but a study of Table B reveals that early acquired syphilis fell to the record low level of 9 cases. The following figures demonstrate the progressive diminution in the number of new cases of early syphilis (both acquired and congenital under one year of age) during recent years:—

Year	Early Syphilis	Congenital Syphilis under 1 year
1949	158	7
1950	76	4
1951	58	4
1952	19	1
1953	9	1

This is highly gratifying. If continued, the next generation should be almost syphilis free. Meantime the problem should continue to be attacked by examining and, if necessary, treating every contact of early syphilis and by providing expert ante-natal supervision to ensure that no case of syphilis in pregnancy is missed.

Unfortunately, non-gonococcal urethritis appears to be coming more prevalent. Figures have been available for only the past three years and these are for males only in the geographical county. They are as follows:—

1951 — 677, 1952 — 715, 1953 — 979 cases.

It is now recognised that the vast majority of these cases are venereal in origin and vaginitis and cervicitis are commonly found on examination of contacts. The disease usually runs a mild course but several cases of severe inflammation of joints and eyes (Reiter's syndrome) have occurred necessitating a stay of weeks or even months in hospital.

So far as gonorrhoea is concerned, after a temporary rise in the number of new cases in 1952 there was a fall to slightly above the record low level of 1951.

In addition to the cases examined and treated at the Treatment Centres (Table C) small numbers were dealt with by the 14 doctors in the General Practitioner V.D. Service. This scheme operates in the rural areas of the county and patients are seen at the medical practitioner's surgery or at home if unfit to travel to the surgery. Each doctor in the service has now been affiliated to a Special Treatment Centre and in future years the figures given in Table C will include the new patients of the General Practitioner V.D. Service.

V.D. Social Work

Contact Tracing — Table D.

Total No. of contacts reported	127				
Located and examined		111			
Not infected			86		
Infected			25		
Already under treatment				—	
Brought under treatment				25	
Syphilis					20
Gonorrhoea					5
Located		12			
Not examined			4		
Transferred to other authority			8		
Not located		4			
Insufficient information			2		
Unable to locate			2		

Ante-natal cases. — Table E.

Patients					Contacts of patients		
No. of positive reports on specimens from ante-natal clinics	No. investigated by Social Workers	No referred direct to Special Treatment Centres	No. found to have syphilis	No. found not to be infected	No. of contacts examined	No. found to be infected *	No. found not to be infected
60	55	5	40	20	56	10	46

* Of the 10 contacts found to be infected, 4 were children, including a boy of 6 years and a girl of 5 years (members of the same family), a boy of 3 years, and a baby 3 months old. The remaining 6 were adults, 1 congenital and 5 late syphilis.

Other cases with positive blood tests. — Table F

No. reported from Laboratory	189				
No action necessary		103			
Action taken		86			
Not requiring follow-up			26		
Referred to Special Treatment Centres			60		
Contacts examined				47	
Not infected					39
*Infected					8

* Of the 8 contacts found to be infected, 2 were children, one 8 years of age and one 11 years of age. The remaining 6 were adults with late syphilis.

Defaulters. — Table G

Total number of defaulters	Returned to clinic after visiting	Failed to return	Removed, unable to locate	Transferred	Number of ineffective visits	Number of re-visits
456	315	79	20	40	597	650

During the year the V.D. Social Workers had 890 interviews with doctors and 1,434 miscellaneous interviews.

The staff consists of one confidential clerk-typist and four Venereal Diseases Social Workers (Qualified Health Visitors) who are trained nurses with special experience in V.D. work.

The Administrative County has been divided into four areas and each V.D. Social Worker is responsible for the case finding, case holding and social work at one or more of the clinics in her area. Three of the areas are respectively coterminous with the County Boroughs of Dewsbury, Doncaster and Wakefield, and, by arrangement, the three Social Workers concerned undertake similar duties in these County Boroughs also. This arrangement operates satisfactorily as the Social Worker is able to cover the whole of the district from which patients attending the main clinic in her area are drawn.

Every effort is made to bring under examination any person who may be infected with a venereal disease. Information about possible cases is received from many sources including:—

(a) Patients with venereal disease — Contact Tracing (Table D)

(b) Ante-natal cases with positive blood tests for syphilis (Table E)

(c) Other cases with positive blood tests (Table F)

All the information concerning contacts, both statistical and factual, comes through the Central Office and every care is taken to ensure that the strictest confidence is observed. The V.D. Social Worker responsible for the area finds the contact and persuades him or her to be medically examined either at a Special Clinic or by a General Practitioner. In this difficult work a combination of tact, persuasion and perseverance is necessary. Some credit for the remarkable reduction in the number of new cases of early syphilis in recent years must be attributed to the painstaking thoroughness with which the work has been done. This is illustrated in Table D where it will be seen that 96 per cent. of contacts reported were located and 87 per cent. were brought under examination.

Case holding (Table G) is the work undertaken to ensure that the maximum number of V.D. patients is kept under treatment and observation until the disease is cured. The majority of defaulters have received sufficient treatment to relieve their symptoms and also render them non-infectious by the time they discontinue attending. Inadequate treatment constitutes a risk of future ill-health for patients but not, as a rule, to other persons with whom they come in contact.

Each Social Worker carries out socio-medical work at one or more Special Treatment Centres in her area, under the direction of the physician in charge of the clinic. She interviews the patients, obtains information about contacts, advises and helps them with innumerable problems and generally acts as a health teacher with a preventive outlook.

Tuberculosis

Deaths from Tuberculosis.—There were 285 deaths from tuberculosis (254 respiratory and 31 non-respiratory) representing a death rate of 0.18 (0.16 respiratory and 0.02 non-respiratory), which compares favourably with the England and Wales rates of 0.20 (0.18 respiratory and 0.02 non-respiratory) and maintains the downward tendency which has been constant since 1948.

It is a chastening thought however that 65% of these deaths occur during the most productive age of life, the 25-65 age group.

The details are given in the following table:—

Classification	AGE AT DEATH IN YEARS																Total		Grand Total
	0—		1—		5—		15—		25—		45—		65—		75 —				
	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	
Respiratory	2	—	—	—	1	1	5	6	35	33	85	24	44	6	9	3	181	73	254
Non Respiratory	1	1	5	5	2	3	1	1	2	2	1	3	1	1	—	2	13	18	31
Total	3	1	5	5	3	4	6	7	37	35	86	27	45	7	9	5	194	91	285

Notification of Tuberculosis.—The notification of new cases of tuberculosis does not reveal the same satisfactory trend as shown in the mortality nor is this surprising; improved methods of treatment and particularly chemotherapy have made a marked impact upon the fatality of the disease without a corresponding effect upon its incidence. Furthermore, the use of mass radiography has facilitated early diagnosis of hitherto unknown cases.

Under the revised Public Health (Tuberculosis) Regulations, 1952, the Ministry of Health no longer requires Local Health Authorities to record as supplemental notifications cases arising from transfers and becoming known from other sources as this information is to be obtained from the chest clinics. In consequence of this change the notifications now recorded can be compared with those of previous years, only if the latter are reduced by those cases which are no longer recorded. With this adjustment, as shown in the table on page 13 the comparison shows that the reduction in notifications over the past six years is significant only in the non-respiratory forms of the disease. Details of the sex, age groups, and form of disease of the 1,470 new cases notified during the year are summarised in the following table:—

	AGE PERIODS												Total all Ages
	0—	1—	2—	5—	10—	15—	20—	25—	35—	45—	55—	65—	75	
FORMAL NOTIFICATIONS:—														
Respiratory, Males	3	6	26	23	14	49	50	136	101	128	105	50	11	702
Respiratory, Females	2	8	19	20	16	65	94	129	62	26	20	11	2	474
Non-Respiratory, Males	—	6	18	26	19	8	6	10	8	9	5	—	1	116
Non-Respiratory, Females	2	3	9	21	19	11	11	20	10	11	3	1	2	123
														1,415
SUPPLEMENTAL NOTIFICATIONS:—														
Respiratory, Males	1	—	—	—	—	—	—	3	2	9	12	1	—	28
Respiratory, Females	—	—	1	—	—	1	1	4	4	3	3	2	—	19
Non-Respiratory, Males	—	—	—	2	—	—	—	—	—	—	—	—	—	2
Non-Respiratory, Females	—	1	—	1	—	—	2	—	—	—	1	1	—	6
														55

The sources of information of the supplemental notifications were Local Registrars (30 respiratory, 6 non-respiratory); transferable deaths from the Registrar General (12 respiratory, 1 non-respiratory) and posthumous notifications (5 respiratory, 1 non-respiratory).

There were, therefore, 42 cases in the area where knowledge of the tuberculous condition was not available until after the death of the patient. This feature has been the cause of much concern, national as well as local, and is under constant surveillance. The number of cases in the West Riding is not large but even these should not occur. Investigation suggests that the initial diagnosis of tuberculosis has been made shortly before the death of the patient and circumstances have diverted the attention of the medical attendant, in hospital or general practice, from his statutory duty to notify the occurrence of the disease.

After adjustment for removals, recoveries and deaths, the total number of notified cases of tuberculosis on our register at the end of the year was 10,351, an increase of 388 compared with the previous year. The following table summarises the revision of the registers in the respective divisional areas:—

Division No. Area	Number of cases on register 1/1/53				Number of cases added to register				Number of cases removed from register				Number of cases remaining on register 31/12/53			
	Respiratory		Non-Resp.		Respiratory		Non-Resp.		Respiratory		Non-Resp.		Respiratory		Non-Resp.	
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
1 Skipton	150	92	42	57	30	22	10	5	23	8	2	9	157	106	50	53
2 Settle	58	38	10	18	6	15	8	5	9	7	5	4	55	46	13	19
3 Keighley	161	130	52	28	28	17	3	3	15	9	2	1	174	138	53	30
4 Shipley	182	134	31	46	54	18	11	8	30	15	8	8	206	137	34	46
5 Horsforth	173	119	44	60	54	30	6	10	28	28	8	13	199	121	42	57
6 Otley	113	67	26	20	22	18	5	1	36	19	17	11	99	66	14	10
7 Ripon	41	25	15	14	5	10	—	5	12	9	9	10	34	26	6	9
8 Harrogate	198	141	38	57	47	33	10	19	47	35	15	20	198	139	33	56
9 Wetherby	69	66	30	24	20	18	3	8	14	13	6	5	75	71	27	27
10 Goole	132	106	45	49	14	22	2	4	14	7	18	11	132	121	29	42
11 Castleford	212	154	39	53	36	18	7	2	21	9	13	11	227	163	33	44
12 Pontefract	188	138	48	70	35	19	2	3	19	10	12	10	204	147	38	63
13 Ossett	76	49	20	31	16	7	—	4	19	12	4	9	73	44	16	26
14 Morley	75	42	16	31	10	10	3	5	12	9	1	8	73	43	18	28
15 Batley	69	70	35	26	11	10	2	3	4	3	—	1	76	77	37	28
16 Rothwell	131	107	30	29	19	20	—	2	15	16	4	9	135	111	26	22
17 Spenborough	169	105	63	71	11	6	2	8	14	7	5	5	166	104	60	74
18 Brighouse	181	116	51	32	54	32	7	—	33	13	8	5	202	135	50	27
19 Todmorden	166	121	59	40	44	23	6	9	32	16	19	16	178	128	46	33
20 Colne Valley	162	112	60	70	57	42	12	9	31	18	12	12	188	136	60	67
22 Wortley	317	215	108	76	69	38	7	8	24	13	2	5	362	240	113	79
23 Hemsworth	225	152	34	43	37	27	3	7	30	15	7	4	232	164	30	46
24 Barnsley	72	59	12	13	14	15	4	—	12	6	3	2	74	68	13	11
25 Wombwell	156	117	27	21	27	24	3	2	20	16	3	6	163	125	27	17
26 Wath	100	67	31	25	13	14	1	6	7	3	3	7	106	78	29	24
27 Adwick-le-St't	131	109	46	33	16	15	4	3	16	11	3	6	131	113	47	30
28 Doncaster	150	135	59	47	44	23	4	2	23	13	6	2	171	145	57	47
29 Thorne	117	119	26	28	16	23	4	4	10	7	1	1	123	135	29	31
30 Mexborough	216	188	41	29	41	32	1	3	28	23	4	5	229	197	38	27
31 Rotherham	190	123	45	43	54	22	8	7	28	13	2	5	216	132	51	45
Total	4,380	3,216	1,183	1,184	904	623	138	155	626	383	202	221	4,658	3,456	1,119	1,118

Divisional Medical Officers have received 2,429 notifications (1,209 admissions and 1,220 discharges) relating to patients admitted to, or discharged from, treatment in the under-mentioned 82 hospitals.

INSTITUTION	Respiratory								Non-Respiratory							
	Admitted				Discharged				Admitted				Discharged			
	Adults		Children		Adults		Children		Adults		Children		Adults		Children	
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Batley General Hospital	—	—	—	—	—	—	—	—	—	—	1	—	—	—	—	—
Beaumont Hospital, Lancaster	—	—	—	—	—	—	—	—	—	—	1	—	—	—	1	—
Beckett Hospital, Barnsley	1	—	—	—	1	—	—	—	—	—	—	—	—	—	—	—
Bierley Hall Hospital, Bradford	9	12	—	—	8	6	—	—	—	—	—	—	—	—	—	—
Bradford Children's Hospital	—	—	—	—	—	—	—	—	—	—	—	1	—	—	—	1
Bradford Royal Infirmary	3	3	—	—	4	3	—	—	2	1	1	—	2	—	—	—
Bradley Wood Sanatorium, Huddersfield	19	11	—	—	17	10	—	—	—	—	—	—	—	—	—	—
Brompton Hospital, Frimley, Aldershot	1	1	—	—	—	1	—	—	—	—	—	—	—	—	—	—
Castle Hill Sanatorium, Cottingham	—	2	—	—	5	2	—	—	—	—	—	—	—	—	—	—
Catterick Military Hospital	—	—	—	—	1	—	—	—	—	—	—	—	—	—	—	—
Cheshire Joint Sanatorium, Market Drayton, Salop	1	—	—	—	1	—	—	—	—	—	—	—	—	—	—	—
City General Hospital, Sheffield	4	6	—	—	4	4	—	—	—	—	—	—	—	—	—	—
Commonside Sanatorium, Sheffield	—	8	—	—	—	4	—	—	—	—	—	—	—	—	—	—
Connaught Military Hospital, Hindhead, Surrey	1	—	—	—	1	—	—	—	—	—	—	—	—	—	—	—
Crimicar Lane Hospital, Sheffield	4	1	—	—	5	—	—	—	—	—	—	—	—	—	—	—
Crookhill Hall Sanatorium, Conisbrough	57	—	1	—	58	—	1	—	—	—	—	—	—	—	—	—
Davos-Platz, Switzerland	5	—	—	—	6	—	—	—	—	—	—	—	—	—	—	—
Dewsbury General Hospital	1	—	—	—	1	—	—	—	—	2	—	—	—	—	—	—
Doncaster Royal Infirmary	—	—	—	—	—	—	—	—	—	—	1	—	—	—	1	—
Dronfield Hospital, Sheffield	—	—	4	1	—	—	4	1	—	—	—	—	—	—	—	—
Fairfield Sanatorium, York	2	—	—	—	2	—	—	2	—	—	—	—	—	—	—	—
Fielden Hospital, Todmorden	—	—	—	—	—	—	—	—	—	—	—	1	—	—	—	—
Gateforth Sanatorium, Hambleton, nr. Selby	26	—	1	—	38	—	—	—	—	—	—	—	—	—	—	—
Harrogate General Hospital	—	1	—	—	—	1	—	—	—	—	—	—	—	—	—	—
High Wood Hospital, Brentwood	—	—	—	1	—	—	—	—	—	—	—	—	—	—	—	—
Huddersfield Royal Infirmary	2	—	—	—	4	2	—	—	1	3	1	1	5	6	1	2
Iscoyd Park Colony, Shropshire	—	—	—	—	4	1	—	—	—	—	—	—	—	—	—	—
Kendray Hospital, Barnsley	—	—	1	—	—	—	—	—	—	—	3	—	—	—	1	—
Killingbeck Hospital, Leeds	51	33	—	1	48	38	—	1	2	1	—	—	2	1	—	—
Kilton Hospital, Worksop	2	—	—	1	1	—	—	—	—	—	—	—	—	—	—	—
King Edward VII Hospital, Rivelin Valley Road, Sheffield	—	—	—	—	—	—	—	—	3	—	1	1	3	—	—	—
King Edward VII Welsh National Memorial Hospital, Llangwysan, nr. Denbigh	1	—	—	—	1	—	—	—	—	—	—	—	—	—	—	—
Leeds General Infirmary	2	—	—	—	2	—	—	—	2	—	1	—	2	—	1	—
Leeds Road Hospital, Bradford	—	19	—	—	—	15	—	—	—	—	—	—	—	—	—	—
Lodge Moor Hospital, Sheffield	5	—	—	—	6	—	—	—	—	—	—	—	—	—	—	—
Marguerite Hepton Memorial Orth. Hospital, Thorp Arch	—	—	—	—	—	—	—	—	—	—	4	1	—	—	2	—
Markfield Sanatorium, Leicester	—	1	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Mill Hill Isolation Hospital, Huddersfield	18	8	—	—	17	4	—	—	—	1	—	—	—	—	—	—
Moorgate General Hospital, Rotherham	3	1	—	—	3	—	—	—	—	—	—	—	—	—	—	—
Mowbray Grange Sanatorium, Bedale	—	1	—	—	—	2	—	—	—	—	—	—	—	—	—	—
Nether Edge Hospital, Sheffield	—	1	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Newstead Sanatorium, Fishpool, Mansfield	—	—	—	—	—	—	1	—	—	—	—	—	—	—	—	—
Northowram Isolation Hospital, Halifax	46	—	—	—	50	—	—	—	—	—	—	—	—	—	—	—
Oakwood Hall Sanatorium, Moorgate, Rotherham	22	16	1	3	22	23	2	4	—	—	—	—	—	—	—	—
Osgodby Hospital, Lincoln	—	—	—	—	1	—	—	—	—	—	—	—	—	—	—	—
Otley General Hospital	—	—	—	—	2	—	—	—	—	—	—	—	—	—	—	—
Papworth Hospital, Cambridge	3	2	—	—	2	1	—	—	—	—	—	—	—	—	—	—
Pinderfields General Hospital, Wakefield	—	—	—	—	1	—	—	—	1	—	1	—	—	—	—	1
Pontefract General Infirmary	1	—	—	—	1	—	—	—	—	—	—	—	—	—	—	—
Ransom Sanatorium, Rainworth, Notts.	—	—	—	—	—	1	—	—	—	—	—	—	—	—	—	—
Rawdon Orthopaedic Hospital, nr. Leeds	—	—	—	—	—	—	—	—	1	—	—	—	—	—	—	—
Raywell Sanatorium, Cottingham	2	1	—	—	2	2	—	—	—	—	—	—	—	—	—	—
Robert Jones and Agnes Hunt Orth. Hospital, Oswestry	—	—	—	—	—	—	—	—	—	2	—	—	—	2	—	—
RN. Hospital, Gosport, Hants.	1	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Rotton Banks Sanatorium, Knaresborough	—	105	1	—	—	119	—	5	—	8	—	3	—	14	—	2
Sacroft Hospital, Leeds	7	—	7	6	9	—	4	11	—	—	—	1	1	—	—	—
Sheffield Children's Hospital	—	—	2	2	—	—	—	—	—	—	—	3	—	—	—	—
Sheffield Royal Hospital	—	1	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Sheffield Royal Infirmary	1	—	—	—	1	—	—	—	—	—	—	—	—	—	—	—
Shelf Sanatorium, near Halifax	16	29	—	—	16	34	—	—	—	—	—	—	—	—	—	—
Shapethorpe Hospital, Wakefield	3	6	—	—	5	11	—	—	—	—	—	—	—	—	—	—
Staincliffe General Hospital, Dewsbury	1	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Stanley Royd Hospital, Wakefield	—	—	—	—	1	—	—	—	—	—	—	—	—	—	—	—
Storthes Hall, Kirkburton	1	2	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Tinesdale Sanatorium, Oldham	—	2	—	—	—	2	—	—	—	—	—	—	—	—	—	—
St. George's Hospital, Rothwell, nr. Leeds	—	11	—	—	—	13	—	—	—	—	—	—	—	—	—	—
St. Helen's Hospital, Barnsley	—	—	2	—	—	—	—	—	—	—	—	—	—	—	—	—
St. James's Hospital, Leeds	—	—	—	—	—	—	—	—	—	1	—	—	—	—	—	—
St. Luke's Hospital, Bradford	5	4	—	—	4	4	—	—	—	—	—	—	—	—	—	1
St. Luke's Hospital, Huddersfield	1	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
The Hollies Hospital, Meanwood, Leeds	—	—	1	1	—	—	1	2	—	—	—	—	—	—	1	—
The Hospital, Grassington, nr. Skipton	62	52	—	2	51	40	—	—	—	—	—	—	—	—	—	1
The Hospital, Middleton-in-Wharfedale, nr. Ilkley	123	85	18	20	115	90	23	20	14	4	11	3	12	2	7	6
Thornton Lodge Sanatorium, Aysgarth	—	—	2	4	—	1	3	3	—	—	—	—	—	—	—	—
Tickhill Road Isolation Hosp. and San., Doncaster	16	14	—	—	14	12	—	—	1	—	—	—	—	—	—	—
Toth Wood Isolation Hospital	12	19	1	—	19	3	—	—	—	—	—	—	—	—	—	—
Tharncliffe Hospital, Wadsley, Sheffield	—	—	—	—	—	1	—	—	—	—	—	—	—	—	—	—
Whitley Grange Sanatorium, Dewsbury	9	9	—	—	9	13	—	—	—	—	—	—	—	—	—	—
Winter Street Hospital, Sheffield	5	7	—	—	4	12	3	1	—	—	—	—	—	—	—	—
Wrightington Hospital, Appley Bridge, nr. Wigan	—	—	—	—	—	—	—	—	1	—	1	—	1	1	—	—
York City General Hospital	1	1	—	—	1	1	—	—	—	—	—	—	—	—	—	—
York County Hospital	—	1	—	—	—	1	—	—	—	—	—	—	—	—	—	—
	556	476	42	42	568	477	42	50	28	23	27	15	28	26	15	14

B.C.G. Vaccination.—During the year under review B.C.G. vaccination continued to be restricted to contacts of known cases of tuberculosis. 681 cases were vaccinated with only 8 unsuccessful results; the vaccinations were undertaken by Chest Physicians, 507 in the Leeds Region (6 unsuccessful) and 174 in the Sheffield Region (2 unsuccessful). The only significant feature to which attention should be drawn is the increased proportion of children under 1 year of age afforded this protection, 249 against 179 in 1952 and 112 in 1951.

	AGE GROUPS												
	Under 1 year Months.				Years								All Ages
	0—	1—	3—	6—	1—	2—	3—	4—	5—	10—	15—	20—	
Vaccinated:													
Male	31	34	45	33	33	27	18	13	76	29	3	1	343
Female	23	21	33	29	34	26	20	29	72	33	14	4	338
Total	54	55	78	62	67	53	38	42	148	62	17	5	681
Result of Vaccination Successful:													
Male	22	32	43	29	26	27	15	13	70	28	3	1	309
Female	16	19	31	26	30	24	20	28	66	31	9	4	304
Total	38	51	74	55	56	51	35	41	136	59	12	5	613
Unsuccessful	1	2	—	1	1	—	1	—	2	—	—	—	8
Not finally ascertained	15	2	4	6	10	2	2	1	10	3	5	—	60

Towards the end of the year the Ministry of Health issued Circular 22/53 authorising Local Health Authorities to seek an extension of the scheme for B.C.G. vaccination to 13 year old school children. The action taken following receipt of this circular will be dealt with in the next Annual report.

Mass Radiography.—58,322 persons from the administrative county area were examined by the mass radiography service during the year (45,425 by units of the Leeds Regional Hospital Board and 12,897 by those of the Sheffield Regional Hospital Board); 87 (0.15%) were found to be suffering from active tuberculosis, 350 (0.60%) had signs of inactive tuberculosis and in 1,328 cases (2.28%) other non-tuberculous abnormalities were discovered.

In the five years 1949-53, the number of examinations in the county area undertaken by the mass radiography service of the two Regional Hospital Boards totalled 262,276 by which standard it may be assumed that each resident in the county is likely to have the opportunity of examination once in 30 years. It should be recalled, however, that a number of the examinees are of special priority classes and these, as with others included in the totals, are examined at more frequent intervals; this lengthens still further the period of examination for other groups.

The inadequacy of the service to cope with this task is obvious and may lead either to an expansion of the service, or alternatively, to accept that a periodic examination of all is not the aim and to concentrate on those groups of the population, the survey of which may be justified on economic as well as epidemiological grounds. Details of the examinations undertaken during the year are given in the following table:—

A. LEEDS UNITS

Survey undertaken at	No. Examined	Abnormalities Discovered			
		Tuberculosis		Other	Total
		Active	Inactive		
Skipton	223	—	4	2	6
Earby	850	—	18	19	37
Barnoldswick	2,340	3	34	36	73
Skipton	447	—	7	4	11
The School, Sedbergh	447	1	1	—	2
The Mansion House, Victoria Park, Bradford Road, Keighley	2,982	4	27	96	127
Woodrow Hostel, Ingrow, Keighley	318	1	9	8	18
Bingley	2,366	4	21	13	38
Shipley	3,289	8	18	52	78
Ripon	1,079	—	11	6	17
St. Mark's Parochial Hall, Harrogate	4,475	2	16	9	27
Holy Trinity Church Parochial Hall, Knaresborough	780	—	5	3	8
Y.M.C.A. Hostel, North Street, Goole	2,072	2	6	3	11
Salvation Army Hall, Castleford	2,887	2	13	36	51
Methodist Church Hall, Normanton	947	2	1	6	9
West Riding Colliery, Altofts	716	—	10	4	14
Fryston Colliery	609	3	1	6	10
Glasshoughton Colliery	1,046	3	6	8	17
Wheldale Colliery	622	7	9	3	19
Croft House, Ossett	1,776	2	11	9	22
Salvation Army Hall, Ackroyd Street, Morley	2,848	10	17	13	40
Mineworkers Institute, Mickletown, Methley	470	1	5	5	11
Cleckheaton	1,271	1	7	16	24
Liversedge	875	2	3	13	18
Methodist Sunday School, Marsden	1,101	3	11	32	46
Civic Hall, Slaithwaite	1,867	—	27	35	62
Carlile Institute, Meltham	874	—	6	4	10
Messrs. D. Brown (Tractors) Ltd., Meltham	1,129	3	2	4	9
Mechanics Institute, Uppermill	622	1	6	8	15
The County School, Greenfield	1,076	2	10	17	29
The Reform Club, Delph	691	1	5	17	23
New Monckton Colliery	2,330	4	9	35	48
	45,425	72	336	522	930

B. SHEFFIELD UNITS

Darton and Mapplewell	2,072	3	2	35	40
Worsborough	1,736	1	—	65	66
Wombwell	3,520	3	4	127	134
Swallownest	1,192	1	—	22	23
Dinnington	2,178	5	5	42	52
Thurcroft	1,319	1	1	49	51
Dalton	880	1	2	29	32
	12,897	15	14	369	398

Total for the County Area	58,322	87	350	891	1,328

The 891 non-tuberculous abnormalities revealed by the Surveys are classified as follows:—

Abnormalities of bony thorax and lungs	118
Chronic bronchitis and emphysema	95
Pneumonia (non-tuberculous)	14
Consolidation of unknown cause	2
Bronchiectasis	47
Pulmonary fibrosis (non-tuberculous, e.g. post-pneumonic)	59
Pneumoconiosis (silicosis, asbestosis, etc.)	163
Basal fibrosis	46
Pleural thickening	49
Pleural and interlobar effusion (non-tuberculous)	7
Intra-thoracic new growth (mediastinal, pulmonary, etc.)	9
Cardiovascular lesions—congenital	15
Cardiovascular lesions—acquired	114
Miscellaneous (including acquired condition of ribs, etc.)	38
Enquiries not completed	115

PART III

MIDWIFERY AND MATERNITY SERVICES

Institutional Midwifery

There is no general agreement on the advantages and disadvantages of institutional midwifery as opposed to domiciliary confinement, although it is accepted that there is a much greater risk of infection among infants born in hospital. In spite of this however, there is an increasing desire for hospitalisation and reference to the under-mentioned table shows a very high proportion of hospital cases in some of the administrative divisions. The overall picture for the county was that 60 per cent. of the total births took place in hospital, although in the administrative areas of Leeds and Sheffield Regional Hospital Boards the figures were 66 per cent. and 47 per cent. respectively.

Div. No.	Area	Total Births (Live & Still)	Percentage of Hospital Births	Div. No.	Area	Total Births (Live & Still)	Percentage of Hospital Births
1	Skipton	842	82	18	Brighouse	831	72
2	Settle	339	65	19	Todmorden	801	66
3	Keighley	844	73	20/21	Colne Valley Saddleworth	1,165	71
4	Shipley	995	67				
5	Horsforth	1,012	81	22	Wortley	1,258	58
6	Otley	507	81	23	Hemsworth	1,312	41
7	Ripon	389	74	24	Barnsley	531	57
8	Harrogate	1,010	80	25	Wombwell	797	47
9	Wetherby	726	64	26	Wath	824	45
10	Goole	762	44	27	Adwick-le-Street	717	41
11	Castleford	954	56	28	Doncaster	1,070	42
12	Pontefract	1,044	45	29	Thorne	733	38
13	Ossett	703	48	30	Mexborough	1,097	48
14	Morley	621	78	31	Rotherham	1,543	45
15	Batley	805	77	Leeds Hospital Board Region		17,089	66
16	Rothwell	756	54	Sheffield Hospital Board Region		8,570	47
17	Spenborough	671	81	West Riding Administrative County		25,659	60

Domiciliary Midwifery

There is no indication that the National Health Service in introducing maternity medical services has interfered with the independence of the midwife; there were 10,503 domiciliary births and of these the midwife was in sole charge of 9,263 of them (88 per cent.). The duties of the midwife in latter years have become more varied and in fact taken on a wider outlook so that she has been made to feel that she is a member of a team. Gone are the days when caseload could alone be determined by the number of deliveries which could be undertaken in the course of the year. Greater co-operation exists with the general practitioner involving case conferences; many midwives are in complete charge of ante-natal clinics where relaxation for child birth is taught and breast feeding sessions form a feature in conjunction with ultra violet light irradiation; many have also been trained in the nursing care of the premature infant; furthermore, ante-natal care has come more within their compass in respect of cases booked for institutional confinement, whilst early discharge of cases from hospital to the care of the domiciliary midwife has increased the number of her nursing and post-natal visits.

Some indication of the work may be gleaned from the following summary:—			
Clinic attendances			9,864
New bookings			14,864
Removals from register:—			
Miscarriages or abortions		357	
Removals from the area		469	
Transferred to hospital:—			
Ante-natally	762		
In labour	581		
Post-natally	277		
		1,620	
			2,446
Ante-natal visits:—			
Domiciliary cases		75,354	
Hospital cases		6,791	
			82,145
Births attended			10,503
Hospital cases discharged from hospital prior to 10th day to care of midwife			4,911
Post-natal visits:—			
Domiciliary cases		198,125	
Hospital cases		19,167	
			217,292

Of the 456 midwives who notified their intention to practise in the administrative County area, 280 were in the whole-time employ of the County Council, 142 were employed in institutions, and 34 were engaged in private practice.

A practising midwife must, in accordance with the rules of the Central Midwives Board, call medical aid in all cases of illness or abnormality of the mother or child whether it be during pregnancy, labour or lying-in; 3,551 medical aid notices were issued during the year and are summarised opposite.

Pregnancy (602)

Abdominal pain	20	General Condition	39	Post Maturity	1
Abortion	251	Glycosuria	3	Renal Condition	8
Albuminuria	29	Haemorrhoids	2	Skin Condition	3
Ante-natal Examination	8	High Blood Pressure	24	Toxaemia	40
Ante-Partum Haemorrhage	122	Jaundice	1	Vaginal Discharge	2
Breast Condition	2	Malpresentation	8	Varicose Veins	4
Cystitis	1	Multiple Pregnancy	11	Vomiting	6
Disproportion	4	Oedema	13		

Labour (2,097)

Anaesthetic	12	Notification of labour	10	Retained membranes	5
Delayed labour	91	Obstetric shock	5	Retained placenta	82
Episiotomy	14	Obstructed labour	10	Rigidity of perineum	6
Foetal distress	22	Post Partum Haemorrhage	85	Rigidity of cervix	5
General condition	20	Precipitate labour	13	Ruptured perineum	1,214
Labial laceration	9	Premature labour	82	Still birth	18
Malpresentation	122	Prolonged labour	219	Toxaemia	2
Maternal distress	13	Pyrexia	8	Uterine inertia	30

Lying-in (344)

Abdominal pain	3	Haemorrhoids	3	Rapid pulse	6
Anaemia	6	Headache	3	Skin condition	6
Breast condition	57	Jaundice	2	Subinvolution	1
Chest condition	25	Oedema	4	Thrombosis	5
Eclampsia	1	Offensive lochia	4	Varicose veins	10
General condition	30	Phlebitis	37	Vomiting	2
Haemorrhage	14	Pyrexia	125		

Child (508)

Asphyxia	28	Haemorrhage	9	Prematurity	76
B.B.A.	5	Injury	1	Skin condition	27
Chest condition	16	Jaundice	29	Snuffles	2
Congenital defect	49	Laryngismus	1	Tongue tie	3
Convulsions	1	Melaena	3	Unsatisfactory condition	86
Cyanosis	29	Oedema	2	Vomiting	15
Discharging eyes	121	Phimosis	5		

Other notifications were:— Maternal deaths 1; infant deaths 85; stillbirths 202; laying out of the dead 54; liability of constituting a source of infection 132; substitution of breast feeding 1,172.

Flying Squad.—Arrangements are in operation from the under-mentioned hospitals whereby emergency units are available for the domiciliary treatment of patients whose condition is too grave to justify immediate transfer to hospital.

St. Helen's Hospital, Barnsley.
St. Luke's Hospital, Bradford.
General Hospital, Halifax.
General Hospital, Harrogate.
Royal Infirmary, Huddersfield.
Maternity Hospital, Leeds.
Montagu Hospital, Mexborough.
Jessop Hospital, Sheffield.
General Hospital, Wakefield.

Analgesia.—All the domiciliary midwives are trained in the administration of gas and air analgesia for which purpose 296 machines are available; in addition, some are proficient in the administration of pethidine. Of the 10,503 cases of domiciliary birth, gas and air was administered in 6,376 of them and pethidine in 4,702; in the main, pethidine was used complementarily to gas and air:—

Division No.	Percentage receiving Analgesia		Division No.	Percentage receiving Analgesia	
	Gas and Air	Pethidine		Gas and Air	Pethidine
1	47	55	19	75	58
2	44	40	20/21	69	55
3	47	42	22	33	6
4	80	66	23	59	57
5	71	39	24	69	24
6	65	46	25	75	78
7	71	31	26	40	39
8	61	45	27	57	28
9	33	21	28	56	22
10	74	47	29	59	43
11	80	30	30	75	24
12	56	58	31	25	50
13	78	62	Leeds Hospital Region	64	51
14	75	40			
15	54	50	Sheffield Hospital Region	51	35
16	55	63			
17	72	66	W.R. Administrative County	59	44
18	77	70			

Post Certificate Instruction.—Courses organised by the Royal College of Midwives in Leeds and London were attended by twenty midwives of the midwifery staff, whilst a long week-end course on relaxation in childbirth was held at Grantley Hall.

Ante and Post-natal Services

At the end of the year there were 152 ante and post-natal clinics in operation. New centres were opened at Bentham, Swinefleet, Stannington, Dodworth and Hatfield whilst the mobile clinic was also available for that purpose. Clinics were discontinued at Grassington, Methley, Great Houghton, Lindholme and Shipley. The number of expectant mothers who attended the ante-natal clinics was 14,206 of which 10,813 were new cases and the total number of attendances made was 62,616. Post-natal attendances were 2,293 representative of 2,106 women of which 1,615 were new cases.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PART IV

CHILD WELFARE

The total number of deaths of children under the age of fifteen years was 957, but of these, 733 had taken place during the first year, constituting an infant mortality rate of 29.3. This is the lowest rate so far achieved in the administrative county, and we have now reached the stage where no dramatic reduction in this rate can be expected.

Of the infant deaths occurring in the first year, 465 or 63.4 per cent. of them had taken place during the first four weeks. The principal causes of these neo-natal deaths were prematurity 58.7 per cent.; congenital malformation 14.8 per cent.; infection 7.5 per cent. Whilst neo-natal deaths have declined, it is to a lesser extent than other deaths under the age of one year, but it is true to say that quite a number of these deaths are inevitable.

The work of an infant welfare centre cannot be wholly successful unless it is conducted in association with the other agencies which are intimately connected with it, both inside and outside the home, and this work continues to be a great asset to the community in contributing to the health and well-being of the under-five population. In the past, a policy of concentration of service within the clinic for those infants under one year of age was dictated by the high wastage of life within that group. Today, whilst our policy is not dictated by this wastage, the highest attendances are still being made at our clinics by the same age group, as the under-mentioned figures indicate.

CHILD ATTENDANCES AT WELFARE CENTRES

Group I under one year	Group II one to two years	Group III two to five years	Total
267,541	80,102	66,165	413,808

The attendances made by the infants of Group I represent 17,438 children or 69 per cent. of the age group; Group II — 15,559 or 63 per cent.; Group III — 17,018 or 22 per cent.

New Child Welfare Centres were opened at Hellifield, Swinefleet, Parson Cross, Brodsworth, Hatfield and plans were approved for the erection of a multiple clinic at Morley and a satellite clinic at Hemsworth. In June, a mobile clinic (see photograph) was put into operation to provide maternal and child welfare services in the rural areas of Health Divisions 1, 2, 7, 8 and 9, where the sparseness of population does not justify static premises. The clinic itself with an overall length of 22′, width 6′ 11″, maximum height 6′ 2″ and ground clearance of 14″, is divided by sliding panel doors to make provision for a small waiting room, a weighing room with two dressing cubicles and a consulting room. Heating and lighting are provided by Calor Gas with an alternative emergency electricity system from stored batteries. The clinic is towed bya "Land Rover". Staff consists of a clinic nurse and a driver handyman; in addition, a medical officer and a health visitor on the staff of the public health division in which the clinic is operating, are also in attendance. The service is operated over ten sessions per week, necessitating the clinic being absent from its base during three nights of each fortnight when the nurse and driver have to find accommodation. In areas where local transport is difficult, the towing vehicle is uncoupled and utilised to bring mothers to and from the clinic. During six months' running, there was one breakdown due to a defect in the axle which resulted in the loss of three-and-a-half sessions. The unit has proved very satisfactory and the service which it has provided has been acclaimed. The total attendances during the period were 2,774, made up of 2,732 infant welfare and 42 ante-natal attendances.

The clinics provided for maternity and child welfare services are used also by the School Health and Dental Services and for group training classes for mental defectives. Full details of the clinics available and of the services provided thereat are included as an appendix to this Part of the report.

Dr. Harvey, the County Paediatrician reports:— "The sheer weight of statistics will, before long, force upon us a keener study of still-births for one day they may outnumber the decreasing group of live-born infant deaths; in both groups alike there is the discouragement of dashed hopes and prospects in the family. We need, if possible, far more of a clinical enquiry with necropsy in every possible case of still-birth even those born at home, in the interests of parents and of others also.

It seems probable that brain damage at birth may often be due not merely to haemorrhage, but to compression of the circulation, even in the absence of any manipulative difficulty in delivery. In one such case, everything seemed to be well until the child was two days old, when he lost his cry and ability to suck for six days. As the months passed, it became obvious that he was mentally retarded, epileptic and spastic, with partial blindness.

This year, we have been encouraged by the healthy survival of a number of very tiny premature babies, including one with a birth weight of two pounds. Anaemia is such a constant feature in the follow-up examination of prematures that it seems reasonable for every premature baby to receive medicinal iron regularly from the age of one to six months. It seems from recent studies that

genetic clues may be worth following with premature babies; in particular that we should record where possible the weight and height of both parents for future study. Retrolental fibroplasia has emerged as a cause of blindness, probably due to concentrated oxygen administration in the most immature babies."

Illegitimate Children

The rates of neo-natal and infant mortality are always higher in respect of illegitimate babies than those born in wedlock, and the same can be said of the still-birth rate. There are obvious reasons why this should be so, preference to secrecy being the chief of these rather than obtaining medical and nursing care in consequence of which not only does the mother suffer, but also the child. The answer to this problem is principally one of education.

There were 950 illegitimate births registered of which 485 were males and 465 females. A summary of the cases referred to the Divisional Medical Officers for attention is given below:—

1. Number of cases dealt with during the year:

(a) Referred by Moral Welfare Organisations		80
(b) Ascertained by staff of the Health Department		484
(c) Referred by Other Services		101
	Total	665

2. Analysis of cases:

(a) Married	(i) with previous illegitimate children		78
	(ii) without previous illegitimate children		96
(b) Unmarried	(i) with previous illegitimate children		126
	(ii) without previous illegitimate children		338
(c) Widowed	(i) with previous illegitimate children		11
	(ii) without previous illegitimate children		16
		Total	665

3. Ages:

(a) Under 20 years of age		127
(b) 20-25 years of age		252
(c) 26-30 years of age		124
(d) 31-40 years of age		143
(e) Over 40 years of age		19
	Total	665

4. Disposal:

(a) Cases settled	(i) Marriage		54
	(ii) Baby died		32
	(iii) Grandparents taking baby		34
	(iv) Baby adopted		66
	(v) Baby fostered		18
	(vi) Mother keeping baby		426
(b) Cases referred elsewhere			12
(c) Cases not finally settled			23
		Total	665

Day Nurseries

A further two nurseries were opened at Baildon and Barnoldswick, each of which provides accommodation for 50 children. At the end of the year, there were 1,275 places available in 30 nurseries; the average attendances at each are indicated in the following table:—

Division	Day Nursery	No. of Places Provided	Average Daily Attendance
1	Barnoldswick	50	33
	Earby	40	30
3	Keighley: Woodbine	40	33
	" Oakworth Road	50	39
4	Shipley: Manor Lane	50	40
	" Windhill	50	36
	" Victoria Park	50	37
	" Saltaire Road	50	41
	Bingley	50	36
	Baildon	50	38
5	Stanningley	35	29
	Horsforth	40	28
	Yeadon	40	30
	Guiseley	40	33
6	Burley-in-Wharfedale	40	27
	Ilkley	40	31
	Otley	40	25
8	Harrogate: Station Avenue	40	32
	" Albany Avenue	40	32
14	Morley	40	30
	Gildersome	40	24
15	Heckmondwike	40	33
16	Stourton	40	26
17	Cleckheaton	40	30
18	Brighouse: Ogden Lane	30	24
	" Wellholme Park	40	35
	" Holme House	40	31
19	Todmorden	40	33
	Hebden Bridge	40	33
	Sowerby Bridge	50	40
		1,275	969

The training of students for the National Nursery Examination Board Certificate was fulfilled by the attendance of students at the following course centres:— Dewsbury — at which 20 students were in attendance: Shipley — 39 students; Burnley — 2 students, and at "One Oak" Hostel, Ilkley — 53 students.

Premature Babies

Prematurity is defined in accordance with a standard which has been adopted on an international basis, so that any infant whose birth weight is 5½lbs. or less is considered to be premature. It was responsible for 58.7 per cent. of the neo-natal deaths in the administrative county.

Whilst the cause of prematurity is not always evident, we are aware that toxaemia of pregnancy, ante-partum haemorrhage, multiple pregnancy and foetal malformation are the predominant factors in its causation; also that its incidence is affected by social class. In the light of existing knowledge, the problem of prevention is mainly obstetrical, although improved economical standards and improved maternal health would offer notable contributions.

There were 1,675 premature infants born to mothers normally resident in the administrative county which is representative of 6.7 per cent. of the total live births; the fate of these infants is tabulated below:—

The Fate of Premature Babies born in the Year 1953, to Mothers normally residing in the West Riding Administrative County Area wherever the Birth took place

Total adjusted live births—25,150

Number of live premature births—1,675
Number born dead—271

Percentage of premature live births to total live births—6.7

Weight Group	Number of Premature Births						Number Dying (Days of Survival)														Number surviving over 28 days					Percentage survival 1953	Percentage Survival in previous years		
	Born Alive					Born Dead	First Week							Second Week							Over 14 up to 28 days									
lbs.	A	B1	B2	C	Total		1	2	3	4	5	6	7	8	9	10	11	12	13	14		A	B1	B2	C	Total		1952	1951	1950
5—5½	171	17	201	262	651	32	11	9	2	1	2	2	1	—	1	—	—	—	—	1	4	165	15	190	247	617	94.8	94.9	95.5	96.3
4½—5	116	2	91	175	384	35	5	6	4	1	1	1	—	1	—	—	1	1	—	—	1	109	1	87	165	362	94.3	93.9	92.2	93.0
4—4½	43	1	49	116	209	43	9	6	2	3	1	1	1	—	—	—	—	—	—	—	1	35	1	46	103	185	88.5	87.4	84.7	87.0
3½—4	40	1	41	71	153	36	14	5	2	3	—	1	1	1	1	—	—	—	—	—	2	32	—	30	61	123	80.4	77.4	72.1	78.0
3—3½	30	1	29	41	101	37	17	7	2	2	2	3	1	—	2	—	—	—	1	—	2	19	1	18	24	62	61.4	67.1	58.4	55.2
2½—3	24	—	10	48	82	32	23	8	—	1	4	—	1	1	—	—	—	1	—	—	—	10	—	4	29	43	52.4	40.6	34.8	36.1
2—2½	10	—	8	20	38	26	21	5	2	—	1	—	1	—	—	—	—	—	—	1	1	1	—	3	2	6	15.8	7.3	14.7	9.8
1½—2	14	—	1	16	31	22	20	4	—	—	—	1	1	—	—	—	—	—	—	—	1	1	—	—	3	4	12.9	6.1	2.8	5.9
1½ and under	9	—	1	16	26	8	18	6	2	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	3.7	—	8.3
Total	457	22	431	765	1,675	271	138	56	16	11	11	9	7	3	4	—	1	2	1	2	12	372	18	378	634	1,402	83.7	82.6	82.7	83.3
																					273									

A —Born in Domiciliary Practice.
B1—Born in a Private Nursing Home.
B2—Born in a Maternity Home.
C —Born in a General Hospital.

The weight groups in the first column of this table should be read as under:—
"5—5½lbs." means "Over 5lbs. up to and including 5½lbs."
"4½—5lbs." means "Over 4½lbs. up to and including 5lbs."
The remaining weight groups should be read in the same way.

Follow-Up of Premature Babies Born in 1949 to Mothers Normally Resident in The West Riding Administrative County Area

Total Born 1,426
Number who have removed outside Administrative County 170
1,256

Weight Group lbs.	Period of Survival — Number Dying at following periods of life															Surviving over 4 years
	Under 1 year	1 year and under 2 years	2 years and under 3 years	36 and under 37 months	37 and under 38 months	38 and under 39 months	39 and under 40 months	40 and under 41 months	41 and under 42 months	42 and under 43 months	43 and under 44 months	44 and under 45 months	45 and under 46 months	46 and under 47 months	47 months and under 4 years	
5—5½	48	2	2	—	—	—	—	—	—	—	—	—	—	—	—	503
4½—5	32	2	—	—	—	1	—	—	—	—	—	—	—	—	—	233
4—4½	35	2	—	—	—	—	—	—	—	—	—	—	—	—	—	132
3½—4	39	—	—	—	—	—	—	—	—	—	—	—	—	—	—	66
3—3½	27	—	—	—	—	—	—	—	—	—	—	—	—	—	—	32
2½—3	31	—	—	—	—	—	—	—	—	—	—	—	—	—	—	14
2—2½	31	—	—	—	—	—	—	—	—	—	—	—	—	—	—	4
1½—2	13	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
1½ and under	7	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Total	263	6	2	—	—	1	—	—	—	—	—	—	—	—	—	984
Percentage Survival	79.1	78.6	78.4	78.4	78.4	78.3	78.3	78.3	78.3	78.3	78.3	78.3	78.3	78.3	78.3	78.3

Clinics

Particulars of Clinics held, showing day, time and frequency of sessions and staff in attendance, as at 31st December, 1953.

See note at end of table for explanation of abbreviations.

Premises	Ante-natal	Infant Welfare	U.V. Light	Minor Ailments	School	Speech Therapy	Immunisation	Child Guidance	Remedial Exercises	Mental Health	Ophthalmic	Orthopaedic	Paediatric	Dental	Other
DIV. 1. (SKIPTON)															
Addingham Mobile Clinic	—	Thurs. p.m. (alternate) DMO/HV/CN	—	—	—	—	—	—	—	—	—	—	—	—	—
Barnoldswick Secondary Modern School	—	—	—	—	—	—	—	—	—	—	as required HMO/HV	—	—	—	—
Barnoldswick Methodist S. School, Mosley St. ...	Fri. a.m. & p.m. (1st & 3rd) ACMO/HV/M	Thurs. p.m. ACMO/HV(2)	Wed. p.m. Fri. a.m. H.V.	—	Thurs. a.m. (alternate) ACMO/HV	Wed. a./p.m. S.T.	—	—	—	—	—	—	—	—	—
Barnoldswick Kelbrook Rd.	—	—	—	—	—	—	—	—	—	—	—	—	—	Daily	—
Carleton Mobile Clinic	—	Thurs. a.m. (alternate) ACMO/HV/CN	—	—	—	—	—	—	—	—	—	—	—	—	—
Cononley Mobile Clinic	—	Wed. a.m. (alternate) ACMO/HV/CN	—	—	—	—	—	—	—	—	—	—	—	—	—
Cowling Mobile Clinic	—	Wed. p.m. (alternate) DMO/HV/CN	—	—	—	—	—	—	—	—	—	—	—	—	—
Crosshills Ebenezer S. Sch.	Tues. a.m. (alternate) ACMO/HV	Tues. p.m. ACMO/HV(1/2)	—	—	—	—	—	—	—	—	—	—	—	—	—
Earby Old Grammar School ...	Wed. p.m. (alternate) ACMO/HV/M	Wed. p.m. (alternate) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Gargrave The Institute	—	Thurs. p.m. (alternate) DMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Grassington Church House	Tues. p.m. (1st in month) GP/M	Wed. p.m. (alternate) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Lothersdale Mobile Clinic	—	Wed. a.m. (alternate) ACMO/HV/CN	—	—	—	—	—	—	—	—	—	—	—	—	—
Silsden Kirkgate Methodist Sunday School	—	Tues. p.m. (alternate) ACMO/HV(2) Thurs. p.m. (alternate) HV	—	—	Tues. a.m. (alternate) ACMO/HV	—	—	—	—	—	—	—	—	—	—
Skipton Millfields Hall	—	Wed. p.m. Thurs. p.m. ACMO/HV(2) Wed. a.m. HV	—	—	Fri. a.m. (2nd & 4th) ACMO/HV	Fri. a./p.m. S.T.	—	Mon. a./p.m. (1st in mth.) Ps/MH	—	—	Mon. a./p.m. (2nd & 4th) HMO/HV	—	—	—	—
DIV. 2. (SETTLE)															
Austwick Mobile Clinic	—	Tues. p.m. (every 4 weeks) HV/CN	—	—	—	—	—	—	—	—	—	—	—	—	—
Bentham Town Hall	—	Tues. p.m. (alternate) GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—

Bentham Ashfield House	Tues. p.m. (alternate) M. *Relax.*	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Burton-in-Lonsdale Mobile Clinic	—	Tues. a.m. (alternate) HV/CN	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Clapham Mobile Clinic	—	Tues. a.m. (alternate) HV/CN	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Clitheroe The Castle	—	—	—	—	—	—	—	—	—	—	As required HMO/HV	—	—	—	—	—
Gisburn Mobile Clinic	—	Monday a.m. (alternate) HV/CN	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Hellifield Methodist Sunday School	—	Thurs. p.m. (alternate) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Helwith Bridge Mobile Clinic	—	Tuesday p.m. (every 4 weeks) HV/CN	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Horton-in-Ribblesdale Mobile Clinic	—	Tues. p.m. (every 4 weeks) HV/CN	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Ingleton Literary Institute ...	—	Tues. p.m. (alternate) ACMO/HV	—	—	—	—	—	—	—	—	As required HMO/HV	—	—	—	—	—
Sedbergh Masonic Hall	—	Wed. p.m. (1st & 3rd) DMO/HV/M	—	—	—	—	—	—	—	—	As required HMO/HV	—	—	—	—	—
Settle Wesleyan Sunday School	—	Thurs. p.m. (alternate) DMO/HV	—	—	—	—	—	—	—	—	As required HMO/HV	—	—	—	—	—
Settle Divisional Office Cragdale	Tues. p.m. (alternate) ACMO/HV/ M(2)	—	—	—	—	Tues. a.m. S.T.	—	—	—	—	—	—	—	—	—	—
	Tues. p.m. (alternate) M. *Relax.*	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Slaidburn Mobile Clinic	—	Mon. p.m. (alternate) HV/CN	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Waddington St. Helen's Sunday School	—	Thurs. p.m. (alternate) GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—	—
DIV. 3. (KEIGHLEY)																
Haworth Hall Green Baptist Church	Wed. a.m. ACMO/HV/M	Tues. p.m. ACMO/HV	—	Tues. a.m. HV	Tues. a.m. (1st in mth.) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—
	Wed. p.m. M. *Relax.*	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Haworth The Institute	—	—	—	—	—	—	—	—	Tues. p.m. ON	—	—	—	—	—	—	—
Keighley Westgate Clinic, Oakworth Road	Tues. p.m. ACMO/HV(2) M(2) Fri. a.m. ACMO/HV(2) /M. Wed. p.m. M. *Relax.*	Thurs. p.m. DMO/HV Fri. p.m. ACMO/HV	—	—	—	—	Mon. p.m. last in mth. ACMO/HV	—	—	—	—	—	—	—	—	—

CLINICS—*(continued)*

Premises	Ante-natal	Infant Welfare	U.V. Light	Minor Ailments	School	Speech Therapy	Immunisation	Child Guidance	Remedial Exercises	Mental Health	Ophthalmic	Orthopaedic	Paediatric	Dental	Other
Keighley Mansion House, Victoria Park	Tues. a.m. ACMO/HV/M	Wed. a.m. HV Wed. p.m. ACMO/HV	—	—	—	—	Mon. p.m. (1st in mth) ACMO/HV	—	—	—	—	—	—	—	—
Keighley 147, Skipton Road ...	—	—	Wed. a.m. Sat. a.m. HV	Daily HV	Mon. a.m. Thurs. a.m. Sat. a.m. ACMO/HV	Mon. a./p.m. Thurs. a./p.m. ST	—	—	Mon. a/p.m. Tues. a.m. Wed. p.m. Thurs. a./p.m. Fri. p.m.	—	Tues. a.m. (alternate) HMO/HV	—	—	Daily	—
Oakworth Methodist Sunday School	Tues. a.m. (1st & 3rd) ACMO/HV/M	Thurs. p.m. (alternate) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Oxenhope Methodist Sunday School	Thurs. p.m. (alternate) before I.W. ACMO/HV/M	Thurs. p.m. (alternate) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Morton Memorial Institute, East Morton	—	Fri. p.m. (alternate) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
DIV. 4. (SHIPLEY)															
Baildon Methodist School ...	Wed. a.m. (alternate) GP/HV/M	Mon. p.m. GP/HV(2)	—	Mon. a.m. H.V.	—	—	—	—	—	—	—	—	—	—	—
Bingley County Secondary School	—	—	—	At S.C.	Fri. a.m. ACMO/HV	—	—	—	—	—	—	—	—	—	—
Bingley Old Technical Institute, Mornington Road. ...	Tues. p.m. ACMO/M(2) Wed. p.m. M/HV *Relax.*	Thurs. p.m. ACMO/HV(2)	Mon. p.m. Fri. p.m. HV	Daily a.m. HV	Fri. p.m. ACMO/HV	Mon. p.m. ST	—	—	Mon. p.m. ON	—	Thurs. a.m. (twice monthly) HMO/HV	—	—	—	—
Cullingworth Church House	—	Tues. p.m. (alternate) GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Denholme Methodist School ...	With Infant Welfare	Wed. p.m. (alternate) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Harden (Bingley) Memorial Hall	—	Wed. p.m. (alternate) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Shipley Somerset House	Tues. p.m. M(2) Wed. p.m. ACMO/M(2) Tues. p.m. M/ON *Relax.*	Tues. p.m. ACMO/HV(3) Thurs. p.m. ACMO/HV(2)	Wed. a.m. Sat. a.m. HV	Daily a.m. HV	Mon. p.m. ACMO/HV	Wed. a.m. Thurs. a./p.m. ST	Thurs. a.m. ACMO/HV	Mon. a./p.m. Ps	Mon. a.m. Wed. a.m. Fri. a.m. ON	—	Tues. a.m. Thurs. a.m. Fri. a.m. HMO/HV	Fri. a.m. (monthly) HMO/ON	—	Daily	E.N.T. Tues. a.m. (monthly) HMO/HV Dermatological Mon. a.m. (monthly) HMO/HV Audiometry Fri. p.m. HV

Shipley 105, Wrose Road ...	—	Tues. a.m. HV Fri. p.m. ACMO/HV(2)	—	With I.W. With I.W.	—	—	—	—	—	—	—	—	—	—	—
Shipley Maternity Hospital ...	Wed. a.m. ACMO	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Wilsden Royd House	—	Tues. p.m. (alternate) GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
DIV. 5. (HORSFORTH)																
Calverley Chapel Street	Wed. p.m. (1st in month) GP/HV(2)M Mon. p.m. M, *Relax.*	Wed. p.m. GP/HV(2)	Wed. a.m. Fri. a.m. HV	—	—	—	—	—	—	—	—	—	—	—	—
Farsley Farfield House	Fri. p.m. GP/HV(2) Fri. p.m. M, *Relax.*	Tues. p.m. GP/HV(2)	—	Mon. a.m. Thurs. a.m. HV	—	—	—	—	—	—	—	—	—	—	—
Guiseley Baptist Church, Oxford Road	Wed. p.m. ACMO/HV(2) M	Thurs. p.m. ACMO/HV(2) Wed. p.m. ACMO/HV(2)	—	—	Thurs. a.m. ACMO/HV (2)	Mon. a.m. ST	—	—	—	—	As required HMO/HV	—	As required HMO/HV	—	—
Horsforth St. Margaret's Hall ...	Mon. p.m. (1st & 3rd) GP/HV/M	Wed. p.m. GP/HV(2)	—	Wed. a.m. (except 4th) HV	Wed. a.m. (4th in mth.) ACMO/HV	—	—	—	—	—	—	—	—	—	—
Pudsey St. Lawrence House ...	Thurs. p.m. ACMO/HV(2) M Fri. p.m. M, *Relax.*	Mon. p.m. GP/HV(2) Wed. p.m. GP/HV	Tues. a.m. Thurs. a.m. HV	—	—	Wed. p.m. Fri. a./p.m. ST	—	—	Wed. p.m. Sat. a.m. ON	—	—	Fri. a.m. (3rd in mth.) HMO/ON	—	—	—
Pudsey Richardshaw Lane ...	—	—	—	Tues. a.m. Wed. a.m. Fri. a.m. HV	Tues. a.m. (except 1st) ACMO/HV	—	—	—	—	—	Wed. a./p.m. (1st in mth.) HMO/HV	—	Thurs. a.m. (1st & 3rd) HMO/HV	Daily	E.N.T. Tues (1st in mth.) HMO/HV
Rawdon Methodist Sunday School, Harrogate Road	Wed. a.m. (2nd in mth.) GP/HV(2)M	Thurs. p.m. GP/HV(2)	—	—	—	—	—	—	—	—	—	—	—	—	—
Yeadon Town Hall	Wed. a.m. (1st & 3rd) GP/HV(2)M	Tues. p.m. ACMO/HV(2)	—	—	Tues. a.m. ACMO/HV	—	—	—	—	—	—	—	—	—	—
Yeadon South View School ...	—	—	—	—	—	—	—	—	—	—	As required HMO/HV	—	—	—	—
DIV. 6. (OTLEY)																
Bramhope Craven Institute	—	Mon. p.m. (alternate) DMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Burley The Lecture Hall... ...	—	Tues. p.m. ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Ilkley South Hawksworth Street	Thurs. p.m. (alternate) DMO/HV Thurs. p.m. ON, *Relax.*	Wed. p.m. DMO/HV	Tues. p.m. Fri. p.m. HV	Mon. a.m. ACMO/HV	—	Tues. a.m. ST	—	—	Thurs. a.m. ON	—	Mon. a./p.m. (3rd in mth.) HMO/HV	—	—	—	—
Menston Kirklands	—	Thurs. p.m. (alternate) DMO/HV	—	Mon. a.m. Fri. a.m. HV	—	—	—	—	—	—	—	—	—	—	—

CLINICS—(*continued*)

Premises	Ante-natal	Infant Welfare	U.V. Light	Minor Ailments	School	Speech Therapy	Immunisation	Child Guidance	Remedial Exercises	Mental Health	Ophthalmic	Orthopaedic	Paediatric	Dental	Other
Otley The Licks	Tues. a.m. (1st & 3rd) ACMO/HV(3) Tues. a.m. ON, *Relax.*	Thurs. p.m. ACMO/HV(3)	Mon. a.m. Fri. a.m. HV(3)	Thurs. a.m. ACMO/HV (3)	—	—	—	—	Fri. p.m. ON	—	Mon. a./p.m. (1st in mth.) HMO/HV (3)	—	—	—	—
Otley Whiteley Croft	—	—	—	—	—	Tues. p.m. ST	—	—	—	—	—	—	—	—	—
Pool-in-Wharfedale Church Room	—	Mon. p.m. (alternate) DMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
DIV. 7. (RIPON)															*Cardiac* see Div. 8
Birstwith Mobile Clinic	—	Mon. p.m. (alternate) DMO/HV/CN	—	—	—	—	—	—	—	—	—	—	—	—	—
Bishop Monkton Mobile Clinic	—	Fri. p.m. (alternate) ACMO/HV/CN	—	—	—	—	—	—	—	—	—	—	—	—	—
Bishop Thornton Mobile Clinic	—	Mon. a.m. (alternate) DMO/HV/CN	—	—	—	—	—	—	—	—	—	—	—	—	—
Copt Hewick Mobile Clinic	—	Tues. p.m. (alternate) ACMO/HV/CN	—	—	—	—	—	—	—	—	—	—	—	—	—
Darley Mobile Clinic	—	Mon. p.m. (alternate) DMO/HV/CN	—	—	—	—	—	—	—	—	—	—	—	—	—
Galphay Mobile Clinic	—	Tues. a.m. (alternate) ACMO/HV/CN	—	—	—	—	—	—	—	—	—	—	—	—	—
Grewelthorpe Mobile Clinic	—	Tues. a.m. (alternate) ACMO/HV/CN	—	—	—	—	—	—	—	—	—	—	—	—	—
Kirkby Malzeard Mobile Clinic	—	Tues. a.m. (alternate) ACMO/HV/CN	—	—	—	—	—	—	—	—	—	—	—	—	—
Markington Mobile Clinic	—	Mon. a.m. (alternate) DMO/HV/CN	—	—	—	—	—	—	—	—	—	—	—	—	—
Pateley Bridge Methodist Buildings ...	—	Wed. p.m. (1st & 3rd) GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Pateley Bridge Welfare Centre, Council Offices	—	—	—	Fri. a.m. ACMO/HV	—	—	—	—	—	—	As required HMO/HV	—	—	—	—
Ripon Alma House	Thurs. p.m. GP/HV(2)	Mon. p.m. ACMO/HV(2)	Mon. a.m. ACMO/HV Thurs. a.m. DMO/HV	Daily a.m. HV(2)	Mon. a.m. ACMO/HV (2)	Wed. a.m. Fri. a./p.m. ST	—	—	—	—	Tues. p.m. Wed. a./p.m. (3rd in mth.) HMO/HV	Fri. p.m. (3rd in mth.) HMO/HV	Fri. p.m. (2nd in mth.) HMO/HV (2)	Daily	—

Ripon Hospital	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	E.N.T. Thurs. a.m. (1st in mth.) HMO/HV
Shaw Mill Mobile Clinic	—	Mon. a.m. (alternate) DMO/HV/CN	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Skelton Mobile Clinic	—	Tues. p.m. (alternate) ACMO/HV/CN	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Summerbridge Methodist Buildings ...	—	Wed. p.m. (2nd in month) GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—	—
DIV. 8. (HARROGATE)																
Boroughbridge Methodist Sunday School	—	Fri. p.m. ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Burton Leonard Mobile Clinic	—	Fri. p.m. (alternate) ACMO/HV/CN	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Follifoot Mobile Clinic	—	Fri. a.m. (4-weekly) ACMO/HV/CN	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Hampsthwaite Mobile Clinic	—	Fri. a.m. (4-weekly) ACMO/HV/CN	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Harrogate Dragon Parade	Tues. p.m. Wed. a.m. GP/HV(2) Tues. p.m. Wed. a.m. HV, *Relax.*	Mon. p.m. Thurs. p.m. ACMO/HV(2)	Mon. a.m. Wed. p.m. Fri. a.m. HV	Mon. a.m. Thurs. a.m. DMO/HV	Wed. p.m. DMO/HV	Mon. p.m. Tues. a.m. Wed. p.m. ST	Fri. a.m. ACMO/HV	—	—	Mon. a.m. Wed. a.m. MH	—	Tues. a.m. (alternate) HMO/ ACMO/HV	—	Daily	E.N.T. Tues. a.m. (alternate) HMO/HV
Harrogate 11, Ripon Road, ... (Hospital premises)	—	—	—	—	—	—	—	—	—	—	Wed. a.m. Fri. a.m. (1st & 4th) HMO/HV	—	—	—	—
Harrogate General Hospital... ...	—	—	—	—	—	—	—	—	—	—	—	—	—	—	*Cardiac* Sat. a.m. HMO/ ACMO/HV includes Div. 7
Harrogate Methodist School Room, High St., Starbeck ...	—	Wed. p.m. ACMO/HV(2)	—	—	—	—	—	—	—	—	—	—	—	—	—
Harrogate St. Joseph's Schoolroom, Skipton Road	—	Mon. p.m. ACMO/HV(2)	—	—	—	—	—	—	—	—	—	—	—	—	—
Harrogate Penny Pot Lane ... ... (Army premises)	—	Wed. p.m. (2nd & 4th) HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Knaresborough Fysche Hall	Fri. p.m. M, *Relax.*	Tues. p.m. GP/HV Thurs. p.m. (2nd & 4th) GP/HV	—	Mon. a.m. Thurs. a.m. ACMO/HV	—	—	—	—	—	Mon. p.m. Wed. p.m. MH	Fri. a./p.m. (3rd in mth.) HMO/HV	—	—	—	—
Poppleton Church Hall	—	Tues. p.m. (2nd & 4th) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—

CLINICS—*(continued)*

Premises	Ante-natal	Infant Welfare	U.V. Light	Minor Ailments	School	Speech Therapy	Immunisation	Child Guidance	Remedial Exercises	Mental Health	Ophthalmic	Orthopaedic	Paediatric	Dental	Other
Whixley Village Hall	—	Thurs. p.m. (1st & 3rd) GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
DIV. 9. (WETHERBY)															
Appleton Roebuck Mobile Clinic	With Infant Welfare	Thurs. a.m. (alternate) ACMO/HV/CN	—	—	—	—	—	—	—	—	—	—	—	—	—
Bardsey Trustees Hall	—	Mon. p.m. (alternate) HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Barwick-in-Elmet Methodist Schoolroom ...	With Infant Welfare	Tues. p.m. (alternate) GP/HV(2) Tues. a.m. (alternate) HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Boston Spa West End Nursery School	With Infant Welfare	Wed. p.m. (alternate) ACMO/HV(2)	—	—	—	—	—	—	—	—	—	—	—	—	—
Copmanthorpe Mobile Clinic	With Infant Welfare	Thurs. p.m. (alternate) ACMO/HV/CN	—	—	—	—	—	—	—	—	—	—	—	—	—
Church Fenton Methodist Sunday School	With Infant Welfare	Wed. p.m. (alternate) GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Church Fenton R.A.F. Station	With Infant Welfare	Thurs. p.m. (alternate) MO(RAF)/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
East Keswick Mobile Clinic	With Infant Welfare	Fri. a.m. (alternate) GP/HV/CN	—	—	—	—	—	—	—	—	—	—	—	—	—
Huby Mobile Clinic	With Infant Welfare	Fri. p.m. (alternate) ACMO/HV/CN	—	—	—	—	—	—	—	—	—	—	—	—	—
Ledston Mobile Clinic	With Infant Welfare	Wed. a.m. (alternate) GP/HV/CN	—	—	—	—	—	—	—	—	—	—	—	—	—
Micklefield Methodist Chapel ...	With Infant Welfare	Tues. p.m. (alternate) GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Sherburn-in-Elmet Methodist Sunday School	With Infant Welfare	Tues. p.m. (alternate) GP/HV(2)	—	—	—	—	—	—	—	—	—	—	—	—	—
Swillington Clinic Hut, Wakefield Rd.	With Infant Welfare	Thurs. p.m. GP/HV	—	Wed. a.m. HV	—	—	—	—	—	—	—	—	—	—	—
Tadcaster Multiple Clinic, Leeds Road	Wed. a.m. (alternate) Fri. p.m. (alternate) DMO/HV(2)/M Fri. p.m. (alternate) HV, *Relax.*	Tues. p.m. (alternate) ACMO/HV(2)	Mon. a.m. Thurs. a.m. HV Oct.—Apl.	Tues. a.m. Thurs. a.m. HV	—	Thurs. a.m. ST	—	—	Mon. p.m. ON	Mon. a.m. MH	Fri. a.m. (alternate) HMO/HV	Thurs. p.m. (1st in mth.) HMO/HV	Wed. p.m. (2nd in mth.) HMO/HV	Daily	E.N.T. Tues. a.m. (4th in mth.) HMO/HV

Thorner Mobile Clinic	With Infant Welfare	Wed. p.m. (alternate) GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Tockwith Methodist Sunday School	With Infant Welfare	Mon. p.m. (alternate) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Wetherby Crossley Street	Wed. p.m. (alternate) ACMO/HV(2)	Thurs. p.m. (alternate) ACMO/HV(2)	—	Thurs. p.m. HV	—	Tues. p.m. ST	—	—	—	—	Fri. a.m. (alternate) HMO/HV	—	—	Daily	—
DIV. 10. (GOOLE)															
Goole Bartholomew Ave. ...	Fri. p.m. DMO/ACMO /HV(3) Mon. p.m. HV/M, *Relax.*	Tues. p.m. ACMO/HV(3)	Mon. a.m. Thurs. a.m. HV	Mon. a.m. Weds. a.m. HV	Fri. a.m. ACMO/HV (2)	Wed. a.m. Thurs. p.m. ST	—	—	Tues. a.m. Thurs. a.m. ON	Wed. p.m. MH	Thurs. p.m. As required HMO/HV	Tues. a.m. (2nd in mth) HMO/HV	Wed. p.m. (1st in mth.) HMO/HV	—	—
Goole Westfield Avenue ...	—	—	—	—	—	—	—	—	—	—	—	—	—	Daily	—
Hirst Courtney Social Centre, West Bank	With Infant Welfare	Wed. p.m. (3rd in month) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Old Goole St. Mary's Hall	—	Thurs. p.m. ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Selby Brook Street	Mon. p.m. ACMO/HV(2) Wed. p.m. HV/M *Mothercraft*	Fri. p.m. ACMO/HV(2)	—	Mon. a.m. ACMO/HV (2) Fri. a.m. HV	—	—	—	—	Tues. p.m. ON	Tues. p.m. MH	Thurs. a./p.m. As required HMO/HV	—	—	—	—
Selby Hawdon Institute, Church Avenue	—	—	—	—	—	Wed. p.m. ST	—	—	—	—	—	—	—	—	—
Snaith Rose Cottage ... ... (temporarily in Old Grammar School)	Wed. p.m. (alternate) ACMO/HV(2)	Thurs. p.m. ACMO/HV(2)	—	—	—	—	—	—	—	—	—	—	—	—	—
Swinefleet Prospect House	Wed. p.m. (alternate) ACMO/HV(2) Wed. p.m. (alternate) HV/M, *Mothercraft*	Mon. p.m. ACMO/HV(2)	—	Wed. a.m. (alternate) HV	Wed. a.m. (alternate) ACMO/HV	—	—	—	—	Thurs. a.m. MH	—	—	—	—	—
DIV. 11. (CASTLEFORD)															
Airedale Methodist Church ...	Thurs. p.m. (1st, 2nd & 4th) GP/HV(2)/M (2)	Mon. p.m. GP/HV(2)	—	—	—	—	—	—	—	—	—	—	—	—	—
Altofts Upper Altofts Methodist Church	—	Wed. p.m. GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Castleford Castledene	Tues. p.m. Fri. p.m. M(2) U.V.L. Fri. p.m. M. *Relax.*	—	Tues. a.m. Fri. a.m. HV(2)	—	—	—	—	—	—	—	Wed. a./p.m. HMO/HV	Tues. a.m. (4th in mth.) HMO/ON	Wed. p.m. (3rd in mth.) HMO/HV	—	—
Castleford Barnes Road	—	—	—	—	—	—	—	—	—	—	—	—	—	Daily	—

CLINICS—(*continued*)

Premises	Ante-natal	Infant Welfare	U.V. Light	Minor Ailments	School	Speech Therapy	Immunisation	Child Guidance	Remedial Exercises	Mental Health	Ophthalmic	Orthopaedic	Paediatric	Dental	Other
Castleford Methodist Church, Hightown	Thurs. p.m. GP/HV/M(2)	Mon. p.m. GP/HV(2)	—	—	—	—	—	—	—	—	—	—	—	—	—
Castleford Hightown Hospital ...	—	—	—	—	—	—	—	—	—	—	—	—	—	—	E.N.T. Wed. p.m. (alternate) HMO/HV
Castleford Old Council Offices, Sagar Street	Wed. p.m. GP/HV(2)/M(2)	Mon. p.m. Thurs. p.m. GP/HV(2)	—	Mon. a.m. Wed. a.m. Fri. a.m. HV	Wed. a.m. ACMO/HV(2)	Tues. a./p.m. Fri. a./p.m. ST	—	—	Wed. p.m. ON	—	—	—	—	—	—
Glasshoughton St. Paul's Church ...	Wed. p.m. (2nd & 4th) GP/HV/M	Tues. p.m. GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Normanton Park Pavilion	Wed. p.m. ACMO/HV/M(2) Mon. p.m. M(2), *Relax.* Mon. p.m. Thurs. p.m. M(2), U.V. Light	Tues. p.m. Fri. p.m. ACMO/HV(3)	Tues. p.m. Fri. p.m. HV(2)	Daily a.m. HV	Tues. a.m. ACMO/HV(2)	—	—	—	—	—	—	—	—	—	—
DIV. 12. (PONTEFRACT)															
Beal Methodist Chapel ...	—	Thurs. p.m. (1st & 3rd) DMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Featherstone Albert Street	Tues. p.m. ACMO/HV/M(3) Mon. p.m. M(2), *Relax.*	Wed. p.m. ACMO/HV(2) Thurs. p.m. (2nd & 4th) GP/HV, *Toddlers.*	—	Daily a.m. HV	Mon. a.m. (1st & 3rd) ACMO/HV	Mon. a./p.m. ST	Thurs. a.m. (1st in mth.) ACMO/HV	—	—	Mon. p.m. Tues. a.m. MH	—	—	—	—	—
Ferrybridge Wesleyan Chapel... ...	Tues. p.m. (1st & 3rd) GP/HV/M(2)	Wed. p.m. GP/HV(3)	—	Wed. a.m. HV	—	—	—	—	—	—	—	—	—	—	—
Knottingley Chapel Street	Tues. p.m. (2nd & 4th) GP/HV/M(2) Thurs. p.m. (1st & 3rd) GP/HV/M(2) Thurs. p.m. (2nd & 4th) ACMO/M(2)	Mon. p.m. GP/HV(3)	—	Mon. a.m. Fri. a.m. HV	Mon. a.m. (2nd & 4th) ACMO/HV(2)	Thurs. a.m. ST	—	—	—	Wed. p.m. Fri. p.m. MH	—	—	—	—	—
Knottingley Racca Green	—	—	—	—	—	—	—	—	—	—	—	—	—	Daily	—
Loscoe Grove Wesleyan Chapel... ..	—	Thurs. p.m. HV/ACMO (on 1st, 3rd & 5th)	—	—	—	—	—	—	—	—	—	—	—	—	—

Pontefract Headlands Road ...	Fri. a.m. DMO/HV/M (2) Wed. p.m. HV/M, *Relax.*	Mon. a./p.m. ACMO/HV(2)	Tues. a.m. Fri. a.m. HV	Daily HV	Thurs. a./p.m. ACMO/HV	—	Tues. p.m. (2nd & 4th) DMO/HV	—	Wed. a.m. ON	Mon. a.m. Thurs. p.m. MH	Thurs. a.m. HMO/HV	Tues. p.m. (1st in mth.) HMO/ON	—	Daily	E.N.T. Wed. p.m. (alternate) HMO/HV
Streethouse Methodist Chapel ...	—	Mon. p.m. GP/HV(2)	—	—	—	—	—	—	—	—	—	—	—	—	—
DIV. 13. (OSSETT)															
Crigglestone Village Institute	Fri. a.m. (1st in month) ACMO/HV/M	Wed. p.m. GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Crofton Mission Hall	Wed. a.m. (alternate) ACMO/HV/M	Mon. p.m. ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Crofton Parochial Hall	—	—	—	Mon. a.m. Thurs. a.m. HV	—	—	—	—	—	—	—	—	—	—	—
Horbury Congregational School, Tithe Barn Street ...	Thurs. p.m. ACMO/HV/M	Mon. p.m. GP/HV	—	Mon. a.m. Thurs. a.m. HV	Thurs. a.m. (1st in mth.) ACMO/HV (2)	—	—	—	—	—	—	—	—	—	—
Middlestown Church School	Tues. a.m. (alternate) ACMO/HV/M	Tues. p.m. GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Ossett Croft House	Fri. p.m. ACMO/HV/M(3) Wed. p.m. M, *Relax.*	Mon. p.m. Thurs. p.m. GP/HV(2)	—	Daily p.m. HV	Wed. p.m. DMO/HV	Mon. a./p.m. Wed. a.m. ST	Wed., (1st for under 5's and 2nd for over 5's) GP/HV	—	Fri. a.m. ON	—	Tues. a./p.m. HMO/HV	—	—	Daily	—
Sharlston St. Luke's Hall	Wed. a.m. (alternate) ACMO/HV/M	Tues. p.m. ACMO/HV/M	—	Tues. a.m. Fri. a.m. HV	—	—	—	—	—	—	—	—	—	—	—
Wakefield Central Dental Clinic, Bond Street	—	—	—	—	—	—	—	—	—	—	—	—	—	Daily	—
Wakefield County Health Department	—	—	—	—	—	—	—	Wed. a./p.m. Thurs. a./p.m. Sat. a.m. Ps	—	—	Mon. a./p.m. Fri. a./p.m. As required HMO/HV	—	—	—	—
Wakefield Pinderfields Hospital ...	—	—	—	—	—	—	—	—	—	—	—	Mon. p.m. (monthly) HMO/ON Includes Div. 16.	—	—	—
DIV. 14. (MORLEY)															
Drighlington Methodist School ...	Thurs. p.m. (2nd & 4th) ACMO/M	Fri. p.m. GP/HV	—	Tues. p.m. Fri. p.m. HV	—	—	—	—	—	—	—	—	—	—	—
East Ardsley Methodist School, The Falls	Tues. a.m. (2nd & 4th) ACMO/M	Tues. p.m. GP/HV	—	Tues. p.m. Fri. p.m. HV	—	—	—	—	—	—	—	—	—	—	—

CLINICS—(*continued*)

Premises	Ante-natal	Infant Welfare	U.V. Light	Minor Ailments	School	Speech Therapy	Immunisation	Child Guidance	Remedial Exercises	Mental Health	Ophthalmic	Orthopaedic	Paediatric	Dental	Other
Gildersome Council Offices	Thurs. p.m. (1st & 3rd) M	Wed. p.m. GP/HV	—	Mon. p.m. Wed. p.m. HV	—	—	—	—	—	—	—	—	—	—	—
Morley Commercial Street ...	Fri. p.m. ACMO/M(2) Mon. p.m. M(2), *Relax.*	Mon. p.m. Wed. p.m. ACMO/HV(2)	Tues. p.m. Thurs. p.m. HV	Daily a./p.m. except Fri. a.m., HV	Fri. a.m. GP/HV	Fri. a./p.m. (alternate) ST	Fri. a.m. GP/HV	—	Wed. a.m. HV	—	2/3 monthly as required HMO/HV	—	Wed. p.m. (2nd & 4th) HMO/HV	Daily	—
West Ardsley 1, Syke Lane	Thurs. p.m. (1st & 3rd) ACMO/M Mon. p.m. M(2), *Relax.*	Thurs. p.m. ACMO/HV	—	Mon. p.m. Wed. p.m. Thurs. p.m. HV	—	—	—	—	—	—	—	—	—	—	—
DIV. 15. (BATLEY)															
Batley Wellington Street ...	Mon. p.m. GP/HV/M(2)	Tues. p.m. Fri. p.m. GP/HV(3)	Mon. a.m. Thurs. a.m. HV	Tues. a.m. Wed. a.m. Fri. a.m. HV	Mon. a.m. Thurs. a.m. ACMO/HV	Wed. a./p.m. ST Fri. a./p.m. (alternate) ST	—	—	—	—	Wed. a.m. HMO/HV Fri. a./p.m. (alternate) HMO/HV	—	Tues. a.m. (alternate) HMO/HV	—	—
Batley Market Street	—	—	—	—	—	—	—	—	—	—	—	—	—	Daily	—
Batley Temperance Hall... ...	—	—	—	—	—	—	—	—	Mon. a./p.m. Thurs. a./p.m. ON	—	—	Thurs. p.m. (2nd in mth.) HMO/ON	—	—	—
Batley Carr King Street Mission ...	—	Thurs. p.m. (alternate) GP/HV(2)	—	—	—	—	—	—	—	—	—	—	—	—	—
Birstall Conservative Club, Low Lane	—	Wed. p.m. GP/HV(3)	—	Wed. p.m. HV	—	—	—	—	—	—	—	—	—	—	—
Hanging Heaton Church Hall, Ebenezer Methodist Chapel ...	—	Thurs. p.m. (alternate) GP/HV(2)	—	—	—	—	—	—	—	—	—	—	—	—	—
Heckmondwike Greenside	Wed. p.m. (alternate) GP/M(2)	Thursday p.m. GP/HV(2) Wed. p.m. (alternate) GP/HV Toddlers	—	Daily a.m. except Tues. HV	Tues. a.m. DMO/HV	—	Tues. a.m. DMO/HV	—	—	—	—	—	—	—	—
DIV. 16. (ROTHWELL)												See Div. 13			
Allerton Bywater Miners' Welfare Institute	—	Wed. p.m. (alternate) ACMO/HV Wed. p.m. (alternate) HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Garforth Brunswick Methodist Chapel	Mon. p.m. ACMO/HV/M	Mon. a.m. (alternate) ACMO/HV Mon. a.m. (alternate) HV	Mon. p.m. Wed. p.m. Fri. p.m. HV	—	—	—	—	—	—	—	—	—	—	—	—

Kippax Methodist Chapel, Chapel Lane	Tues. a.m. ACMO/HV/M	Tues. p.m. (alternate) ACMO/HV Tues. p.m. HV	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Lofthouse Wesleyan Chapel School-room, Leeds Road ...	—	Mon. p.m. (alternate) ACMO/HV Mon. p.m. (alternate) HV	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Oulton Harold Hall Institute, Quarry Hill	—	Tues. p.m. (alternate) ACMO/HV Tues. p.m. (alternate) HV	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Outwood Rehobeth Methodist Chapel, Leeds Road ...	Fri. a.m. (alternate) ACMO/HV/M	Wed. p.m. ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Rothwell Oulton Lane	Thurs. a./p.m. DMO/HV/M	Mon. p.m. DMO/HV	Mon. a.m. Wed. a.m. Fri. a.m. HV	—	—	Tues. a./p.m. Fri. p.m. ST	—	—	Mon. a.m. ON	—	Fri. a./p.m. (1st & 3rd) HMO/HV	—	Fri. a.m. (2nd in mth.) HMO/HV	—	E.N.T. As required HMO/HV	
Rothwell Carlton Lane	—	—	—	—	—	—	—	—	—	—	—	—	—	Daily	—	
Stanley Zion Methodist Chapel, Aberford Road	Mon. a.m. (alternate) ACMO/HV/M	Thurs. p.m. GP/HV Mon. p.m. HV	—	—	—	—	—	—	—	—	—	—	—	—	—	
Wrenthorpe St. Anne's Church Rooms	Mon. p.m. ACMO/HV/M	Mon. p.m. (alternate) ACMO/HV Mon. p.m. (alternate) HV	—	—	—	—	—	—	—	—	—	—	—	—	—	
DIV. 17. (SPENBOROUGH)																
Birkenshaw Old Lane	Wed. p.m. ACMO/HV/M	Tues. p.m. ACMO/HV(2)	—	—	—	—	—	—	—	—	—	—	—	—	—	
Cleckheaton Elm Bank	Thurs. p.m. ACMO/HV/M(2) Tues. p.m. (alternate) M, *Relax.* Wed. p.m. (alternate) M, *Relax.*	Wed. p.m. ACMO/HV(2) Wed. p.m. (alternate) HV(2) Mothers	—	—	Mon. a.m. ACMO/HV	—	—	—	Fri. a./p.m. ON	—	Mon. p.m. Tues. p.m. HMO/HV	—	Mon. a.m. (alternate) HMO/HV	Daily	*Chiropody* Thurs. a.m. Ch	
Gomersal Public Hall	—	Fri. p.m. (alternate) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—	
Liversedge Valley Road	Mon. p.m. ACMO/HV/M(2)	Tues. p.m. ACMO/HV(2)	Tues. a.m. Sat. a.m. HV	—	—	Thurs. a./p.m. ST	—	—	—	—	As required HMO/HV	—	—	—	Mon. a.m. Ch	
Mirfield Ings Grove	Wed. p.m. ACMO/HV/M Mon. p.m. M, *Relax.*	Fri. p.m. ACMO/HV(2)	Wed. p.m. Sat. a.m. HV	—	Fri. a.m. ACMO/HV	Tues. p.m. ST	—	Tues. a./p.m. Ps	Tues. a.m. ON	—	As required HMO/HV	—	—	—	Fri. a.m. Ch	

CLINICS—*(continued)*

Premises	Ante-natal	Infant Welfare	U.V. Light	Minor Ailments	School	Speech Therapy	Immunisation	Child Guidance	Remedial Exercises	Mental Health	Ophthalmic	Orthopaedic	Paediatric	Dental	Other
Roberttown Sunday School	—	Thurs. p.m. (3rd in month) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Scholes Temperance Hall... ...	—	Thurs. p.m. (2nd in month) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
DIV. 18. (BRIGHOUSE)															
Brighouse Bonegate House ...	—	—	—	—	—	—	—	—	—	—	—	—	—	Daily	—
Brighouse 10, Huddersfield Road ...	Tues. p.m. (alternate) ACMO/HV/M	Wed. p.m. Thurs. p.m. ACMO/HV(2)	—	—	—	—	Fri. a.m. DMO/HV	—	—	—	—	—	—	—	—
Brighouse Brook Street	—	—	—	Daily HV	Thurs. a.m. ACMO/HV	Mon. a.m. Tues. a.m. ST	—	—	—	—	—	—	—	—	—
Elland St. Paul's School ...	Mon. p.m. (alternate) DMO/HV/M Mon. p.m. HV, *Relax.*	Wed. p.m. DMO/HV(2)	Mon. a.m. Wed. a.m. HV	Mon. a.m. Wed. a.m. HV	Wed. a.m. (alternate) DMO/HV	—	—	—	—	—	—	—	—	—	—
Greetland Clay House	Wed. p.m. (alternate) ACMO/HV/M	Tues. p.m. GP/HV(2)	Tues. a.m. Fri. a.m. HV	Tues. a.m. Thurs. a.m. HV	Tues. a.m. (3rd in mth.) DMO/HV	—	—	—	Tues. a.m. HV	—	Thurs. a.m. (alternate) HMO/HV	—	—	—	—
Hipperholme Wesleyan School ...	Fri. p.m. (alternate) ACMO/HV/M	Mon. p.m. ACMO/HV(2)	Mon. a.m. Fri. a.m. HV	—	Mon. a.m. DMO/HV	—	—	—	—	—	—	—	—	—	—
Queensbury Cricket Pavilion ...	Fri. p.m. (alternate) ACMO/HV/M Fri. p.m. (alternate) M, *Relax.*	Mon. p.m. ACMO/HV(2)	—	Tues. a.m. Fri. a.m. HV	—	—	—	—	—	—	—	—	—	—	—
Shelf Witchfield Chapel ...	Mon. p.m. ACMO/HV/M	Mon. p.m. ACMO/HV(2)	Mon. a.m. HV	Mon. a.m. HV	—	—	—	—	—	—	—	—	—	—	—
Southowram St. Anne's in the Grove...	Thurs. p.m. ACMO/HV/M	Thurs. p.m. ACMO/HV	Mon. a.m. Thurs. a.m. HV	Thurs. a.m. HV	—	—	—	—	—	—	—	—	—	—	—
DIV. 19. (TODMORDEN)															
Halifax Royal Infirmary	—	—	—	—	—	—	—	—	—	—	—	Wed. a.m. (bi-monthly) HMO/HV	—	—	—
Hebden Bridge Pitt Street	Fri. p.m. GP/HV/M(2)	Wed. p.m. Thurs. p.m. GP/HV(2)	Mon. p.m. Thurs. a.m. HV(2) Oct.—Apl.	—	Wed. a.m. ACMO/HV	Tues. a.m. ST	—	—	—	—	As required HMO/HV	—	—	—	—

Luddendenfoot The Institute	Fri. p.m. (1st in month) ACMO/HV/ M	Fri. p.m. ACMO/HV	—	Fri. a.m. HV	—	—	—	—	—	—	—	—	—	—	—
Mytholmroyd Scout Road Methodist Sunday School	—	Wed. p.m. (alternate) GP/HV Wed. p.m. (alternate) HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Ripponden Zion Congregational Sunday School	Tues. p.m. (1st in month) ACMO/HV/ M	Tues. p.m. ACMO/HV	—	Tues. a.m. HV	—	—	—	—	—	—	—	—	—	—	—
Sowerby Bridge Allan House	Mon. p.m. ACMO/HV (2)M	Thurs. p.m. ACMO/HV(2)	Tues. a.m. Fri. p.m. HV Oct.—Apl.	—	Mon. a.m. ACMO/HV	Fri. a./p.m. ST	—	—	—	Mon. p.m. Tues. p.m. Thurs. a.m. Fri. a.m. MH	As required HMO/HV	—	—	Daily	—
Todmorden Abraham Ormerod Medical Centre	Wed. p.m. GP/HV/M(2) Thurs. p.m. GP/HV Wed. p.m. M, *Relax.*	Tues. p.m. HV Wed. p.m. ACMO/HV	Mon. a.m. Fri. p.m. HV Oct.—Apl.	Daily a.m. except Fri., HV	Fri. a.m. ACMO/HV	Tues. p.m. ST	—	—	Mon. a./p.m. Thurs. a.m. HV/ON Thurs. p.m. ON	Tues. a.m. Wed. a./p.m. Fri. p.m. MH	As required HMO/HV	Wed. a.m. (bi-monthly) HMO/ON	—	Daily	—
Todmorden Vale Baptist Sunday School Cornholme, ...	—	Tues. p.m. ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Todmorden Walsden Wesley Sunday School	—	Thurs. p.m. ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
DIV. 20. (COLNE VALLEY)															
Delph Independent Chapel ...	—	Tues. p.m. GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Denby Dale Victoria Memorial Hall...	Wed. p.m. (1st) GP/HV/M with Infant Welfare Thurs. p.m. M, *Relax.*	Wed. p.m. (1st & 3rd) GP/HV	Tues. p.m. Fri. p.m. HV	—	—	—	—	—	—	—	—	—	—	—	—
Emley Reading Rooms ...	—	Thurs. p.m. (3rd in month) HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Golcar Woodville, Scar Lane ...	Wed. p.m. (4th in month) GP/HV with Infant Welfare	Wed. p.m. GP/HV Toddlers quarterly by arrangement	Tues. p.m. Fri. p.m. HV	—	—	Wed. a.m. ST	—	—	—	—	As required HMO/HV	—	—	—	—
Greenfield Methodist Chapel ...	—	Thurs. p.m. GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Holmfirth Wesley Methodist Chapel	Thurs. p.m. (4th in month) GP/HV/M With Infant Welfare	Thurs. p.m. GP/HV	Mon. a.m. Thurs. p.m. HV	Thurs. a.m. HV	—	—	—	—	—	—	As required HMO/HV	—	—	—	—

CLINICS—(*continued*)

Premises	Ante-natal	Infant Welfare	U.V. Light	Minor Ailments	School	Speech Therapy	Immunisation	Child Guidance	Remedial Exercises	Mental Health	Ophthalmic	Orthopaedic	Paediatric	Dental	Other
Honley Southgate Methodist Schools	—	Fri. p.m. GP/HV	—	—	—	—	—	—	—	—	As required HMO/HV	—	—	—	—
Honley High Street Methodist Church	—	—	—	—	—	—	—	—	—	—	As required HMO/HV	—	—	—	—
Honley Council Chambers ...	—	—	—	—	—	As required ST	—	—	—	—	—	—	—	—	—
Huddersfield Divisional Education Offices	—	—	—	—	—	Wed. p.m. ST	—	—	—	—	—	—	—	—	—
Huddersfield Old Boys' Pavilion, Tandem, Waterloo ...	—	—	—	—	—	—	—	—	—	—	As required HMO/HV	—	—	—	—
Huddersfield Royal Infirmary	—	—	—	—	—	—	—	—	—	—	—	Thurs. a.m. (last in mth.) HMO/HV	—	—	E.N.T. Mon. a.m. as required HMO/HV
Kirkburton Dogley Lane Congregational Church, Fenay Bridge	—	Tues. p.m. GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Kirkburton C. of E. School	—	—	—	—	—	As required ST	—	—	—	—	—	—	—	—	—
Lepton Council Offices, Wakefield Road	Thurs. p.m. (3rd in month) ACMO/HV/M	Tues. p.m. GP/HV Toddlers quarterly by arrangement	—	—	—	—	—	—	—	—	—	—	—	—	—
Linthwaite Grove House	—	Tues. p.m. GP/HV Toddlers quarterly by arrangement	—	—	—	—	—	—	—	Wed. a./p.m. Fri. a./p.m. MH	—	—	—	—	—
Marsden Conservative Club ...	—	Thurs. p.m. GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Marsden Mechanics' Institute ...	—	—	—	—	—	—	—	—	—	—	As required HMO/HV	—	—	—	—
Meltham Baptist School	Thurs. p.m. (1st in month) ACMO/HV/M	Tues. p.m. GP/HV Toddlers quarterly by arrangement	—	Tues. a.m. HV	—	—	—	—	—	—	—	—	—	—	—
Meltham Oddfellows Hall ...	—	—	—	—	—	—	—	—	—	—	As required HMO/HV	—	—	—	—
Nields County School	—	—	—	—	—	As required ST	—	—	—	—	—	—	—	—	—
New Mill Council Offices	—	Wed. p.m. (2nd & 4th) ACMO/HV Wed. p.m. (other), HV	—	—	—	—	—	—	—	—	—	—	—	—	—

Scholes County School	—	—	—	—	—	As required ST	—	—	—	—	—	—	—	—	—	—
Skelmanthorpe Wesley Reform Chapel, Gibb Lane	Wed. p.m. (4th in month) GP/HV With Infant Welfare	Wed. p.m. (2nd & 4th) GP/HV	—	—	—	—	—	—	—	Mon. p.m. Thurs. a./p.m. MH	—	—	—	—	—	—
Slaithwaite Central Hall	Wed. p.m. (1st in month) GP/HV With Infant Welfare Mon. p.m. HV/M, *Relax.*	Wed. p.m. GP/HV Toddlers quarterly by arrangement	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Springhead Congregational Sunday School, Radcliffe Street...	Mon. p.m. (4-weekly) GP/HV/M Mon. p.m. HV/M, *Relax.*	Fri. p.m. GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Uppermill Mechanics' Institute ...	Mon. p.m. (4th in month) GP/HV/M	Wed. p.m. ACMO/HV	Tues. p.m. Fri. p.m. HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Uppermill Youth Employment Office, High Street ...	—	—	—	—	—	As required ST	—	—	—	Tues. p.m. MH	—	—	—	—	—	—
Uppermill National Spiritualist Church	—	—	—	—	—	—	—	—	—	—	As required HMO/HV	—	—	—	—	—
DIV. 23. (HEMSWORTH)																
Ackworth Mission Rooms, Wake- field Road	Tues. p.m. (alternate) GP/HV/M	Wed. p.m. (alternate) GP/HV(2)	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Fitzwilliam Church Hut	Thurs. p.m. GP/HV(2)/M	Tues. p.m. GP/HV(2)	—	Tues. a.m. HV	—	—	—	—	—	—	—	—	—	—	—	—
Fitzwilliam Council School	—	—	—	—	—	—	—	—	—	—	As required HMO/HV	—	—	—	—	—
Great Houghton Methodist Church ...	—	Tues. p.m. (alternate) GP/HV(2)	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Grimethorpe Church Hall	—	Wed. p.m. GP/HV(2)	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Grimethorpe Infants School	—	—	—	—	—	—	—	—	—	—	As required HMO/HV	—	—	—	—	—
Hemsworth West End School Hut ...	Wed. a.m. ACMO/HV (2)M Thurs. p.m. HV/M, *Relax.*	Mon. p.m. ACMO/HV(2)	Tues. a.m. Wed. p.m. Fri. p.m. HV(2)	—	Mon. a.m. ACMO/HV	—	—	—	Fri. a.m. ON	—	Thurs. a./p.m. (4th in mth.) HMO/HV	Tues p.m. (3rd in mth.) HMO/HV	—	—	—	—
Hemsworth Divisional Office ...	—	—	—	—	—	Mon. p.m. Thurs. a./p.m. ST	—	—	—	—	—	—	—	—	—	—
Moorthorpe Miners' Institute	—	—	—	Fri. a.m. HV(2)	—	—	—	—	—	—	Tues. a./p.m. (1st & 3rd) HMO/HV	—	—	—	—	—
Ryhill Church Hall	Tues. p.m. GP/HV/M(2)	Thurs. p.m. (alternate) GP/HV(2)	—	—	—	—	—	—	—	—	—	—	—	—	—	—

CLINICS—*(continued)*

Premises	Ante-natal	Infant Welfare	U.V. Light	Minor Ailments	School	Speech Therapy	Immunisation	Child Guidance	Remedial Exercises	Mental Health	Ophthalmic	Orthopaedic	Paediatric	Dental	Other
Shafton Methodist Chapel ...	—	Thursday p.m. (alternate) GP/HV(2)	—	—	—	—	—	—	—	—	—	—	—	—	—
South Elmsall P.I.C.S. Buildings, Barnsley Road	Thurs. a./p.m. ACMO/HV/M Wed. p.m. M(2), *Relax.*	Mon. a./p.m. GP/HV(2)	—	—	—	—	—	—	—	—	—	—	—	—	—
South Hiendley Methodist Chapel ...	—	Wed. p.m. (alternate) GP/HV(2)	—	—	—	—	—	—	—	—	—	—	—	—	—
South Kirkby P.I.C.S. Buildings, The Green	Tues. p.m. ACMO/HV/M(2) Thurs. p.m. M(2), *Relax.*	Mon. p.m. ACMO/HV(2)	—	—	—	—	—	—	—	Wed. p.m. MH	—	—	—	—	—
Upton Church Hall	—	Tues. p.m. (alternate) GP/HV(2)	—	Mon. p.m. HV	—	—	—	—	—	—	—	—	—	—	—
DIV. 22. (WORTLEY)															
Cawthorne The Golf Club	—	Wed. p.m. DMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Chapeltown Miners' Welfare Institute	—	Wed. p.m. ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Ecclesfield Gatty Memorial Hall ...	Thurs. p.m. GP/HV/M	Mon. p.m. GP/HV(2)	—	Mon. a.m. Thurs. a.m. HV	—	—	—	—	—	—	—	—	—	—	—
Ecclesfield Jeffcock Memorial Home, Home Nurses' Home ...	—	—	Tues. p.m. Fri. p.m. HV(2)	—	—	—	—	—	—	—	—	—	—	—	—
Grenoside Scout Hut, Salt Box Lane	—	Thurs. p.m. GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
High Green Methodist Sunday School, Wortley Road	—	Tues. p.m. ACMO/HV	—	Tues. a.m. (except 1st) HV	Tues. a.m. (1st in mth.) ACMO/HV	—	—	—	—	—	—	—	—	—	—
High Green Divisional Office, Mortomley Hall	—	—	—	—	—	—	—	—	—	—	—	—	Tues. p.m. (4th in mth.) HMO/HV	—	—
Hoyland Miners' Welfare Institute	Mon. p.m. GP/HV/M	Tues. p.m. GP/HV	—	Tues. a.m. Fri. a.m. HV	Tues. a.m. GP/HV	—	—	—	—	—	—	—	—	—	—
Hoyland Council School, King Street	—	—	—	—	—	—	—	—	—	—	As required HMO/HV	—	—	—	—
Hoyland Market Street School ...	—	—	—	—	—	Thurs. a.m. ST	—	—	—	—	—	—	—	—	—
Hoyland Common Methodist Sunday School	—	Thurs. p.m. GP/HV	—	Thurs. a.m. HV	—	—	—	—	—	—	—	—	—	—	—
Loxley Congregation School ...	—	Tues. p.m. (alternate) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—

Oughtibridge Church Hall	—	Thurs. p.m. ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Parson Cross St. Paul's Institute ...	—	Tues. p.m. GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Parson Cross Mansell J.M.I. School ...	—	—	—	—	—	Wed. a.m. ST	—	—	—	—	—	—	—	—	—	—
Parson Cross Monteney J.M. School ...	—	—	—	—	—	Wed. p.m. ST	—	—	—	—	—	—	—	—	—	—
Penistone Shrewsbury Road ...	—	Mon. p.m. GP/HV	—	Mon. a.m. HV	—	Tues. a./p.m. ST	—	—	—	—	As required HMO/HV	—	—	—	—	—
Stannington Methodist Sunday School	—	Wed. p.m. ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Stannington Council School	—	—	—	—	—	—	—	—	—	—	As required HMO/HV	—	—	—	—	—
Stocksbridge British Hall	Fri. p.m. (1st, 3rd and 5th) GP/HV/M	Tues. p.m. GP/HV	—	Tues. a.m. Fri. a.m. HV	—	—	—	—	—	—	As required HMO/HV	—	—	—	—	—
Tankersley Scout Hall	—	Mon. p.m. (alternate) GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Wharncliffe Side Brightholmlee Methodist Chapel	Tues p.m. (alternate) HV/M	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Worrall Memorial Hall	Tues p.m. (alternate) HV/M	Tues. p.m. (alternate) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—	—
DIV. 25. (BARNSLEY)																
Barnsley Divisional Office, 6, Victoria Road ...	—	—	—	—	—	Mon. a./p.m. ST	—	—	—	—	Mon. a.m. HMO/HV	Fri. p.m. (2nd & 4th) HMO/HV	Thurs. a.m. (3rd in mth.) HMO/HV	—	—	
Barnsley Beckett Hospital	—	—	—	—	—	—	—	—	—	—	—	—	—	—	E.N.T. Tues. a.m. (2nd in mth.) HMO/HV See also Div. 30.	
Cudworth St. George's Hall ...	Fri. a.m. GP/HV/M	Wed. a./p.m. GP/HV(2)	Tues. p.m. Thurs. p.m. HV(2) Oct.—May	—	Tues. a.m. (alternate) ACMO/HV	—	—	—	—	—	—	—	—	—	—	
Darfield Methodist Church, Barnsley Road	Fri. a.m. GP/HV/M Wed. a.m. M(2), *Relax.*	Wed. p.m. GP/HV	—	—	Wed. a.m. (alternate) ACMO/HV	—	—	—	—	—	—	—	—	—	—	
Darton Station Road	Mon. a.m. (1st in month) ACMO/HV/ M Tues. p.m. M, *Relax.*	Wed. p.m. GP/HV	—	Wed. a.m. (1st in mth.) HV	Mon. p.m. (alternate) ACMO/HV	—	—	—	—	—	—	—	—	—	—	
Dodworth Mechanics' Institute ...	Tues. a.m. M, *Relax.*	Tues. p.m. GP/HV	—	Tues. a.m. (alternate) HV	Tues. a.m. (alternate) ACMO/HV	—	—	—	—	—	—	—	—	—	—	

CLINICS—*(continued)*

Premises	Ante-natal	Infant Welfare	U.V. Light	Minor Ailments	School	Speech Therapy	Immunisation	Child Guidance	Remedial Exercises	Mental Health	Ophthalmic	Orthopaedic	Paediatric	Dental	Other
Higham Parish Hall, Higham Common Road	Tues. p.m. (3rd in month) ACMO/HV/M with Infant Welfare	Tues. p.m. ACMO/HV	—	Tues. a.m. HV	Wed. a.m. (3rd in mth.) ACMO/HV	—	—	—	—	—	—	—	—	—	—
Royston Wesleyan Sunday School, High Street	Tues. a.m. GP/HV/M	Wed. a./p.m. GP (1 session) /HV	—	Mon. a.m. HV	Fri. a.m. (alternate) ACMO/HV	—	—	—	—	—	—	—	—	—	—
Staincross Wesleyan Sunday School, Barnsley Road	Mon. a.m. (2nd in mth.) ACMO/HV/M	Thurs. p.m. ACMO/HV	—	Thurs. a.m. (except 2nd) HV	Thurs. a.m. (2nd in mth.) ACMO/HV	—	—	—	—	—	—	—	—	—	—
Wombwell Public Library, Station Road	Thurs. a./p.m. GP/HV(2)/M(2) Mon. a.m. Wed. p.m. M(3), *Relax.*	Tues. p.m. GP/HV(4)	Mon. p.m. Fri. p.m. HV	Fri. p.m. HV Mon. p.m. (alternate) HV	Mon. p.m. (alternate) ACMO/HV	—	—	—	—	—	—	—	—	—	—
Wombwell Welfare Hall, Jump ...	—	Mon. p.m. GP/HV(2)	—	—	—	—	—	—	—	—	—	—	—	—	—
Wombwell The Gables	—	—	—	—	—	Thurs. p.m. Fri. a./p.m. ST	—	—	—	Wed. a./p.m. MH	Thurs. a.m. HMO/HV	—	Mon. a.m. (1st in mth.) HMO/ ACMO/HV	Daily	—
Worsborough Methodist Church, Birdwell	Fri. p.m. (alternate) GP/HV/M Fri. p.m. M, *Relax.*	Wed. p.m. GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Worsborough Methodist Chapel, Blacker Hill	—	Thurs. p.m. GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Worsborough Ambulance Hall, Worsborough Bridge ...	Tues. p.m. (alternate) GP/HV/M Thurs. p.m. M, *Relax.*	Mon. p.m. GP/HV	—	Mon. a.m. (alternate) HV	Mon. a.m. (alternate) ACMO/HV	—	—	—	—	Thurs. a.m. MH	—	—	—	—	—
Worsborough Bank End Community Centre, Worsborough Dale	Tues. p.m. (alternate) GP/HV/M Wed. p.m. M, *Relax.*	Thurs. p.m. GP/HV	Mon. p.m. Fri. p.m. HV	Thurs. a.m. HV	—	—	—	—	—	—	—	—	—	—	—
DIV. 26. (RAWMARSH)															E.N.T. See Div. 30
Kilnhurst Church Hall	—	Wed. p.m. GP/HV(2)	—	—	Thurs. a.m. (2nd in mth.) ACMO/HV	—	—	—	—	—	—	—	—	—	—
Parkgate Methodist Church, Broad Street	—	Thurs. p.m. ACMO/HV(2)	—	—	Tues. p.m. (monthly) ACMO/HV	—	—	—	—	—	—	—	—	—	—

Rawmarsh Barbers Avenue	Thurs. a.m. GP/HV(2)/M Thurs. p.m. M	Tues. p.m. GP/HV(3)	Mon. a.m. Thurs. p.m. HV	—	Wed. a.m. ACMO/HV	—	—	Fri. a./p.m. Ps.	—	Mon. p.m. Tues. a.m. MH	Mon. a./p.m. (3rd in mth.) Wed. a./p.m. (3rd in mth.) HMO/HV	Wed. p.m. (monthly) HMO/HV Includes Div. 31	Thurs. a.m. (1st in mth.) HMO/ ACMO/HV	Daily	—
Swinton Rock House	Thurs. a./p.m. GP/HV/M(2) Fri. a./p.m. M, *Relax.*	Mon. p.m. GP/HV(2)	—	—	Mon. a.m. (alternate) ACMO/HV	Wed. a./p.m. ST	—	—	—	Mon. a.m. Tues. p.m. MH	—	—	—	—	—
Wath-on-Dearne Dunford House	Fri. a.m. GP/HV(2)/ /M(2)	Mon. p.m. GP/HV(2)	Mon. a.m. Thurs. a.m. HV	—	Mon. a.m. (alternate) ACMO/HV	—	—	—	—	Wed. a./p.m. Fri. a./p.m. MH	Thurs. a./p.m. (3rd in mth.) HMO/HV	—	—	Daily	—
West Melton Wesleyan Chapel, Princess Street	—	Tues. p.m. GP/HV(2)	—	—	Tues. a.m. (alternate) DMO/HV	—	—	—	—	—	—	—	—	—	—
DIV. 27. (ADWICK-le-STREET)															
Bentley The Pavilion, Askern Road	Fri. a./p.m. GP/HV(2)/ M(4) Tues. a.m. M(2) *Relax.*	Wed. a./p.m. HV(3)/M(2) and ACMO or DMO alternately	Mon. p.m. Wed. a.m. Fri. a.m. HV	Tues. a.m. HV	—	Tues. a./p.m. ST	—	—	—	—	—	—	Mon. a.m. (monthly) HMO/HV	—	—
Carcroft Presbyterian Chapel, Owston Road	Mon. p.m. ACMO/HV (2)/M(2) Mon. a.m. HV/M, *Relax.*	Thurs. a./p.m. HV(2)M ACMO one session only	—	Fri. a.m. HV	—	—	Thurs. a.m. DMO/HV (2) (monthly as required)	—	—	—	—	—	—	—	—
Carcroft Carcroft School	—	—	—	—	—	Thurs. a.m. ST	—	—	—	—	—	—	—	—	—
Woodlands Woodside Chapel ...	Tues. a./p.m. GP/HV(2)/ M(2)	Thurs. a./p.m. HV(2) and DMO one session only	—	Thurs. a.m. HV	—	—	Thurs. a.m. DMO/HV (2) (monthly as required)	—	—	—	—	—	—	—	—
Woodlands Infants' School	—	—	—	—	—	Thurs. p.m. ST	—	—	—	—	—	See Div. 28	—	—	—
DIV. 28. (DONCASTER)															
Armthorpe Miners' Welfare Institute	Tues. a.m. ACMO/HV(2) (2) Tues. p.m. (2nd & 4th) ACMO/HV (2)/M	Thurs. p.m. GP/HV(2)	—	—	—	Wed. p.m. (alternate) ST	Mon. a.m. (monthly) ACMO/HV	—	—	—	—	—	—	—	—
Askern Baptist Chapel, Sutton Road	Thurs. p.m. GP/HV(2)/M Thurs. a.m. (2nd & 4th) GP/HV(2)/M	Mon. p.m. GP/HV(2)	—	Mon. a.m. HV Thurs. a.m. (1st, 3rd & 5th) HV	—	—	—	—	—	—	—	—	—	—	—
Bawtry 25, Council Estate ...	Wed. p.m. (2nd in mth.) ACMO/M	Mon. a.m. ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Brodsworth St. Leonard's and St. Jude's Church, Barnsley Road, Scawsby	—	Tues. p.m. (alternate) HV weighing only	—	—	—	—	—	—	—	—	—	—	—	—	—

CLINICS—*(continued)*

Premises	Ante-natal	Infant Welfare	U.V. Light	Minor Ailments	School	Speech Therapy	Immunisation	Child Guidance	Remedial Exercises	Mental Health	Ophthalmic	Orthopaedic	Paediatric	Dental	Other
Doncaster Nether Hall Road Methodist Church	—	—	—	—	—	Fri. a./p.m. ST	—	—	Mon. a.m. ON	—	—	—	—	—	—
Doncaster Chest Clinic, Merton House, 20, Christ Church Road	—	—	—	—	—	—	—	—	—	—	—	Thurs. p.m. (2nd & 4th) HMO/ON for Divs. 27, 28, 29 & 30	—	—	—
Doncaster Royal Infirmary	—	—	—	—	—	—	—	—	—	—	—	—	—	—	E.N.T. Wed. a.m. (3rd in mth.) HMO/HV
Doncaster Wood Street	—	—	—	—	—	—	—	—	—	—	Thurs. a./p.m. (alternate) HMO/HV	—	—	—	—
Edlington St. John's Church Hall ...	Thurs a./p.m. (1st & 3rd) ACMO/HV (2)/M	Mon. p.m. ACMO/HV(2)	—	Mon. a.m. Fri. a.m. HV	—	—	Fri. a.m. (monthly) ACMO/HV	—	—	—	—	—	—	—	—
Kirk Sandall Denton Green's Lane ...	Tues. p.m. (1st & 3rd) ACMO/HV /M	Thurs. p.m. GP/HV/M	—	Tues. a.m. Thurs. a.m. HV	—	Wed. a.m. (alternate) ST	Mon. a.m. (monthly) ACMO/HV	—	—	—	—	—	—	—	—
Rossington Methodist Church Hall ...	Wed. a.m. ACMO/HV/M Wed. p.m. (1st & 3rd) ACMO/HV/M	Tues. p.m. GP/HV(2)	—	Mon. a.m. Fri. a.m. HV	—	—	Fri. p.m. (monthly) ACMO/HV	—	—	—	—	—	—	—	—
Rossington West End Lane	—	—	—	—	—	—	—	—	—	—	—	—	—	Daily	—
Sprotborough Richmond Hill School Grounds	Fri. a./p.m. (alternate) ACMO/HV/M	Wed. a.m. DMO/HV	Mon. p.m. Thurs. p.m. HV Oct.—May	Thurs. a.m. HV	—	—	Wed. p.m. (monthly) DMO/HV	—	—	—	—	—	Mon. a.m. (3rd in mth.) HMO/HV	—	—
DIV. 29. (THORNE)															
Doncaster Wood Street	—	—	—	—	—	—	—	—	—	—	Fri. a.m. HMO/HV	—	—	—	—
Doncaster Royal Infirmary	—	—	—	—	—	—	—	—	—	—	—	—	—	—	E.N.T. Wed. a.m. (2nd in mth.) HMO/HV
Dunscroft St. Edwin's Hall	Wed. p.m. GP/M(2)	Tues. p.m. ACMO/HV(2)	—	Tues. a.m. Thurs. a.m. HV	—	—	—	—	—	—	—	See Div. 28	—	—	—
Hatfield Victoria Hall	Mon. a.m. ACMO/M(2)	Mon. p.m. ACMO/HV(2)	—	—	—	—	—	—	—	—	—	—	—	—	—

Moorends Wesleyan Chapel Northgate	Thurs. p.m. ACMO/M(2)	Tues. p.m. GP/HV(2)	—	—	—	—	—	—	—	—	—	—	—	—	—
Stainforth Wesleyan Chapel... ...	Fri. a.m. GP/M(2)	Wed. p.m. ACMO/HV(2)	—	Mon. a.m. Wed. a.m. HV	—	—	—	—	—	—	—	—	—	—	—
Thorne Temperance Institute ...	Fri. p.m. GP/M(2) Fri. p.m. M, *Relax.*	Wed. p.m. GP/HV(2)	Mon. p.m. Thurs. a.m. HV	Tues a.m. HV	—	—	—	—	—	—	—	—	—	—	—
Thorne Divisional Office, Council Offices	—	—	—	—	—	—	—	—	—	—	—	—	Thurs. a.m. (2nd in mth) HMO/HV	—	—
Thorne Southend School ...	—	—	—	—	—	Mon. a.m. ST Wed. p.m. (alternate) ST	—	—	—	—	—	—	—	—	—
DIV. 30. (MEXBOROUGH)															
Bolton-on-Dearne Secondary Modern School	—	—	—	—	—	—	—	—	—	—	As required HMO/HV	—	—	—	—
Conisbrough Miners' Welfare Institute Garden Lane	Tues. p.m. Obst/HV/M (3)	Mon. p.m. ACMO/HV(2)	—	Mon. a.m. except on SC days, HV	Twice monthly on MA day, ACMO/HV	—	—	—	—	—	—	—	—	—	—
Denaby Main Church Road	Wed. a.m. Obst/HV/M (3)	Tues. p.m. ACMO/HV(2)	Mon. a.m. ACMO/HV (2) Thurs. p.m. HV(2)	Tues. a.m. Thurs. a.m. except on SC days, HV	Twice per month on MA days ACMO/HV	—	—	—	—	Fri. p.m. MH	3 half day sessions each 3 weeks, HMO/HV	—	—	Daily	—
Goldthorpe Welfare Hall, Washington Road	Thurs. p.m. Obst/HV/M (3)	Mon. p.m. ACMO/HV(2) /M	—	Mon. a.m. HV	—	—	—	—	—	Mon. a.m. MH	—	—	—	—	—
Mexborough Adwick Road	Wed. p.m. Obst/HV/M (3)	Tues. p.m. DMO/HV(3) Thurs. p.m. GP/HV(3)	Tues. a.m. ACMO/HV (2) Fri. a.m. HV(2)	Tues. a.m. Thurs. a.m. except on SC days, HV	Twice per month on MA days, ACMO/HV	—	—	—	—	—	3 half day sessions each 3 weeks HMO/HV	—	Thurs. (4th in mth.) HMO/ ACMO(2) /HV	—	—
Mexborough Montagu Hospital ...	—	—	—	—	—	—	—	—	—	—	—	—	—	—	E.N.T. Wed. p.m. HMO/HV Includes Divs. 25 & 26
Thurnscoe Central Hall	Fri. p.m. Obst/HV/M (3)	Mon. p.m. GP/HV(2)/M	—	Mon. a.m. Fri. a.m. except SC days, HV	Monthly on MA day, ACMO/HV	—	Tues. p.m. GP/HV(2)	—	—	Fri. a.m. MH	—	—	—	—	—
DIV. 31. (ROTHERHAM)															
Aughton 9, Main Street	—	—	—	—	—	—	—	—	—	—	—	See Div. 28	—	Daily	—
Bramley Miners' Welfare Institute Cross Street	Tues. p.m. (alternate) GP/HV/M	Wed. p.m. GP/HV	—	Wed. a.m. except SC HV	Wed. a.m. (1st in mth.) ACMO/HV	—	—	—	—	—	—	—	—	—	—
Brampton Bierlow Methodist Chapel, Chapel Avenue	Wed. p.m. (1st & 3rd) GP/HV/M	Thurs. p.m. GP/HV	—	Thurs. a.m. HV	Thurs. a.m. (quarterly) ACMO/HV	—	—	—	—	—	—	—	—	—	—
Catcliffe 3, Rotherham Road ...	Tues. p.m. (alternate) GP/HV/M	—	—	Tues a.m. HV	Fri. a.m. (2nd in mth.) ACMO/HV	Tues a.m. ST	—	—	—	Wed. a./p.m. MH	As required	—	—	—	—

CLINICS—(*continued*)

Premises	Ante-natal	Infant Welfare	U.V. Light	Minor Ailments	School	Speech Therapy	Immunisation	Child Guidance	Remedial Exercises	Mental Health	Ophthalmic	Orthopaedic	Paediatric	Dental	Other
Catcliffe Church Mission Hall ...	—	Wed. p.m. (alternate) GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Dalton Doncaster Road	Wed. p.m. GP/HV/M Thurs. p.m. (alternate) GP/HV/M	Tues. p.m. GP/HV	—	Tues. a.m. HV Fri. a.m. except SC HV	Fri. a.m. (1st in mth.) ACMO/HV	—	Fri. a.m. monthly ACMO/HV	—	—	Mon. a./p.m. MH	Mon. a./p.m. 3 weekly as required HMO/HV	—	—	—	—
Dinnington Methodist Chapel, Laughton Road	Fri. p.m. GP/HV/M	Tues. p.m. GP/HV	—	Tues. a.m. HV Fri. a.m. except SC HV	Fri. a.m. (4th in mth.) ACMO/HV	Thurs. p.m. ST	—	—	—	Fri. a.m. MH	Wed. a./p.m. 3 weekly as required HMO/HV	—	—	—	—
Kiveton Park Methodist Chapel, Wales Road	Thurs. p.m. (2nd & 4th) GP/HV/M	Mon. p.m. GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Maltby Walters Road	Wed. a./p.m. GP/HV/M	Mon. p.m. GP/HV	Tues. a.m. HV Oct.—Apl.	Tues. a.m. Fri. a.m. HV	Mon. a.m. (1st in mth.) ACMO/HV	Tues. p.m. Thurs. a.m. ST	Mon. a.m. (3rd in mth.) ACMO/HV	—	—	Tues. p.m. Thurs. p.m. Fri. p.m. MH	Thurs. a./p.m. 3 weekly as required HMO/HV	—	Mon. a.m. (2nd in mth.) HMO/HV	—	—
Rotherham Hospital and Dispensary	—	—	—	—	—	—	—	—	—	—	—	—	—	—	E.N.T. Wed.a./p.m. (1st in mth.) HMO/HV
Swallownest Church Hall, Beighton Lane	Wed. a.m. (alternate) ACMO/HV/M	Thurs. a./p.m. GP/HV	Tues. a.m. Fri. a.m. HV Oct.—Apl.	Tues. a./p.m. except SC, HV	Tues. a.m. (2nd in mth.) ACMO/HV	—	—	—	—	—	As required HMO/HV	—	—	—	—
Thurcroft Wesleyan Chapel, Woodhouse Green ...	Wed. p.m. (1st & 3rd) GP/HV/M	Mon. p.m. GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Thurcroft Modern School	—	—	—	—	Thurs. p.m. (2nd in mth.) ACMO/HV	—	—	—	—	—	As required HMO/HV	—	—	—	—
Thrybergh Poplar Avenue	—	—	—	—	—	—	—	—	—	—	—	—	—	Daily	—
Whiston Church Institute, School Hill	—	Thurs. p.m. (alternate) GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—

In addition to the above there are 85 minor ailment clinics held by school nurses in the schools, chiefly at weekly intervals, and minor ailment cases are also treated at 15 centres during Infant Welfare Sessions. There are also three Dental Trailer Caravans operating in rural areas.

NOTE :—The following abbreviations are used.

DMO	Divisional Medical Officer.
ACMO.	Assistant County Medical Officer (Senior or other).
Obst.	Joint Obstetrician (W.R.C.C. and Sheffield R.H.B.).
GP.	General Practitioner.
HMO.	Hospital Medical Officer (Consultant or Other).
Ps.	Psychologist.
HV.	Health Visitor and/or School Nurse.
M.	Midwife.
ON.	Orthopaedic Nurse or Physiotherapist.
ST.	Speech Therapist.
MH.	Mental Health Staff.
Ch.	Chiropodist.
CN.	Mobile Clinic Nurse.
Relax.	Relaxation Exercise Clinic.

PART V

THE HEALTH OF THE SCHOOL CHILD

(This, together with the following Part VI on the County Dental Service constitutes the report for the year 1953 on the School Health Service, being the 46th Annual Report of the Principal School Medical Officer.)

Introduction

There has been little change in the nature and character of the School Health Service during the year 1953, beyond the inescapable fact that a service which originally commenced as a School *Medical* Service is yearly becoming more and more of a School *Health* Service. The aim in this service is so to treat the child that he is able to benefit from the education provided for him, thus in effect it is a treatment as well as a preventive service. The treatment, however, differs from that provided by other agencies in that it deals with the whole child and not with any single aspect of his life or health.

The service has been working for many years in such an unspectacular manner that many people still tend to decry the invaluable work done by the School Medical Officers. The specialist services in particular still do not know enough of the work undertaken by the School Health Service although the liaison between the Local Authority's medical officers and the specialist services is very slowly improving. Even closer liaison is absolutely necessary for the benefit of the child, and in time there will, I hope, be close reciprocity between the two services, to the advantage of both and to the inestimable benefit of the school child.

With regard to the handicapped child, either physically or mentally, the steady progress reported last year has been maintained throughout 1953. The Education Committee are anxious to do their utmost for all handicapped pupils and although no new school has been opened during the year the plans for the alteration to Day Special Schools for Educationally Sub-normal Children of two of our Day Open Air Schools for Delicate Children at Wombwell and Shipley have been steadily proceeding. The special schools already in existence have been functioning to capacity and doing excellent work, often under very adverse circumstances due to staffing difficulties.

The chief difficulty as before lies in the placing of the educationally sub-normal, the spastic, and the epileptic child. With regard to the first named, the need now appears to be for an increase in special classes in ordinary day schools for the higher grade of educationally sub-normal child and the Committee are endeavouring to meet this need.

There is still no comprehensive Child Guidance Service, but the position is more hopeful than last year. Negotiations have been in progress with the University of Leeds to effect a joint appointment of a Psychiatrist who would give seven-elevenths of his time to the Local Authority service. In the meantime, Dr. MacTaggart continues single-handed to give devoted service as the Child Guidance Psychologist. Her services are in great demand and are greatly appreciated by all the staff. In addition, the School Medical Officers continue to render invaluable assistance in the lesser degrees of psychological upset. The need remains for a three-fold service, Psychiatrist, Psychologist, and Psychiatric Social Workers, as no single member of this team can possibly carry out the essential needs of this service, embodying as it does expert medical opinion allied to educational psychology and the home background histories and help given by the Psychiatric Social Workers. Once the services of a Psychiatrist have been obtained, then every effort will be made to implement the team by the appointment of Psychiatric Social Workers.

During the year, the School Medical Officers have attended meetings on several Saturday mornings. The meetings, which have been well attended, have taken the form of clinical talks given by consultants and one visit to a special school, The Yorkshire Residential School for the Deaf at Doncaster: this was a most profitable and enjoyable meeting, Mr. Greenaway, the Headmaster, and Mr. Petty, the Consultant Otologist, both giving very instructive talks before the party were shown round the school.

The position regarding medical staff is more stable than it has been for many years. There have been resignations during the year but new members of staff have been appointed and at the end of the year there were 48 whole-time medical officers working in the School Health and other health services administered by the Authority.

The post of Senior Medical Officer for the School Health Service is still unfilled and I am indebted to Dr. A. Marshall for her services in the Central Office in connection with the School Health Section of the Department.

In conclusion, I should like to take this opportunity of expressing my deep appreciation to my colleagues in the Education Department for their unfailing co-operation and help, and to all the school teachers for their continuing regard for the health of the children in their care. I realise that this happy state of affairs is very largely due to the School Medical Officers, who by their enthusiasm and interest keep themselves abreast of the times, even in these days of rapid clinical change and knowledge, and I look forward to the day when all ranks of the profession will openly acknowledge the debt to the work done so thoroughly and conscientiously by the School Medical Officers who are the real back-bone of the Service.

The Medical Inspection of School Children

The average number of pupils on the registers is as follows:—

	Boys	*Girls*	*Total*
Nursery	304	267	571
Primary (County)	68,392	64,950	133,342
Primary (Voluntary)	23,617	22,634	46,251
Secondary Modern (County)	21,394	20,630	42,024
Secondary Modern (Voluntary)	657	901	1,558
Secondary Grammar	11,176	11,502	22,678
Secondary Technical	1,145	912	2,057
Comprehensive	405	359	764
	127,090	122,155	249,245

77,803 periodic medical inspections and 34,509 special inspections and re-examinations were made during the year compared with 62,156 and 32,969 for the year 1952. The increase is undoubtedly due to the more stable position during 1953 of the staff of School Medical Officers.

During the year the Minister issued the School Health Service and Handicapped Pupils Regulations, 1953, which came into operation on the 4th August, and replaced the Handicapped Pupils and School Health Service Regulations, 1945. The 1945 Regulations provided for the periodic medical examination of children attending maintained schools on three occasions, namely, as entrants for the first time to a maintained school, during the last year at a primary school, and during the last year at a secondary school. Additional periodic inspections could be instituted by agreement between the Minister and the Authority.

Under the 1953 Regulations, the occasions during a child's school life when periodic medical inspections are carried out are not laid down and a Local Education Authority has freedom to implement its own policy as to medical inspections provided there are not less than three inspections during a child's school life. For some time, it had been felt that amendment was desirable to the ages at which periodical medical inspections were carried out. Several heads of secondary schools, particularly grammar schools, have asked for the examination of entrants in order that they may know quite clearly at the outset those children who have some defect which is likely to influence their education or to restrict the extent to which they can safely take part in games and physical education. From the medical side, some school medical officers have frequently expressed the desirability of a medical examination at 7 or 8 years of age — an age when many defects first become apparent and can be treated at the outset. For example, visual defects are not so apparent at 5 years of age, but can be readily assessed in the normal child at age 7 or 8, and appropriate measures taken for treatment to begin at an early stage.

After careful consideration of the new Regulations, the Education Committee agreed that with effect from the commencement of the new school year in September, 1953, children in maintained schools be examined as follows:—

(a) on or as soon as possible after entry for the first time to a maintained school,

(b) during the year the age of 8 years is attained,

(c) as soon as possible after entry to a secondary school, and

(d) during the last year of attendance at a secondary school.

If, in any area, for reasons of inadequacy of medical staff it is not possible to undertake the above four inspections either (a), (c), and (d) are undertaken or in place of (c) an inspection during the last year of attendance at a primary school, as formerly.

In addition to the periodic medical inspections, children brought forward by the teachers, or selected by the School Medical Officers, or referred by parents, will still be examined as special cases.

The unspectacular nature of the work done by the School Medical Officers unfortunately still blinds many people to the invaluable help it gives to parents and teachers. In these enlightened days and very largely as a result of past policy in health education, it is doubtful whether many major defects remain unrecognised and untreated, and the emphasis, therefore, at routine school medical inspections should be placed on the recognition and evaluation of minor deviations from the normal, and on incipient illnesses. Thus it will be seen that not only is a much more leisurely approach to the work at routine medical inspections necessary, but also that the experience and knowledge gained during the years by the School Medical Officers are all vitally necessary to discover these minor deviations and incipient illnesses. In spite of the rather vocal criticism from some quarters of the value or desirability of routine medical inspection of school children, there exists no doubt of its very real value giving as it does an unrivalled opportunity of a communal consultation between parent, school medical officer, teacher, and nurse. This is amply demonstrated by the increasing attendance of parents at routine medical inspections of children in each age group.

The basic fact of the preventive nature of the work of the School Medical Officer is more than justified by the continuing use of routine medical inspections of school children. In spite of all the advantages of the National Health Service, and they are many and varied, yet the family doctors practising under the National Health Service are of necessity fully occupied in the treatment of actual illness. The aim of the School Health Service is to prevent such illness either in childhood or in the future and the doctors who have chosen school health work are already familiar with the treatment side of medicine, but much more interested in the preventive aspect. Hence, even the somewhat dull routine examination of many perfectly healthy children makes them so familiar with the many types of normal child that they become increasingly aware of minor deviations and incipient illnesses.

The circumstances under which medical inspections are carried out are still far from the ideal, but in regard to the plans for new schools or the adaptation of old buildings there is an increasing awareness of the basic needs for medical inspection. A room free from noise is an absolute necessity and in time most schools will be able to supply just such a room.

The following tables give details of the numbers of medical inspections made in the various age groups and the numbers found to require treatment.

Table I

Medical Inspection of Pupils attending Maintained Primary and Secondary Schools (including Special Schools)

A. Periodic Medical Inspections

Number of Inspections in the prescribed Groups

Entrants	32,168
7 to 8 year group	1,789
Last year primary	21,857
First year secondary	2,743
Last year secondary	18,646
Total	77,203
Number of other Periodic Inspections	600
Grand Total	77,803

B. Other Inspections

Number of Special Inspections	23,495
Number of Re-Inspections	11,014
Total	34,509

C. Pupils found to Require Treatment

Number of individual pupils found at Periodic Medical Inspection to require treatment (excluding Dental Diseases and Infestation with Vermin).

Group (1)	For defective vision excluding squint (2)	For any of the other conditions recorded in Table II A (3)	Total Individual Pupils (4)
Entrants	550	5,144	5,468
7 to 8 year group	173	237	379
Last year primary	1,564	2,496	3,836
First year secondary	194	279	449
Last year secondary	1,338	1,968	3,123
Total (prescribed groups)	3,819	10,124	13,255
Other Periodic Inspections	47	93	132
Grand Total	3,866	10,217	13,387

Table II

A. Defects found by Medical Inspection in the Year ended 31st December, 1953.

Note:—All defects noted at medical inspection as requiring treatment are included in this table, whether or not this treatment was begun before the date of the inspection.

Defect or Disease	Periodic Inspections		Special Inspections	
	No. of Defects		No. of Defects	
	Requiring treatment	Requiring to be kept under observation but not requiring treatment	Requiring treatment	Requiring to be kept under observation but not requiring treatment
(1)	(2)	(3)	(4)	(5)
Skin	1,421	673	800	152
Eyes—a. Vision	3,866	3,856	1,046	1,851
b. Squint	651	751	147	265
c. Other	307	240	225	76
Ears—a. Hearing	243	444	116	164
b. Otitis Media	383	492	165	104
c. Other	295	158	180	84
Nose or Throat	2,316	1,441	658	1,182
Speech	317	463	227	229
Cervical Glands	191	1,664	113	410
Heart and Circulation	182	896	76	251
Lungs	599	1,503	291	418
Developmental—a. Hernia	79	165	23	41
b. Other	87	622	28	99
Orthopaedic—a. Posture	456	425	62	95
b. Flat Foot	891	844	171	177
c. Other	723	1,267	239	328
Nervous System—a. Epilepsy	64	99	38	40
b. Other	200	313	148	128
Psychological—a. Development	75	408	141	189
b. Stability	130	352	90	88
Other	1,318	866	1,516	595

B. Classification of the General Condition of Pupils Inspected During the Year

Age Groups	Number of Pupils Inspected	A. (Good)		B. (Fair)		C. (Poor)	
		No.	% of Col. 2	No.	% of Col. 2	No.	% of Col. 2
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Entrants	32,168	14,614	45·43	17,075	53·08	479	1·49
7 to 8 year group	1,789	1,030	57·57	704	39·35	55	3·07
Last year primary	21,857	9,638	44·10	11,904	54·46	315	1·44
First year secondary	2,743	1,356	49·43	1,342	48·92	45	1·64
Last year secondary	18,646	8,999	48·26	9,384	50·33	263	1·41
Other Periodic Inspections	600	224	37·33	363	60·50	13	2·17
Total	77,803	35,861	46·09	40,772	52·44	1,170	1·50

Table III

Infestation with Vermin

(i)	Total number of examinations in the schools by the school nurses or other authorised persons	575,645
(ii)	Total number of *individual* pupils found to be infested	17,815
(iii)	Number of individual pupils in respect of whom cleansing notices were issued (Section 54(2), Education Act, 1944)	915
(iv)	Number of individual pupils in respect of whom cleansing orders were issued (Section 54(3), Education Act, 1944)	20

Table IV

Treatment Tables

NOTES

(a) Treatment provided by the Authority includes all defects treated or under treatment during the year by the Authority's own staff, however brought to the Authority's notice, i.e., whether by periodic inspection, special inspection, or otherwise, during the year in question or previously.

(b) Treatment provided otherwise than by the Authority includes all treatment known by the Authority to have been so provided, including treatment undertaken in School clinics by the Regional Hospital Board.

GROUP 1—DISEASES OF THE SKIN (EXCLUDING UNCLEANLINESS, FOR WHICH SEE TABLE III).

	Number of cases treated or under treatment during the year	
	By the Authority.	*Otherwise.*
Ringworm—(i) Scalp	23	18
(ii) Body	72	22
Scabies	68	5
Impetigo	2,541	101
Other Skin Diseases	4,452	320
Total	7,156	466

GROUP 2—EYE DISEASES, DEFECTIVE VISION AND SQUINT.

	Number of cases dealt with	
	By the Authority.	*Otherwise.*
External and other (excluding errors of refraction and squint)	2,053	206
Errors of refraction (including squint)	—	17,659
Total	2,053	17,865
Number of pupils for whom spectacles were—		
(a) Prescribed	nil.	9,462
(b) Obtained	not known	not known

GROUP 3—DISEASES AND DEFECTS OF EAR, NOSE AND THROAT.

	Number of cases treated	
Received operative treatment—	*By the Authority.*	*Otherwise.*
(a) for diseases of the ear	—	72
(b) for adenoids and chronic tonsillitis	—	2,596
(c) for other nose and throat conditions	—	185
Received other forms of treatment	2,925	375
Total	2,925	3,228

GROUP 4—ORTHOPAEDIC AND POSTURAL DEFECTS.

(a) Number treated as in-patients in hospitals	285	
	By the Authority.	*Otherwise.*
(b) Number treated otherwise, e.g., in clinics or out-patient departments	1,376	460

GROUP 5—CHILD GUIDANCE TREATMENT.

	Number of cases treated	
	In the Authority's Child Guidance Clinics.	*Elsewhere.*
Number of pupils treated at Child Guidance Clinics	629	—

GROUP 6—SPEECH THERAPY.

	Number of cases treated	
	By the Authority.	*Otherwise.*
Number of pupils treated by Speech Therapists	1,947	9

GROUP 7—OTHER TREATMENT GIVEN.

	Number of cases treated	
	By the Authority.	*Otherwise.*
(a) Miscellaneous minor ailments	43,781	531
(b) Other—		
1. Ultra Violet Light treatment	4,296	5
2. Chiropody	586	—
Total	48,663	536

Table V

Dental Inspection and Treatment

1.	Number of pupils inspected by the Authority's Dental Officers—	
	(a) Periodic age groups	89,173
	(b) Specials	7,902
	Total (1)	97,075
2.	Number found to require treatment	70,810
3.	Number referred for treatment	60,238
4.	Number actually treated	52,321
5.	Attendances made by pupils for treatment	98,646
6.	Half-days devoted to: Inspection	911
	Treatment	14,429
	Total (6)	15,340
7.	Fillings: Permanent teeth	53,710
	Temporary teeth	4,160
	Total (7)	57,870
8.	Number of teeth filled: Permanent teeth	47,012
	Temporary teeth	3,964
	Total (8)	50,976
9.	Extractions: Permanent teeth	13,816
	Temporary teeth	75,998
	Total (9)	89,814
10.	Administration of General Anaesthetics for extraction	18,907
11.	Other Operations: Permanent teeth	26,784
	Temporary teeth	3,973
	Total (11)	30,757

The Care of the Handicapped Child

Section 34 of the Education Act requires Local Education Authorities to ascertain those children in their areas who by reason of disability of mind or body require special educational treatment, and Section 33 requires Local Education Authorities to make provision for the special educational treatment recommended. Eleven categories of handicapped children were defined in the Regulations made by the Minister in 1945 under Section 33, namely, the blind, the partially sighted, the deaf, the partially deaf, the delicate, the diabetic, the educationally sub-normal, the epileptic, the maladjusted, the physically handicapped, and children with speech defects. Under the School Health Service and Handicapped Pupils Regulations, 1953, the list has been reduced to 10 by the deletion of the diabetic, children suffering from diabetes to such an extent as to require special educational treatment being included in the delicate category. This amendment is not surprising as only exceptionally does the diabetic child require special educational treatment. Most diabetics are under regular treatment and observation at special out-patient clinics, and only in those cases where parents are not to be relied upon to administer regular insulin treatment and keep strictly to the recommended diet, does it become necessary to make arrangements for the child's admission to a boarding home or hostel for diabetics.

Although prior to the passing of the 1944 Act, many special schools for certain categories of handicapped pupils were already in existence, many under voluntary management, the accommodation provided was totally inadequate to meet the requirements called for by the new Act, and the provision of facilities for the handicapped child has occupied the close attention of Local Education Authorities since 1946. Many new schools, both boarding and day, have, and are still being, provided, and in 1953 there were in England and Wales 61 special schools for the blind and partially sighted (31 day), 45 for the deaf and partially deaf (20 day), 213 for the educationally sub-normal (133 day), 8 for the epileptic, 220 for the delicate and physically handicapped (130 day), 25 for the maladjusted (3 day), and 1 for speech defects. In addition, there were 84 hospital schools and 59 boarding homes or hostels for specific handicaps from which the children attend ordinary day schools in the area.

In the West Riding, 2 boarding schools for the delicate, 3 for the educationally sub-normal, one for the deaf with additional handicap, and 2 hostels for maladjusted children have been established since 1946. A further boarding special school and two day special schools for the educationally sub-normal are due to open early in 1954. The Committee are also planning to build in the near future a further two day special schools for the educationally sub-normal.

With this increased awareness of the need to provide for the handicapped child, it is not surprising that the work of ascertainment, entailing as it does frequent re-examinations, now constitutes an important branch of the School Health Service.

The number of new ascertainments and re-examinations undertaken by the School Medical Officers during the year was as follows:—

Category.	*No. of Examinations.*
Educationally sub-normal	944
Physically handicapped	279
Delicate	377
Deaf	31
Partially deaf	17
Epileptic	27
Speech (Requiring special school)	2
Maladjusted (Requiring hostel or special school)	73
Blind	7
Partially sighted	19
Double defect	26
Total	1,802

The following table gives details of handicapped pupils and placings in special schools and hostels during the year, and particulars of the number of children in residence in special schools at the end of the year.

Category	New Ascertainments	New placings in Special Schools	Total No. attending Special Schools		No. Boarded in Homes	No. Attending Assisted Schools	No. awaiting placement in Special Schools	No. receiving Home Tuition
			Day	Boarding				
Blind	10	8	—	43	—	1	12	—
Partially Sighted	15	12	8	59	—	—	19	—
Deaf	23	20	25	134	—	3	21	—
Partially Deaf	8	3	5	30	—	—	9	—
Delicate	208	215	235	116	1	—	60	—
Physically Handicapped	43	30	3	62	—	4	60	73
Educationally Sub-normal	325	91	31	244	—	2	681	1
Maladjusted	63	26	—	1	36	2	63	—
Epileptic	9	8	—	26	—	—	7	1
Totals	704	413	307	715	37	12	932	75

The figures in the foregoing Table relating to physically handicapped children do not include cases sent to, or awaiting places in Hospital Special Schools.

It will be seen from the above table that new placings in special schools have not kept pace with the number of new ascertainments, particularly in the educationally sub-normal and maladjusted categories.

The Physically Handicapped Child.—The physically handicapped is a somewhat wide category embracing as it does cases of diseases of the central nervous system, diseases of muscles, heart diseases, congenital deformities, blood diseases, rare congenital diseases and children crippled as the result of illness or accident.

The largest groups in this category belong to three of the subdivisions, those of cerebral palsy, post poliomyelitis, and cases of heart disease. The last named, thanks to improved diagnosis and a better evaluation on the part of doctors generally on the child's capabilities, is becoming much smaller numerically. The great advances in cardiac surgery are also playing their part in restoring to a state of normal or near normal health numbers of children who in the past were severely handicapped.

Thus the group of Physically Handicapped now includes as its two largest components the cases of cerebral palsy and the unfortunate children severely crippled as a result of an attack of poliomyelitis. Very many of the latter require special educational treatment in special schools for the physically handicapped, while those who are fortunate enough to have recovered even the partial use of their limbs are able to attend ordinary schools, given sympathetic consideration.

This leaves the cases of cerebral palsy to be dealt with and as this problem is having nation-wide publicity, I shall deal with it in more detail. In the condition of cerebral palsy there is damage to the child's brain either before, during, or after birth, as a result of which a child has a disability of movement which may be general or only affect one or more limbs, and which may be of varying degree. The brain damage leads to interference with the nervous control of the muscles depending on the area of the brain affected. The type of disability varies with the situation of the damaged area of the brain, thus one may have cases of spasticity in which all or nearly all of the muscles are in a constant state of spasm; or athetosis in which the child carries out any simple action by a complicated series of writhing movements; or rigidity which simulates spasticity; or ataxia when it is difficult or impossible to perform a definite act due to inco-ordination of groups of muscles, or merely simple tremors.

In addition to the physical disabilities there may be damage to the organs of special sense leading to blindness, deafness, partial or complete loss of speech, and there is also frequently damage at the intellectual level. The degree of physical handicap bears no direct relationship, however, to the intellectual attainments. The athetoid cases who are the most severely handicapped physically are often quite intelligent children.

The extent of intellectual damage is extremely variable. Some authorities maintain that 75 per cent. of all cases of cerebral palsy are so handicapped intellectually as to be ineducable. There is unfortunately a large percentage of children with cerebral palsy who, although educable, are nevertheless educationally sub-normal. It will be realised that the assessment of the intelligence of these handicapped children is not easy and no case of cerebral palsy is ever pronounced ineducable or even educationally sub-normal merely on the results of one examination, but it has been found that cerebral palsied children with an intelligence quotient of less than 85 are likely to make little or no progress educationally even with all the facilities of special educational treatment.

The incidence of cerebral palsy is not accurately known as it is not notifiable. An American survey indicates that 7 cases are born per 100,000 of the population each year.

On the 23rd April, 1953, a conference on physically handicapped and spastic children was held in the County Hall, Wakefield, and attended by representatives of the British Council for the Welfare of Spastics, Education Authorities, Medical Officers of Health, and members of other interested bodies. At this conference the West Riding County Council made it clear that they were willing and anxious to co-operate in any regional proposals for increasing the provision for physically handicapped children with direct reference to the cerebral palsied, and the problem is at present under consideration by the Yorkshire Association of Education Committees.

While acknowledging the need for special provision for the spastic, the wave of national sympathy should not be allowed to obscure the needs of other physically handicapped children, who merit equal consideration when facilities for special educational treatment are being considered.

It is not surprising that special schools for spastics generally demand that children admitted should be of average or above average intelligence as even with these children any educational and physical progress is slow. The education of the spastic child who is also educationally subnormal is a most difficult problem. In spite of the difficulties involved some boarding special schools for the physically handicapped are prepared to admit cases of cerebral palsy and indeed in some schools they are more numerous than any other single category of physical handicap. Recent figures for 3 boarding special schools show 28 cerebral palsied cases out of a total of 59, 52 out of 96, and 9 out of 25.

It is of the utmost importance that cases of cerebral palsy are diagnosed as early as possible and this Authority is fortunate in that many of the School Medical Officers also attend the Infant Welfare Clinics. The School Medical Officers with their knowledge of handicaped children generally and the provisions for such are the persons on whom devolves the responsibility of early recognition of the condition. This is essentially a medical problem, and one with which the experienced School Medical Officers are eminently suitable to deal as their unrivalled opportunities of dealing with all the minor deviations from the normal make them acutely aware of any young child whose milestones of development are lagging behind the normal.

While it is agreed that the earlier the treatment is given the better, it is hoped that the establishment of pre-school clinics as an alternative to nursery schools will do much to help in assessing the educability of severely handicapped children Children with cerebral palsy are a formidable problem, but it must be remembered that they are part of a very much larger problem —that of the physically handicapped generally. Future provision will depend largely on the experience now being gained in the clinics and special schools.

Particulars relating to educable spastics in the County are shown below. The figures include children of pre-school age and many who are not handicapped to such an extent that they need to be officially ascertained as handicapped children.

Total No. of educable spastics	No. accommodated in Special Schools	No. attending ordinary schools		No. receiving Home Tuition	No. receiving no education
		Satisfactorily	Needing placement in Special Schools		
222	57*	79	35	17	34

*Accommodated as follows:—

St. Margaret's School, Croydon	1
St. Chad's School, Prestatyn	1
Heritage Craft Schools, Chailey	5
Welburn Hall, Kirbymoorside	3
Pinderfields Hospital, Wakefield	4
Halliwick Cripples Home, Edmonton	3
Chipping Norton Children's Home	3
Ian Tetley Memorial Home, Hampsthwaite	1
Hesley Hall, Tickhill	7
Bradstock Lockett Hospital School, Southport	3
Adela Shaw Orthopaedic Hospital, Kirbymoorside	2
Exhall Grange, Coventry	6
Hinwick Hall School, Wellingborough	1
Camphill Rudolf-Steiner School	3
St. Rose's R.C. Special School, Stroud	1

Royd Edge School for Educationally Sub-normal Children	1
Whiteness Manor, Broadstairs	1
Bosworth Park Hospital	1
Derwent Cripples Training College	1
Leasowe Children's Hospital	1
Springfield School for Educationally Sub-normal Children	2
Etton Pasture School for Educationally Sub-normal Children	1
Baliol School for Educationally Sub-normal Children	1
Larchfield Special School, Harrogate	1
Rob Roy Special School, Oakham	2
Bamford Memorial Home, Rochdale	1

The Delicate Child.—The asthmatic and the bronchitic constitute the greater proportion of children in this category. It also includes the debilitated child whose condition may be due to poor feeding, bad housing, overcrowded home, or insufficient sleep. Open-air schools for delicate children have been in existence for many years, but with the gradual improvement during this century in the health and physique of school children, due in part to such things as better housing conditions, improved and better ventilated schools, and the introduction of school milk and meals, the need to provide open air day or boarding special schools is diminishing. Many delicate children can be kept under observation and treated at home, and continue to attend the ordinary school with sympathetic attention by the teaching staff until their physical health improves to such an extent that they no longer need be regarded as delicate. In some cases a stay of a few weeks at a convalescent home with good food and adequate rest quickly restores the child to normal health and ensures a speedy return to the normal routine of the ordinary school. During the year 154 children were provided with convalescent home treatment.

There will, of course, always remain a residue of delicate children for whom a long-stay change of environment is necessary and boarding special school provision will continue to be required. Some asthmatics and bronchitics will always require the regime of an open-air boarding school, as will also the child in whom it is impossible to discover any organic lesion, but who fails to progress physically and educationally within the ordinary school system in spite of care and attention. The needs of these children will continue to be met largely by admission to the Authority's boarding special schools at Ingleborough Hall, Clapham, and Netherside Hall, nr. Skipton. Both schools are meeting a real need and doing valuable work. They are visited periodically by Dr. Harvey, the Consultant Paediatrician, whose advice has proved most helpful.

Dr. Hunter, the Divisional Medical Officer in the Skipton area, acts as Medical Officer to the Netherside Hall School and takes a keen interest in the physical well-being of the boys in residence. He submits the following report on the School:—

"Netherside Hall was opened in the Autumn of 1951 for the reception of forty delicate boys who would be likely to benefit from a prolonged stay at a school where the surroundings, curriculum, and mode of life are especially favourable and designed to deal with their particular disabilities. During the year under review it has been open the whole time except for the Christmas holidays, although most boys have also been granted leave to take a summer holiday with the parents when this was requested.

Of the boys in residence the most important group is undoubtedly that comprising children who suffer from asthma, often complicated by eczema of varying severity, and many with a long history. The majority of these boys have done well, and many have been discharged either apparently cured or greatly improved. Equally important is the fact that whilst at Netherside they have rarely missed any schooling, in contrast to their unhappy records of frequent and prolonged absences prior to admission.

Cases of chronic bronchitis, bronchiectasis and other chest conditions have made good progress; as have the boys with a variety of other less serious conditions who were recommended for admission, often from a poor environment or unsatisfactory home.

The school has kept remarkably free from the usual intercurrent infections, which is probably due in large measure to the diet, adequate rest, fresh air, graduated exercise, good living conditions, and by no means least to the care which every individual receives from the Headmaster and Matron, and resident staff. In a small boarding school and under such conditions it is possible to treat each boy as an individual, and this is particularly important where psychological problems are often part of the disability or disease process. This also applies to the duration of stay, for although it has been possible to discharge some boys after two or three terms, there are others who have been at the school since its very early days. Every advantage is taken of specialist services and boys are referred to consultants at the local hospital, to the speech therapy clinic, or the child guidance clinic when it is considered that they would benefit thereby."

The Blind and Partially Sighted Child.—There is little to report on these two categories. Although there is often a period of waiting before a child can be admitted to a suitable special school, the provision of accommodation in the country as a whole can be regarded as reasonably adequate. The chief difficulty arises in the placement of a child who, in addition to being either blind or partially sighted, also suffers from an additional physical defect, e.g. the deaf blind child, or the spastic. Sometimes it is impossible to place such a child in a suitable special school and it is often equally impossible to provide home tuition as an alternative.

The Deaf and Partially Deaf Child.—The estimate of the number of deaf pupils requiring special educational treatment as given in Pamphlet No. 5. of the Ministry of Education "Special Educational Treatment" is 0.7 to 1.0 per 1,000 registered pupils. On this basis there should be 175—250 deaf pupils in the West Riding. At the end of the year there were in fact 183 deaf pupils on the Register, 162 being accommodated in day or boarding special schools, the remaining 21 awaiting placement. It can be assumed, therefore, that the ascertainment of deaf pupils is

reasonably complete. It is, of course, to be expected that every completely, or nearly completely, deaf child, whether born deaf or acquiring deafness later in life, probably following meningitis, will readily be brought to the attention of the School Medical Officers, when the age is reached at which the child should attend school. If, however, the best possible training and education is to be provided it is important that ascertainment should take place as soon as possible after two years of age and placement in a special school effected by age three years. It is difficult to achieve this as children under five years of age are not subject to the close and frequent medical observation as applied to the school child.

The ascertainment of the deaf pre-school child is, therefore, dependent to a large degree on the co-operation of the parents, the health visitor, the family doctor, the infant welfare clinic medical officer, and the Ear, Nose and Throat Specialist. Where the deaf child reaches the specialist, the School Health Service is invariably informed of the case, but it is only to be expected that some children will reach the age of five without being previously notified to the Authority, particularly as few pre-school children will have attended infant welfare clinics and be known to the health visitors, after reaching two years of age.

While arrangements for the ascertainment of the deaf child may be regarded as reasonably satisfactory, this cannot be said of the partially deaf. Again quoting from the Ministry's pamphlet "Special Educational Treatment", there should be in the West Riding upwards of 250 partially deaf children requiring special educational treatment and probably half of these require educating in special schools. At the end of the year there were 35 partially deaf pupils in day or boarding special schools and 9 awaiting placement, a total of 44 children only requiring special school placement. To this figure could be added those children known to the School Medical Officers and who attend ordinary schools occupying a favourable position in the class, possibly assisted by a hearing aid, but even so there are grave doubts that there may be numerous partially deaf children in the schools who remain unascertained and may be receiving education under a considerable handicap. Some defects of hearing are not readily revealed by the normal tests employed at medical inspection. The defect may be such that the degree of hearing is affected by varying distances from a certain sound, or by the reflecting power of the walls of a classroom. The result of a defect of this nature may mean that a child's educational attainments fall short of the standard expected and one wonders how many children there may be in the schools who are actually suffering from a defect of hearing but have eventually been labelled educationally sub-normal.

With a view to improving the arrangements for the ascertainment of the partially deaf, two gramophone audiometers were purchased in 1950, but the extent to which they have been used has been most disappointing. The County Council would not agree to the appointment of personnel to operate the machines which has meant that surveys with the audiometers have had to be undertaken by existing nursing staff whose other commitments are already heavy. In consequence, surveys have been completed in three Divisional areas only over the past three years. The probable existence of a comparatively large number of partially deaf children in the schools is a challenge to the School Health Service and it is important that everything possible should be done to discover these children and to provide them with the education most suited to their needs.

The Epileptic Child.—The situation in regard to this category of handicapped pupil has not changed very much throughout the year. The treatment of epilepsy by an increasing array of new drugs is doing much to obviate the need for special education in special schools and continuing propaganda by our School Medical Officers to their colleagues in the teaching profession that a "fit" is merely an incident in a child's life, to be treated as such and not as a major disaster, will in time, I think, make placement in a special school decreasingly necessary.

The difficulty as before lies in placing an epileptic pupil who is also educationally sub-normal, as most boarding special schools for epileptic children demand an intelligence quotient in the region of 80 or over. In a few cases the difficulty may be solved by the use of Home Tuition.

With regard to the placing of epileptics in industry, I feel that the position is easing gradually. Employers are slowly becoming more used to the idea of employing epileptics and the growing liaison between School Medical Officer, Youth Employment Officer, and employer is having excellent results.

The Educationally Sub-normal Child.—The majority of children on the Handicapped Pupils Register are to be found in this category. At the end of the year there were 1,379 educationally sub-normal children on the Register, of whom 277 were in day or boarding special schools, 1 receiving home tuition, and 420 recommended special educational treatment in the ordinary school, or in special classes, in the ordinary school, leaving 681 on the waiting list for admission to day or boarding special schools.

The 1,379 ascertained educationally sub-normal children are for the large part the more severely retarded children who require the special facilities provided in day or boarding special schools. In addition, there may be some 20,000 children in the schools who could be classed as educationally sub-normal to a minor degree, and included amongst them would be children with specific educational disabilities, those who fall behind their fellow pupils because of frequent absences due to illness, and many who fall just short of being of average intelligence. The ascertainment of these 20,000 would be an almost impossible task for the Authority's approved medical officers and indeed would be largely wasted effort. Unlike the more severely retarded

children, the problem is almost entirely educational. In an attempt to deal in part with the problem of the 'bright retarded' child in particular, the Education Committee established an experimental centre at Castleford in 1952 at which a form of special educational treatment is given with the object of returning the children to their normal age groups in their own schools as soon as possible. The experiment is proving successful and might, with advantage, be extended. It is obvious, of course, that careful selection of children will be necessary to ensure that the more severely retarded or maladjusted pupils are not, in their own interests, admitted to the centres.

As the large majority of handicapped pupils are to be found in the educationally sub-normal category, it is natural that the provision of special educational facilities for these children has received the close attention of the Education Committee since the War. Four boarding special schools (2 junior and 2 senior) have been established with accommodation for 210 pupils, and two day special schools at Wombwell and Shipley (formerly day open-air schools for the delicate) with accommodation for 110 pupils are due to open early in 1954. It is also intended to establish two further day special schools at Swinton and Cleckheaton. This provision is a gratifying achievement but when it is considered that at the end of the year 681 children were on the waiting list for admission to day or boarding special schools, one realizes how much yet remains to be done for the educationally sub-normal child. The establishment of more special classes within the existing school provision would help considerably towards solving the problem.

During the year 137 children were reported to the Local Health Authority under Section 57 (3) of the Education Act, 1944, as being ineducable, and 100 under Section 57(5) as requiring supervision after leaving school.

The Maladjusted Child.—Another year has passed and I am still unable to report that a psychiatrist and psychiatric social workers have been appointed. No real advance towards establishing an efficient child guidance service can be made until we have a tripartite team of psychiatrist, psychologist, and psychiatric social worker. No doubt it would have been possible to obtain the services of a number of psychiatrists in a sessional capacity by arrangement with the Regional Hospital Boards, but such an arrangement would not, in my opinion, provide the most effective means of dealing with the maladjusted child. In such a large and complex area as the West Riding it is essential that there should be a psychiatrist on the staff who can devote the greater part of his time to the organisation and administration of the child guidance service. Such a person would be able to co-ordinate the various agencies concerned in the treatment of the maladjusted child, and having an overall picture of the service would be able to assess its needs and advise on future development. He would also assume responsibility for the psychiatric work connected with the hostels for maladjusted children.

The services of a number of psychiatrists in the child guidance centres in a sessional capacity, while providing a means of obtaining expert opinion on individual cases would not materially assist in the planning and development of the service as a whole and would not provide that close integration with the work of the psychologists and psychiatric social workers which is so very necessary in the treatment of the maladjusted child.

I am again grateful to Dr. MacTaggart for her valuable work single-handed in the child guidance centres and for the keen interest shown in the work of the hostel for maladjusted girls at Hoober House. Her centres at Wakefield, Rawmarsh, Shipley, Mirfield, and Skipton have been working to capacity as is very evident from the following details of the cases dealt with:—

	Boys	*Girls*	*Total*
1. No. of new cases seen during year	131	85	216
2. No. of cases continuing attendance from previous year	185	98	283
3. Total number of cases seen during year	315	179	494
4. Total number of attendances made during the year	1,453	845	2,298
5. No. of cases recommended for residential treatment in—			
(a) Hostel for Maladjusted Children	27	26	53
(b) E.S.N. Special School	13	5	18
(c) Other	4	1	5
6. No. of cases referred for psychiatric opinion—	1	—	1
7. No. of cases examined at the particular request of the Magistrates	6	1	7
8. Types of problem for which cases were referred to Child Guidance Clinic—			
(a) Behaviour	158	90	248
(b) Delinquency	24	6	30
(c) Nervous problems	55	47	102
(d) Enuresis	29	13	42
(e) Schizophrenia	1	—	1
(f) Educational subnormality	7	6	13
(g) Speech	2	—	2
(h) Physical	4	2	6
(i) Poor progress in School	2	—	2

The two hostels for maladjusted pupils continue to play an important part and are achieving very worthwhile results. It is regrettable that due in some measure to the lack of psychiatric social workers, a number of children have had to be returned to unsatisfactory conditions at home which will in time discount the benefit gained during residence at the hostel. Any real and lasting improvement in the home during the child's absence can only be achieved by the trained psychiatric social worker, who is also the best person to keep the child under observation and supervision on return home.

The accommodation at Hoober House appears to be sufficient for girls requiring hostel placement, but more places than are available at Oakbank for boys are necessary in view of the constant waiting list. At the end of the year, plans were proceeding for the transfer of the hostel for boys to Nortonthorpe Hall, Scissett, nr. Hudderfield, where, it is hoped, additional accommodation will be available.

Children with Speech Defects.—For the past two years there has been an uninterrupted speech therapy service in the whole of the County area with the full establishment of 10 speech therapists employed, the number of school children per speech therapist varying between 18,000 in some areas and 30,000 in others. The reasons for such a wide variation are twofold; some areas are rural and sparsely populated requiring much travelling, and there is also the added difficulty of combining certain districts due to geographical differences.

During the year it became apparent that it would be necessary as a matter of urgency to provide a speech therapy service for the boarding special schools for junior educationally subnormal pupils and approval was given to an increase in the establishment from 10 to 11.

By early 1954, the speech therapy service will have been in uninterrupted existence long enough to assess whether or not the establishment of 11 speech therapists is adequate. As a result of a complete lack of any sort of service in many Divisions before 1952, there were long waiting lists of children requiring treatment superimposed on the normal day to day demand and it was evident that no attempt could be made for some time to assess the adequacy of the service. There was, of course, the Ministry's estimate of one speech therapist per 10,000 school children, but it was felt that this figure was on the generous side even when taking into account the need to allow the speech therapist sufficient time to visit schools and parents in their homes, in addition to undertaking treatment in the clinics. It is probable that a review of the service will reveal that an overall average of one speech therapist per 15,000 is reasonably adequate.

The following table gives details of the number of children dealt with at the clinics during the year, together with the numbers awaiting treatment. Comparative figures for the year 1952 are shown in brackets.

1.	No. of sessions held during the year			4,147 (4,578)
		Stammers	Speech Defects	Total
2.	No. of new cases admitted for treatment during the year	194(242)	681(666)	875(908)
3.	No. of cases continuing treatment from previous year	327(344)	745(585)	1,072(929)
4.	Total No. of cases treated during year	521(586)	1,426(1,251)	1,947(1,837)
5.	No. of cases discharged during year:—			
	(a) Speech normal	133(151)	451(358)	584(509)
	(b) Unsuitable for treatment	12(23)	50(81)	62(104)
	(c) Left school	32(48)	29(36)	61(84)
	(d) By reason of non-attendance	36(40)	119(102)	155(142)
	(e) Other reasons	15	24	39
6.	No. of cases awaiting treatment at end of year	582(417)	108(380)	690(797)
7.	No. of visits made to schools	198(200)	40(28)	238(228)
8.	No. of home visits	77(41)	69(50)	146(91)

The School Ophthalmic Service

The number of children dealt with through the School Ophthalmic Clinics continues to rise. Although the West Riding had a good ophthalmic service prior to 1948 through which spectacles were provided speedily and at no cost to the parent of a school child, it was feared that with the introduction of the Supplementary Ophthalmic Services in July, 1948, parents would be more inclined to take their children to one of the numerous opticians. This fear has proved groundless and the ophthalmic clinics continue to deal with the majority of cases and there is always a small waiting list in most areas.

The ophthalmic service is now under the control of the Regional Hospital Boards with the clinics affiliated to the various Hospital Management Committees. The Board's ophthalmologists attend the clinics and are assisted by the Authority's school nurses. There has been no significant change during the year in the clinic services, but there has been an increase in the number of orthoptic clinics established by the Boards in out-patient departments of certain hospitals.

While figures are readily available of the number of children for whom glasses have been prescribed there is no accurate information as to the numbers who actually receive glasses. The system of follow-up differs in the various Divisions according to the staff available. In some Divisions parents are asked to co-operate in informing the Divisional Medical Officer when glasses are obtained; in others, school nurses visit the schools, not only to ascertain whether the glasses have been obtained, but also to determine whether they are being worn, either constantly or for close work according to the ophthalmologist's recommendation.

The following figures show the number of children examined at the ophthalmic clinics during each of the years 1948 to 1953 and the number for whom glasses were prescribed:—

Year	No. of children examined (including re-examinations)	No. prescribed glasses
1948	10,755	8,113
1949	12,345	7,830
1950	12,341	7,289
1951	12,514	6,970
1952	14,974	8,941
1953	17,659	9,462

Mention is made in the Report of the Chief Medical Officer on the Health of the School Child for the years 1950 and 1951 of the disturbing finding that the number of children with squint found at periodic medical inspection to require treatment had increased from 18,234 in 1949 to 24,264 in 1951, and he asked that School Medical Officers should look into the situation in their own areas.

Despite the evidence that the number of cases of squint in the country appears to be increasing this does not appear to be the case so far as the area of this Authority is concerned. Figures for the years 1947 to 1953 are as follows:—

Year	Total No. of periodic inspections	No. of children with squint			
		Requiring treatment	% of total inspected	Requiring to be kept under observation	% of total inspected
1947	50,277	830	1.7	597	1.2
1948	71,858	863	1.2	659	0.9
1949	64,998	558	0.9	435	0.7
1950	61,977	502	0.8	440	0.7
1951	64,976	616	1.0	438	0.7
1952	62,156	548	0.9	571	0.9
1953	77,803	651	0.8	751	1.0

Similar figures in relation to cases of squint found at special inspections also do not indicate any general increase.

Medical Treatment at Hospitals and Elsewhere

As part of the Authority's arrangements under Section 48 of the Education Act, 1944, for the medical treatment of school children, the following clinics were in operation at the 31st December, 1953:—

Type of Clinic	Number	
	Provided directly by the Authority	Under arrangements with Regional Hospital Boards
Minor Ailment	212	—
Dental	28	—
Ophthalmic	—	69
Speech Therapy	54	—
Orthopaedic Treatment Centres	23	—
Ultra Violet Light	48	—
Paediatric	5	14
Chiropody	3	—
Consultant E.N.T.	—	16
Consultant Orthopaedic	—	18
Consultant Dermatology	—	1
Consultant Cardiac	—	1

A detailed list of the various clinics showing the days and times open will be found on pages 42 to 64.

Consultant E.N.T. Service

CONSULTANT CLINIC.

1.	No. of sessions held during the year		316	
		Pre-school Children.	*School Children.*	*Total.*
2.	No. of individual children seen by consultant, including those continuing attendance from previous year	220	2,611	2,831
3.	No. of (2) above referred for operative treatment	134	1,630	1,764
4.	No. of children—			
	(a) who obtained operative treatment during the year	98	1,537	1,635
	(b) treated at school clinics	2	390	392
5.	Total number of attendances at consultant clinic	267	3,445	3,712

Consultant Orthopaedic Service

A. CONSULTANT CLINIC.

1.	No. of sessions held during the year		325	
2.	No. of individual patients seen by consultant, including those continuing attendance from previous year	664	1,662	2,326
3.	No. of (2) above—			
	(a) referred for operative treatment as short-stay cases only	12	78	90
	(b) recommended long-stay hospital school	—	4	4
	(c) recommended treatment by orthopaedic nurse or physiotherapist—			
	(i) at treatment centres	86	283	369
	(ii) domiciliary	2	12	14
4.	No. of children who obtained operative treatment during the year	10	74	84
5.	Total number of attendances at consultant clinic	881	2,334	3,215

B. TREATMENT CENTRES.

1.	No. of sessions held during the year		1,252	
2.	Total No. of patients treated (including cases continuing treatment from previous year)	144	1,102	1,246
3.	Total number of attendances	1,316	10,846	12,162

C. DOMICILIARY TREATMENT.

1.	Total number treated	10	76	86
2.	Total number of visits to patients homes	384	851	1,235

D. APPLIANCES.

	No. of appliances—			
	(a) recommended	66	219	285
	(b) obtained	55	194	249

Paediatric Service

CONSULTANT CLINICS.

1.	No. of sessions held during the year		282	
2.	No. of individual patients seen	228	968	1,196
3.	Total number of attendances	342	1,259	1,601

The following table gives details of the various types of defect or disease for which children were referred for consultant opinion:—

Defect or Disease.	*Pre-school Children.*	*School Children.*	*Total.*
Central Nervous System	24	50	74
Heart and Circulatory System	10	201	211
Respiratory System including E.N.T. Defects	36	187	223
Speech	7	8	15
Orthopaedic	9	24	33
Skin	4	12	16
Psychological	19	78	97
Mental Defect, including educational sub-normality	24	33	57
Congenital Deformities	6	8	14
Gastro-intestinal System	12	27	39
Epilepsy	6	44	50
Genito-urinary System	—	9	9
Glands	2	13	15
Nutritional	6	24	30
Developmental	39	86	125
Habit Spasms	1	15	16
Incontinence	10	108	118
Unclassified	13	41	54
	228	968	1,196

Minor Ailment Clinics and Other Non-specialised Clinics

Although the treatment of minor ailments remains a function of the School Health Service, it was expected that with the provision of free general medical practitioner services under the National Health Service Act there would be a rapid decline in the attendances at minor ailment clinics. This has not proved to be the case and school nurses still spend an appreciable amount of time in treating minor ailments. In the more populous areas where there are all-purpose clinics, the school nurse attends daily for a specified time. In rural areas, or areas where new housing estates and new schools have been established, probably some distance from doctors' surgeries or fixed clinics, weekly minor ailments clinics have been established in the schools with the co-operation of the head teachers. These clinics have proved most successful: they are convenient, children lose little teaching time, and there is saving of the school nurse's time, as she can combine the treatment of minor ailments with other duties at the schools such as cleanliness inspections. By her frequent visits to the schools, the nurse gets to know the teachers, thus helping to achieve that close co-operation between the education and health services which is so essential.

In most parts of the County, school clinics with the School Medical Officers in attendance are still held and continue to fulfil a very real purpose. This is particularly true in those areas where the School Medical Officer has also undertaken the ante-natal and infant welfare work over a number of years and is well-known to the parents who readily seek advice. The school clinics provide a wealth of case material. Special cases referred by general practitioners, teachers, school nurses, or brought by the parents themselves may be examined and advised upon, probably with further reference to specialist clinics after consultation with general practitioners. Numerous cases of minor ailments are also dealt with. It is inevitable that many well and normal children will find their way to the school clinic and the School Medical Officer can do much to reassure the anxious mother on the development and management of the child. There is no doubt that but for the early intervention of the School Medical Officer, who generally has a knowledge of the home background, a fairly high proportion of these children would probably find their way eventually to the child guidance centres.

Diphtheria Immunisation

Particulars relating to the numbers of school children immunised during the year and the immunisation state of the population of children of school age will be found in the section of the Report dealing with Epidemiology. The schools have continued to play their essential role in furthering this valuable work and our thanks are again due to all teachers for their collaboration.

Cleanliness

The following figures show the number of children found to be infested during the year compared with previous years:—

Year	Total number of examinations made by school nurses	No. of individual children found to be infested	% of school population
1947	368,370	24,862	11.3
1948	560,631	27,361	12.4
1949	574,968	23,457	10.5
1950	523,473	20,214	8.8
1951	559,388	18,599	7.9
1952	610,201	19,772	8.1
1953	575,645	17,815	7.1

It will be seen from the above figures that there was a further improvement during 1953 in the incidence of infestation but the position is still far from satisfactory, the figure of 7.1% being higher than that for the country as a whole. The school nursing staff devote a considerable amount of time to the problem of infestation (examinations, visits to parents, advice on the treatment for head infestation, and the giving of the actual treatment in many cases) and they must frequently feel disheartened that any improvement in the overall position is so slight. As long as the parents themselves remain indifferent to the presence of infestation, it is impossible to ensure that their children remain in a clean condition.

Nutrition

Figures of the general physical condition of children examined at periodic medical inspections are given below for 1953 with a comparison of the figures for previous years. It will be noted that the percentage of children in the "Poor" category continues to show a decrease. Approximately 50% of children examined are in the "Fair" category. The word "Fair" is something of a misnomer implying that the general physical condition is not all that it should be whereas in actual fact it is intended in the Ministry's classification to indicate children of a normal or satisfactory general physical condition. It follows that the category "Good" includes children of better than normal general condition.

Year	Total number of pupils inspected	Classification					
		A (Good)		B (Fair		C (Poor)	
		No.	% of Col. 2	No.	% of Col. 2	No.	% of Col. 2
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1947	50,277	19,497	38.8	28,343	56.4	2,437	4.8
1948	71,858	26,077	36.3	41,876	58.3	3,905	5.4
1949	64,998	23,467	36.1	39,335	60.5	2,196	3.4
1950	61,977	26,820	43.3	33,528	54.1	1,629	2.6
1951	64,676	29,452	45.5	33,598	51.9	1,626	2.5
1952	62,156	30,506	49.1	30,635	49.3	1,015	1.6
1953	77,803	35,861	46.1	40,772	52.4	1,170	1.5

The number of meals provided to school children according to a check made in October, 1953, was 112,436 (49% of the children on registers) compared with 125,538 (56%) in October, 1952. It is significant that the fall in the number of children taking school meals has occurred so soon after a rise in the charge per school meal.

Medical Examination of Entrants to Training Colleges

An appreciable amount of time has been devoted during the year to the examination by the Authority's School Medical Officers of entrants to training colleges, 766 intending students being examined.

Protection of School Children against Tuberculosis

During 1953 there were three distinct lines of development in the arrangements for the protection of school children against tuberculosis—the X-ray examination of non-teaching staffs at schools, the routine tuberculin testing of entrants to schools, and the B.C.G. vaccination of older school children.

X-ray examination of non-teaching staffs at schools.—In my Report for 1952 I referred to Circular 248 of the Ministry of Education which requires all new entrants to the teaching profession to undergo an X-ray examination of the chest before appointment and which also revises the regulations regarding the suspension from employment of teachers suffering from tuberculosis. Although this constituted an advance in the arrangements to safeguard children from tuberculosis, it appeared desirable to direct attention to the non-teaching staffs whose duties brought them into regular contact with children and early in 1953 the Authority agreed that all non-teaching staffs of schools would be required to undergo an X-ray examination of the chest prior to taking up employment, including temporary and part-time workers who would not otherwise be required to pass a medical examination.

Towards the end of the year consideration was also given to the question of applying to non-teaching staffs the regulations applicable to teachers who are absent suffering from tuberculosis as regards the submission of medical certificates and suspension from employment. It is to be hoped that the Authority will agree to this measure but if non-teaching staffs are to be encouraged to divulge the fact that they have the disease, it is only equitable that they receive the same favourable conditions as the teachers as regards payment of salary or wages during the period of absence from duty.

Tuberculin Testing of Entrants.—Following a report by Dr. Harvey, Paediatrician, the Authority agreed early in 1953 to the routine tuberculin jelly testing of entrants to the schools, and pilot surveys were undertaken during the year in a few Divisions of the County. It was felt that routine tuberculin testing of the young school child could prove worthwhile as positive results would lead to:—

(a) the search for a responsible source of infection thus affording a valuable method of tuberculosis case-finding, and

(b) the placing of the young child under careful medical supervision until the risks following primary infection could be eliminated.

It was felt that negative results to the test could also be of value in diagnosing obscure illnesses in childhood by cancelling out suspicions of various forms of tuberculosis, and would direct diagnosis to other alternatives.

The following is a report submitted by Dr. J. M. Russell, Divisional Medical Officer, who carried out a survey in some of the schools in the Wortley (No. 22) Division:—

"During December, 1953, and January, 1954, I Patch Tested the school entrants in the Hoyland and Stocksbridge districts, and these are the results of the survey.

HOYLAND DISTRICT

School	Reactors		
	Positive	Negative	Total
St. Helen's R.C. School	1	27	28
Elsecar C.E. School	11	27	38
Hoyland Common Council School	5	43	48
West Street Council School	3	39	42
Market Street Council School	—	66	66
King Street Council School	4	40	44
Total	24	242	266

The above results would indicate that approximately 9% of this selected group of children were positive reactors to the Jelly Test. This figure is slightly higher than the average, but the relatively high percentage in the one school—Elsecar, naturally tends to raise the general average.

REACTORS.

Out of the total of 24 children who reacted to the test, 4 were already known to the Tuberculosis Health Visitor as being contacts with known cases of Tuberculosis. Some of the children were, in fact, already being regularly checked by the Chest Physician. The remaining 20 were all referred to the Chest Physician for examination, and all were X-rayed. At the same time all members of each respective reactor's family were invited to the Chest Clinic for a check-up, and 12 child contacts, together with 42 adult contacts, were X-rayed. A thorough investigation was made into the probable source of infection and none was discovered after the most exhaustive enquiries. At the present moment 3 of those reactor children are still under observation at the Chest Clinic.

There is one feature of this survey to which I must draw particular attention, and that is the relatively high number of positive patch tests in Elsecar School, a little less than 33% positive in the school. At once one was suspicious that there was a source of infection somewhere in the school with which those children were coming in contact. I visited the school personally, consulted with all the staff, the canteen workers and the caretaker, and I am very glad to say that all were so co-operative and helpful that they each volunteered to go for a thorough check-up at the Chest Clinic. I am also glad to be able to say that no evidence of infection was found amongst any of them and one must conclude that this high rate of reactors in the school just happened to be coincidental at that time.

STOCKSBRIDGE DISTRICT

School	Reactors		
	Positive	Negative	Total
Stocksbridge Council School	12	113	125
Stocksbridge C.E. School	1	40	41
Deepcar C.E. School	3	39	42
Total	16	192	208

The above figure indicates, therefore, that approximately 7% of this selected group of children were positive reactors to the Jelly Test. This is a fair average for such a selected group.

REACTORS.

Out of the total of 16 reactors, 6 were already known, having been in contact with positive cases of Tuberculosis in the family. It was decided that a thorough investigation would be made in the families of the remaining 10 cases. The Tuberculosis Health Visitor visited each home, made exhaustive enquiries, and was extremely fortunate in getting all members of each family to attend at the Chest Clinic for a routine check.

This check involved a considerable amount of clinical work on the part of the Chest Physician and his staff, and altogether involved the making of approximately 50 X-ray examinations. As a result of this extensive investigation, only one previously unknown case of infection was discovered. This was an elderly man whom the Chest Physician thought might be infectious, and steps were taken immediately to arrange for his treatment.

All other probable sources of infection to which the reactors might have been exposed were also fully investigated, with negative results. Needless to say, all those children shall have supervision for the next year or two as a precautionary measure.

As a complementary feature to this report I might add that I have now completed arrangements, along with the Divisional Education Officer, for all the school leavers in the Hoyland, High Green, Chapeltown, and Ecclesfield districts (over 900 pupils and staff) to attend the Mass Radiography Unit during the period it is established in Chapeltown. The dates fixed are the 8th and 9th April, 1954.

Similarly, I am at present engaged in preparatory arrangements in connection with the visit of all school leavers in the Stocksbridge, Oughtibridge, and Stannington area to the Mobile X-ray Unit when it visits Stocksbridge early in May, 1954."

B.C.G. Vaccination of Older School Children.—Towards the end of 1953 Circular 22/53 was issued to Local Health Authorities by the Ministry of Health. The Circular indicated that approval would be given to applications by Local Health Authorities to extend the scheme of B.C.G. vaccination (at present limited to contacts of known cases of tuberculosis) to older school children who had reached their thirteenth birthday and were not yet fourteen. The Ministry indicated that as a result of trials both here and abroad, it could now be assumed that the vaccine would confer some degree of protection against an infection of virulent tuberculosis, which would, in turn, probably lead to a lower incidence of active tuberculosis in its various forms.

By the end of the year a scheme was in the course of preparation for early submission to the Health Committee, and fuller details will be given in the Report for the year 1954.

The Work of a Children's Specialist in the School Health Service

The following notes relating to school children are taken from a report on the year's work submitted by Dr. Harvey, Paediatrician:—

The Delicate Child

There are still occasional instances of children losing much school time for prolonged periods on the supposition that they are delicate. For instance, one girl had in the Junior School attended the Sun-Ray Clinic two mornings every week for 2 years, to which enormous loss of school time her mother attributed, with some probability, her failure to get a Grammar School scholarship like her older sister. This girl only later reached the Paediatric Consultant Clinic, when her constitution and her fair, pale complexion and slim physique were found normal. I personally would welcome early consultation with School Medical Officers over such interesting problems as this, for which we could do much more than for some of the bed wetters, who are referred so freely.

MIGRAINE in childhood is best discussed in this section, since it is commonly misdiagnosed and is a puzzle and consternation to parents, teachers and doctors for years. The child is regarded as a mystery sufferer. This is probably because textbooks describe migraine as rare in childhood. In our experience it is one of the commonest disorders of school children. At one Divisional Paediatric Clinic 3 new migraines were recorded on one morning—boys of 14, 14 and 12 years. We fail to recognize it because children, in their inexperience, cannot describe the classical symptoms as they occur. Moreover, the typical headache of adults is often replaced by abdominal pain which goes with the vomiting in childhood. In one boy the pain was sub-sternal. It was too bad that in his case his mother failed to recognize migraine, of which she has had a lifetime's experience in her husband. This boy gave a clear account of full fortification spectra on a dozen occasions. Among older children onset of attacks can often be predicted in time to give drugs to abort attacks. "Cyclical Vomiting" at any age is, in my practice, rarely seen.

ASTHMA. "The Asthma, the grown-ups had told him, was an illness, but Ben had known quite well that he choked because his father and mother quarrelled . . . . He had understood it all quite well in his own mind, but he hadn't been able to explain it; so he had had to go on choking." ("The Bird in the Tree"—Elizabeth Goudge).

This quotation agrees closely with our experience of many asthmatic children, though emotional insecurity and distress is only part of the complex picture. The attitude of parents often makes all the difference between success and failure in our regime of physiotherapy, sport, swimming, hygiene and drugs. At a follow-up clinic visit we know before the words are spoken by the tight-lipped scowling female parent (spoken in the tone of demanding her money back from the Health Service) that " his chest is no better". In refreshing contrast there was the optimistic mother of Pamela, aged 8, who had not only obtained decisive relief through physiotherapy breathing exercises, but had gone on to teach her own exercises to her asthmatic grandmother and aunt.

A recent visit to Netherside Hall School makes me wonder what happens to the hard core of resistant asthma in senior school children. Do they leave school to become a long term burden upon the employment authorities as a group of unemployable adult respiratory invalids? This would perhaps be a fruitful and feasible task of Social Medicine Research which might be undertaken between School Medical Officers, Youth Employment Officers, Disablement Rehabilitation Officers, and a University Department of Social Medicine.

RECURRING NOCTURNAL COUGH continues to be a main cause of anxiety in parents, and of consultant reference by family doctors. We could probably, with more detailed study, differentiate two groups:—

(a) Irritable cough due to post-nasal drip from infected sinuses.

(b) A more paroxysmal cough, deep toned, noisy, like a dog barking, in which there is no post-nasal discharge or X-ray opacity of sinuses. Parents seem to accept some comfort from describing this tracheal tickle as "all bark and no bite".

I am intrigued by the morale value of showing the parent the chest X-rays of such children —"I feel so much better now I've SEEN that". Why they have to see with their eyes that which they are not skilled to interpret I cannot explain—perhaps here also preventive education is needed.

School Children's Hearts

New cases of rheumatic heart disease continue, happily, not very numerous. Unfortunately, many cases of probable Rheumatic Fever are treated in bed at home with small doses of aspirin, which mask the pain and swelling without giving the benefit of high dosage of salicylates which could be afforded in a special Hospital Department. During the year it has been gratifying to secure re-check at the age of 18 or 19 years of several borderline cases of supposed minimal rheumatic mitral valve scarring. Several of these were found to have no murmur or sign of damage whatever: the murmurs had probably been innocent all along.

Study of our records of over 200 innocent heart murmurs, with the anxiety and repression of games for many of them, prompts the odd speculation that the stethoscope may cause more distress than it relieves at medical inspection of healthy children. A detailed study is being prepared for publication.

Surgical progress with congenital heart disease (as with rheumatic mitral stenosis) now makes the expert study of these children imperative. It seems reasonable now to propose every persistent ductus arteriosus for surgical ligation just before entering school. I am glad to acknowledge the most valuable and practical consultation reports given for many of our children by Dr. James W. Brown at the newly opened Regional Cardio-Vascular Centre at the City General Hospital, Sheffield. For the last time I express my keen indebtedness also to Professor E. J. Wayne who has now left Sheffield for the Regius Chair of Medicine at Glasgow.

Bed Wetting

I am impressed more than ever by the quintessential gormlessness of mothers leaving their enuretic children to lie abed till 7.45 every morning, as well as their neglect in many cases to lift the child at their own bedtime. I suppose an elementary knowledge of bladder physiology cannot be taken for granted. We have to explain that in many children the kidney output of urine is very brisk during the first hour of sleep, so that the bladder may be distended to danger point before parents retire. In most households mother or father is up again by 6.0 a.m. and could relieve the further distention of a long night's sleep. Something can be done by voluntary training of the bladder capacity by day to hold 10 to 15 ozs. and thus improve the subconscious capacity by night. Parents further may need encouragement not to natter or show a defeatist tendency. They need to be told that Amphetamine does not act as a once for all cure by a single box of tablets. If significant improvement is not obtained by these measures, then our problem is which cases to select for the Urologist and which for the Psychiatrist. School Medical Officers could sometimes save pressure on their Paediatric Clinic lists by getting parents to go through all the routine drill outlined above before the first Paediatric Consultation.

Emotional Disorders

During November I encountered several acute problems of truancy and panic absentees from school. One was a 10 year old only son of kindly ineffectual parents, heart-broken at being kept down instead of being promoted with his friends to the next class, where he would have commenced art. He was accommodated by compromise at another school a mile away. The next was an 11 year old only girl of a hemiplegic mother, desolated by the impersonal magnitude of the Secondary Modern School, a long bus journey from home. In her case there was emotional immaturity with a wide scatter of retarded attainment. The third, a very spoilt 11 year old boy, began truanting in his first weeks at the Secondary Modern School through fright of the rough boys. He was lucky enough to be fitted in successfully under a sympathetic Headmaster at a neighbouring authority's school, where his grandparents lived. A considerable number of "Child Guidance" problems can be solved at the domestic level of School and Family Doctor and Paediatrician, though we keenly appreciate consultation with Psychiatrist and Psychologist in the more complex cases.

I am impressed by recurring cases of emotional breakdown at Grammar Schools, which are apparently due to poor cultural standards in the home. In one case, the father outspokenly grudged his 14 year old daughter any table space for homework in the evenings and derided the benefit she might get from wasting time at the Grammar School. (Her presenting symptoms were limb pains and dizzy sensations). In two other instances, mothers were bitterly at loggerheads with Form Mistresses over homework and made a great story about health breakdown, apparently more in the parent than the child.

It is intriguing how many adopted and step-children are not allowed to know the facts— even the respectable facts— about their birth; thus, one rheumatic boy, whose father had died of tubercle the month before his birth, is not allowed to know even when 8 years old that he is not the son of his stepfather, lest he love the latter less.

Thread-Worm Neurosis

We were all squirming at the end of 20 minutes with the tense, unstable mother of a miserable 11 year old only child, whose scholarship prospects were in danger through mother's nattering about her lifelong warfare upon thread-worms.

I have not seen much of the emotional problems of crossed laterality in school children, but this seemed to be the likely basis of peculiar tantrums in a twin boy who, in the Infant School, had appeared to be educationally sub-normal, but by 9 years old was managing lessons well.

Only preventive education on a broad front can cut down the large number of unhappy households, where parents are terrified that some mortal disease is threatening their tall or pale or thin or languid offspring.

Keighley Excepted District

The following report on the year's work is submitted by Dr. H. M. Holt, the School Medical Officer to the Keighley Excepted District:—

I have the honour to submit this, my twenty-fourth Annual Report on the work of the School Health Services of the Borough for the year 1953.

Perhaps the most gratifying feature during the year was the establishment of the Mental Health Social Worker and the Speech Therapist in the School Clinic under conditions where their work could be efficiently carried out. The time spent in adapting this accommodation to their particular needs has proved well worth while and I am glad to see a well organised service in operation.

The appointment of a Physiotherapist after a vacancy lasting two and a half years was a great relief; Mr. Skinner succeeded Mrs. Murray after an interval of fourteen days, and it is to be hoped that we may now look forward to a complete recovery of this important branch of the School Health Service.

Although the number of children immunised against Whooping Cough shows a gratifying increase as compared with last year's figure I should like to see a much greater response, particularly in the under 6 months group. I have every reason to believe that this procedure is sound in principle and in practice, and I appeal to all parents to make full use of it in the prevention of a serious and most distressing disease.

I am glad to acknowledge the kind co-operation of the Baths Committee of the Keighley Corporation and of the Baths Superintendent in promoting orthopaedic classes at the Public Swimming Baths where school children with various deformities are taught the art of swimming.

These classes are invaluable in a whole range of orthopaedic cases, more particularly in certain "spastic" cases. Apart from the excellent psychological effect they have, no other form of training can provide such beneficial exercise.

I urge all parents of crippled children to consult their own doctor on the advisability of allowing their children to attend these classes.

The rather high incidence of measles during the year 1952 (270 cases) fell during the year under review (113 cases).

I am glad to acknowledge the support of my staff, likewise that of the Borough Education Officer and his staff in maintaining the efficiency of the School Health Service.

I am,

Your obedient Servant,

H. M. Holt
School Medical Officer

Co-ordination

The scheme for co-ordination between the Maternity and Child Welfare and School Health Services continues on much the same lines as hitherto, that is to say School Clinic facilities are at the disposal of Mothers and Children under five years of age by arrangement with the School Medical Officer and the School Dental Surgeons. Specialist Services are available for appropriate cases which may be referred at any time to the consultants at the Keighley Victoria Hospital. Institutional treatment for cases of Tuberculosis is provided by the Regional Hospital Board, the West Riding County Council providing for the training and treatment of Handicapped children.

School Hygiene

Advice is offered on all aspects of School Hygiene. New floors have been installed in the Main Hall at Utley, and in the Main Hall at Haworth Junior, and in the Main Hall at Haworth Secondary Schools. New floors have also been installed in the Classroom at Long Lee, in the Corridors and Toilets at Strong Close, and in the Nursery Hut at Eastwood Infants School. Pipes have been renewed for the outside lavatories and tanks replaced at Worth Village School. Extensive repairs to buildings have been undertaken at St. Mary's C. of E. and East Morton C. of E. Schools. Playgrounds have been re-surfaced at Oakworth, Eastwood, Parkwood and Stanbury Schools. Guard House Junior and Infants and Bracken Bank Junior and Infants Schools were opened during the year. The boiler at the Technical College was converted to automatic stoking. The usual internal and external painting has been carried out at the schools according to rota.

School Medical Inspection

This service provides for the routine medical inspection of all scholars on three separate occasions during their school life with special examinations and re-examinations as necessary, the arrangement being that—

(a) every pupil who is admitted for the first time to a maintained school shall be inspected as soon as possible after the date of admission;

(b) every pupil attending a maintained Primary School shall be inspected during the last year of attendance at such a school;

(c) every pupil attending a maintained Secondary School shall be inspected during the last year of attendance at such a school; and

(d) every pupil attending a maintained school or County College shall be inspected on such other occasions as the Minister may from time to time direct or the Authority with the approval of the Minister may determine.

In addition children attending Nursery Schools are examined at least once per year until reaching compulsory school age and where possible pupils are examined immediately after admission to a maintained Secondary School so as to provide the Head Teacher with details as to whether or not the pupil concerned is fit to take part in games and physical training.

Having regard to the Authority's Youth Employment Service particular attention has been given to the medical examination at para. c. above. The Area Youth Employment Officers are visiting schools and interviewing parents during or near the child's last term at school. In order that they may know whether there is any physical or mental defect which might in the opinion of the Assistant School Medical Officer influence or restrict the choice of employment, pupils receive their final periodic medical inspection at the commencement of or immediately prior to entering upon their last term at school. The greatest care is taken to ensure that all information passed to the Area Youth Employment Officer is treated as confidential.

The average number of pupils on the registers at the end of the year was as follows:—Nursery (40), Primary (5,753), Secondary Modern (1,231), Secondary Grammar (1,217), Secondary Technical (258).

The following table gives details of the number of medical inspections corresponding to the various age groups as set out above, viz. (a)=Entrants, (b)=Second Age Group, (c)=Third Age Group and (d)=Other Periodic Inspections.

TABLE I

A. PERIODIC MEDICAL INSPECTIONS

Number of Inspections in the prescribed Groups.	
Entrants	697
Second Age Group	424
Third Age Group	573
Total	1,694
Number of other Periodic Inspections	
First Year Secondary	101
Grand Total	1,795

B. OTHER INSPECTIONS

Number of Special Inspections	509
Number of Re-inspections	1,238
Total	1,747

C. NO. OF SESSIONS HELD FOR ROUTINE MEDICAL INSPECTIONS

Where the Assistant School Medical Officer was present	87
Where the School Nurse was present	87

D. NO. OF SESSIONS HELD FOR SPECIAL INSPECTIONS

Where the Assistant School Medical Officer was present	46
Where the School Nurse was present	163

Findings of Medical Inspection

(a) GENERAL CONDITION.

Detailed figures regarding the general condition found during the year, at the medical inspection of the routine age groups are shown in the following table:—

TABLE II.

Age Groups	No. of pupils inspected	A (Good)		B (Fair)		C (Poor)	
		No.	% of Col. 2	No.	% of Col. 2	No.	% of Col. 2
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Entrants	697	362	51.94	328	47.05	7	1.00
Second Age Group	424	211	49.76	207	48.82	6	1.41
Third Age Group	573	377	65.79	189	32.98	7	1.22
Other Periodic Inspections	101	74	73.27	27	26.73	—	—
Total	1,795	1,024	57.04	751	41.84	20	1.11

All cases of malnutrition are investigated and parents advised on the care and feeding of these children and the necessity of adequate sleep is emphasised, severe cases being referred to the Open Air School. The provision of free milk and mid-day meals at school has done much to lessen the incidence of malnutrition. The following are particulars of the number of meals and milk provided at Primary and Secondary Modern Schools on two days in the year:—

Date.	*Free Meals.*	*Meals for Payment.*	*Free Milk.*
30.6.53	316	2,756	6,027
17.10.53	283	3,093	6,079

In addition to the above the Authority has made arrangements for the issue of branded foods free of charge to appropriate cases, the distribution of such foods is made on the authorisation of the Assistant School Medical Officer who examines each case prior to an issue being approved. The following foods were distributed under the provisions of this scheme during the year:—

Maltoline	40
Adexolin	848
Vitamin C.	142
Minadex	84
Vitamin B.	383
Fersolate	100
Calcium and Vitamin D.	20

(b) Pupils Found to Require Treatment and Defects Found.

The following table shows the number of individual pupils found at periodic Medical Inspections to require treatment (excluding Dental Diseases and Infestation with Vermin).

Table III

Group	For defective vision (excluding squint)	For any of the other conditions recorded in Table IV	Total Individual Pupils
Entrants	—	83	78
Second Age Group	25	30	55
Third Age Group	32	13	45
Total (Prescribed Groups)	57	126	178
First year Secondary	1	4	5
Grand Total	58	130	183

All defects noted at medical inspections as requiring treatment are included in the following table whether or not treatment was begun prior to the date of the inspection.

Table IV

Defect or Disease	Periodic Inspections		Special Inspections	
	No. of Defects		No. of Defects	
	Requiring Treatment	Requiring to be kept under observation but not requiring treatment	Requiring Treatment	Requiring to be kept under observation but not requiring treatment
Skin	11	37	90	—
Eyes—a. Vision	58	66	27	—
b. Squint	15	6	5	—
c. Other	6	7	33	—
Ears—a. Hearing	1	6	6	—
b. Otitis Media	1	5	19	—
c. Other	—	6	21	—
Nose or Throat	12	149	30	3
Speech	5	7	5	—
Cervical Glands	2	26	9	1
Heart and Circulation	7	29	6	—
Lungs	20	36	11	—
Developmental—a. Hernia	3	4	1	—
b. Other	—	3	—	—
Orthopaedic—a. Posture	1	9	—	—
b. Flat Foot	7	2	2	—
c. Other	14	18	15	—
Nervous System—a. Epilepsy	1	—	1	—
b. Other	5	6	2	—
Psychological—a. Development	—	3	—	—
b. Stability	1	2	3	—
Other	13	50	226	4

Treatment Tables

Treatment provided by the Authority includes all defects treated or under treatment during the year by the Authority's own staff irrespective of how the case was brought to the Authority's notice, i.e. whether by periodic inspection, special inspection or otherwise. Treatment provided otherwise than by the Authority includes all treatment known by the Authority to have been so provided including treatment undertaken by the Regional Hospital Board.

GROUP 1. DISEASES OF THE SKIN (EXCLUDING UNCLEANLINESS)

	Number of cases treated or under treatment during the year.	
	By the Authority.	*Otherwise.*
Ringworm—(1) Scalp	1	—
(2) Body	11	—
Scabies	—	—
Impetigo	54	—
Other skin diseases	126	—
Total	192	—

As is usual, the treatment of cuts, abrasions, septic fingers and skin diseases form a large part of the work carried out at the minor ailments clinic. A large portion of the skin conditions treated comprise impetigo, scabies and ring worm. The number of cases of scabies among school children has fallen considerably as indicated by the figures for the past five years.

1949—18 School children were treated.
1950— 3 School children were treated.
1951—Nil.
1952— 1 School child was treated.
1953—Nil.

GROUP 2. EYE DISEASES—DEFECTIVE VISION AND SQUINT

	Number of cases dealt with	
	By the Authority.	*Otherwise.*
External and other, excluding errors of refraction and squint	54	—
Errors of refraction (including squint)	—	214
Total	54	214
Number of pupils for whom spectacles were—		
(a) prescribed	—	149
(b) obtained	—	130

During the year 158 cases of defective vision and 56 cases of squint were examined by the Visiting Ophthalmic Surgeon, 20 cases of Blepharitis, 19 of Conjunctivitis and 15 of other eye conditions were treated at the minor ailments clinic, these are classified as follows:—

Defective Vision—158	
Hypermetropia	26
Hypermetropic Astigmatism	66
Nystagmus	3
Mixed Astigmatism	10
Myopia	21
Myopic Astigmatism	30
Amblyopia	2
Squint—56	
Hypermetropia	36
Hypermetropic Astigmatism	19
Myopia	1
Other Eye Conditions—54	
Blepharitis	20
Conjunctivitis	19
Non-classified	15

The number of repairs to spectacles and replacements amounted to 214. After testing there were 31 cases in which spectacles were not prescribed and 16 cases where existing spectacles were found to be satisfactory. 18 cases were also referred to the Bradford Eye and Ear Hospital.

GROUP 3. DISEASES AND DEFECTS OF EAR, NOSE AND THROAT

	Number of cases treated:—	
	By the Authority.	*Otherwise.*
Received operative treatment:—		
(a) For Tonsils and Adenoids	—	389
(b) For Other Conditions	—	26
Received other forms of treatment	48	14
Diseases of the Ear	—	5

Of the 48 children who received treatment at the School Clinic 20 were cases of Otitis Media, the remaining 28 were suffering from other ear diseases. In addition 12 children suffering from diseases or defects of the Ear, Nose and Throat were referred to the Consultant at the Keighley Victoria Hospital.

GROUP 4. ORTHOPAEDIC AND POSTURAL DEFECTS

	Number of cases treated in hospital:—	
	Under School Age.	*Attending School.*
No. of children who obtained operative treatment during the year	4	14

It is not generally realised that the scope of the Physiotherapist appointed to the School Health Service is preventive in character. Slight orthopaedic defects noticed by the teacher or their discovery in the course of Routine Medical Inspection are rarely in need of the services of the Orthopaedic Surgeon, their need is the rehabilitation of normal physical function, neglected, they lead to permanent disability and possibly crippledom.

In order to carry out such work successfully, the co-operation of both parent and teacher is essential and it is seldom we find this difficult to obtain. It is gratifying to record that excellent liaison exists between the School Medical Service and the Orthopaedic Department at the Keighley Victoria Hospital.

A child may lose much, sitting out during the P.E. Class, because of some simple defect which could be readily remedied by regular attendance at our physiotherapy clinic. I am glad, therefore, that this branch of the School Health Service is once more in full operation.

The following are details of the cases treated by the physiotherapist during the year:—

	No. of cases.
Asthma	8
Bronchitis and Breathing	7
Pes Planus	8
Hallux Rigidus	1
Valgus Ankles	1
Talipes Equino Varus	1
Genu Valgum	1
Posture	7
Torticollis	1
Erbs Palsy	1
Spastic Monoplegia	1
Hemiplegia	1
Mild Diplegia	2
Anterior Poliomyelitis	1
Congenital Dislocation of the Hip	1
Minor injuries	1
Rheumatism	2
Bronchiectasis	1
Scoliosis	1
	47

Attendances at the Orthopaedic Swimming Class from 1st September, 1953, Winter Session—255.

Summer season numbers are included in the class attendances at the end of the Report.

Group 5. Child Guidance Treatment

	Number of cases treated in the Authority's Child Guidance Clinic
No. of pupils who attended during the year	6

Dr. Mary M. MacTaggart, who was appointed to the Authority's staff on the 1st May, 1951, as a Psychologist, holds her nearest clinic at Shipley where children from this area attend. Of the above 6 children who attended for treatment during the year 1 was a new case and 5 were attending during the previous year; these children made 39 attendances during the year.

Group 6. Speech Therapy

	Number of cases treated:—	
	By the Authority.	*Otherwise.*
Number of pupils treated by Speech Therapist	50	—

Details of the work carried out by the Authority's Speech Therapist during the year is given in the following table.

Table V

	Stammers	—	Speech Defects
Total No. of sessions held during the year		174	
No. of new cases admitted for treatment during year	7		13
No. of cases already attending for treatment from previous year	18		12
Total No. of cases treated	25		25
No. of cases discharged during year—(a) Speech normal	—		6
(b) Unsuitable for treatment	—		—
(c) Left School	5		—
(d) By reason of non-attendance	3		2
(e) Other reasons	3		—
No. of cases awaiting treatment at end of year		32	
No. of visits made to schools		—	
No. of home visits		1	

GROUP 7. OTHER TREATMENTS GIVEN

	Number of cases treated	
	By the Authority.	*Otherwise.*
Miscellaneous minor ailments	616	—
Ultra Violet Light Treatment	49	—
Total	665	—

In addition to the 616 children who received treatment at the clinic for miscellaneous minor ailments a further 58 cases were kept under observation, all cases being initially examined by the Assistant School Medical Officer. Of the 49 school children who received ultra violet light treatment at the School Clinic 12 were still under treatment at the end of the year. The results of the treatment are classified below:—

TABLE VI

Disease	No.	Cured	Result Improved	No. Change	Still under treatment 31/12/53
Asthma	1	—	—	—	1
Adenitis	2	—	2	—	—
Coughs and Colds	19	—	14	1	4
Bronchitis	3	—	1	—	2
Bronchial Catarrh	7	—	5	1	1
Debility	12	—	8	1	3
Boils	1	1	—	—	—
Harrisons Sulcus	1	—	1	—	—
Psoriasis	1	—	—	—	1
Genu Varum	1	—	—	1	—
Rheumatism	1	—	1	—	—
Total	49	1	32	4	12

Through the interavailability of Clinics a further 27 children from the Infant Welfare Department received Ultra Violet Light Treatment, of these 2 were cured, 19 improved, 1 no change and 5 were still under treatment at the end of the year.

Attendance of Parents at Routine Medical Inspections

Every effort is made to ensure the co-operation of the parents and notice is given to the parent of the time and place at which the examination will be held, the parent is entitled to be present at the examination if he so desires. As will be seen from the following table a good proportion of parents attend at the routine inspections.

TABLE VII

Age Group	No. of children	No. of parents present	Percentage
Entrants	697	595	85.36
2nd Age Group	424	264	62.27
3rd Age Group	573	53	9.25
Other Periodic Inspections	101	22	21.78
Total	1,795	934	52.03

Follow-up of Medical Inspections

The School Nurses by making regular visits of inspection during the intervening periods between the routine medical inspections secure a continuous supervision of the health of the school child. Particular attention is given at such inspections to the detection of handicaps, the early defects of vision and hearing, behaviour other than normal and any other abnormalities. A total number of 523 home visits were made by School Nurses during the year.

Infestation with Vermin

The scheme for ensuring cleanliness at schools within the Borough provides, as far as possible, for the inspection of children and their clothing on four separate occasions during the year. Details of the work carried out under the provisions of this scheme are given in the following table:—

TABLE VIII

Total number of examinations in the schools by the school nurses or other authorised persons	21,169
Total number of individual pupils found to be infested	987
Number of individual pupils in respect of whom cleansing notices were issued (Section 54(2) Education Act, 1944)	—
Number of individual pupils in respect of whom cleansing orders were issued (Section 54(3) Education Act, 1944)	—

The Open Air School for Delicate Children

The Open Air School at Braithwaite has accommodation for 50 boys and 50 girls.

The children who attend this school are selected for admission from the secondary modern and primary schools by the School Medical Officer at the routine inspections and the School Clinic. Many children are referred too by their family Doctor, by their teachers and by their parents, who find that the children are not progressing well at ordinary schools.

After admission, each child is examined by the School Medical Officer at least once each term and the parents are invited to be present at these examinations to discuss their child's health and progress.

The relevant figures for 1953 are given below:—

Number of Admissions	27
Number of Re-admissions	5
Number of children discharged as physically fit to attend ordinary schools	14
Number discharged at 15 years for employment	5
Number removed to Secondary Technical School	1
Number removed to Girls' Grammar School	1
Number removed from the district	2
Number removed to Special Schools	4
Number removed for Home Teaching	1

Handicapped Pupils

Details of the number of handicapped pupils are given in the following table.

TABLE IX

Category	At a Special School	At an Ordinary School	At no School	Not receiving suitable education
Blind	1	—	—	—
Partially sighted	4	1	—	1
Deaf	5	—	—	—
Partially deaf	2	5	—	5
Delicate	94	22	—	22
Diabetic	1	1	—	—
Epileptic	2	3	1	4
Maladjusted	2	7	—	7
Other physically handicapped	2	8	1	9
Educationally sub-normal	6	14	—	15
Total	119	61	2	63

There are a further eleven educationally sub-normal children who require education in a special class of an ordinary school, and who are not receiving education suitable to their needs.

Mentally Defective Children

There were five children notified during the year ended 31st December, 1953, under the provisions of Section 57(3) of the Education Act, 1944.

Dental Inspection and Treatment

The arrangement as regards the dental inspection of pupils is that—

(a) Every pupil who is admitted for the first time to a maintained school shall be inspected by a dental officer as soon as possible after the date of his admission, and

(b) Every pupil attending a maintained school or County College shall be inspected by a dental officer on such other occasions as the Minister may from time to time direct.

Details of the inspections and treatment carried out during the year in connection with this service are given in the following table.

TABLE X

1.	No. of Pupils Inspected	4,598
2.	No. found to require treatment	2,666
3.	No. offered treatment	2,655
4.	No. treated	2,458
5.	Attendances made by pupils for treatment	5,087
6.	Extractions:—	
	Temporary	3,978
	Permanent	792
	Total	4,770
7.	Administration of General Anaesthetics	752
8.	Fillings:—	
	Temporary	190
	Permanent	4,048
	Total	4,238
9.	No. of Other Treatments:—	
	Temporary	100
	Permanent	1,464
	Total	1,564

Infectious Diseases

Four cases of Tuberculosis were notified during the year as occurring amongst school children, two were pulmonary, and two non-pulmonary; none of these cases proved to be fatal. Details of all other cases of notifiable infectious disease as occurring amongst the school population during the year 1953 which were notified to the Public Health Department are given in the following table.

TABLE XI

	Children attending Keighley schools	Children attending other schools	No. of Fatal cases
Scarlet Fever	99	2	—
Diphtheria	—	—	—
Pneumonia	—	—	—
Meningococcal Infection	—	—	—
Poliomyelitis	1	—	—
Encephalitis	1	—	—
Dysentery	4	—	—
Para Typhoid Fever	—	—	—
Chicken Pox	2	—	—
German Measles	21	—	—
Whooping Cough	40	—	—
Measles	113	—	1

Immunisation against Diphtheria and Whooping Cough

(a) *Diphtheria*—Facilities are offered free of charge to the parent or guardian of every child for immunisation against diphtheria either by the Authority's staff or by a registered medical practitioner. Details of the number of children immunised against diphtheria are given in the following table:—

TABLE XII

No. of children who received a full course of primary immunisation			No. of children who received re-inforcing injections
0—4	5—14	Total	273
300	18	318	

(b) *Whooping Cough*—The Authority's scheme for immunisation against whooping cough takes the same lines as that for immunisation against diphtheria. Details of the number of children immunised against whooping cough are given in the following table:—

TABLE XIII

No. of children who received a full course of immunisation				
Under 6 months	6 mths. to 1 year	1 and under 2	2 and under 3	3 and under 4
5	129	—	1	1

Co-operation of Teachers, School Attendance Officers, Home Nurses and Voluntary Bodies

(a) *Teachers.*

Teachers assist in the work of the School Medical Service by selecting children suffering from defects and by referring them to the school clinic greatly assist the School Medical Officer in treating them.

(b) *School Attendance Officers.*

As usual the Attendance Officers meet with mentally and physically defective children during the course of their home visits, and by referring them to the school clinic greatly assist the School Medical Officer in treating them.

(c) *Home Nursing Service.*

The Home Nurses are always ready to assist where children require nursing treatment at home.

(d) *Voluntary Bodies.*

(1) The Craven Branch of the National Society for the Prevention of Cruelty to Children.

The report of the local Inspector is as follows:—

"During the period under review 104 new cases were dealt with and classified as under:—

Neglect	47	Abandonment	2
Ill Treatment	12	Moral Danger	2
Immoral Offence	1	Advice Sought	40

These cases involved the welfare of 224 children, 96 boys and 128 girls. In order to encourage progress and check relapse 625 supervisory visits were made.

I have dealt with one medical case concerning a baby of 6 months old who was underweight due to incorrect feeding. The medical authorities were notified and they promptly dealt with the case. The child is now doing well."

(2) The Keighley Infant Aid Society.

The Keighley Infant Aid Society provides assistance in such cases as are appropriate to its sphere of activity.

Miscellaneous

Swimming Instruction.

The Report of the Baths Superintendent—Elementary Schools' Swimming 1953.

Class Attendances		*Attendances by individuals on 2d. tickets*	
Boys	7,400	Boys	6,969
Girls	6,630	Girls	3,371

Results of Instruction

Preliminary Certificate	164
Elementary Certificate	246

The children passing for the Borough Elementary Swimming Certificate also received a free pass to the 2nd Class Swimming Bath for twelve months.

(End of report for the Keighley Excepted District.)

PART VI

THE COUNTY DENTAL SERVICE

The following is the Report of the Principal School Dental Officer and Orthodontic Consultant, Mr. B. R. Townend, F.D.S., R.C.S. (Eng.), L.D.S. (Liv.).

The outstanding event of the year in the School Dental Service of the West Riding has been the opening of the Central Dental Clinic at "The Elms", 9, Bond Street, Wakefield, by the Minister of Education, Miss Florence Horsbrugh, on the 27th November, 1953. Miss Horsbrugh described this clinic as one of the best in the country and paid a tribute to the Dental Services of the County Council. "The Elms" consists of a large house of three storeys which has lent itself admirably for adaptation as a dental centre. The ground floor is devoted to clinical work and comprises a pleasant waiting room and four surgeries. One of the surgeries which contains two operating chairs is devoted to orthodontic treatment with its necessary ancillaries—X-Ray machine, spot-welder, etc. Another surgery with an adjacent recovery room is used exclusively for general anaesthetic cases and the two other surgeries are general purpose units. The first floor is devoted to administration offices and the second floor to laboratories where dentures, inlays, crowns, orthodontic appliances, etc., are made for the whole of the County Dental Service by a staff of technicians.

The establishment of this Centre has given those working in it a new zest for their work and we have been able to widen the scope of treatment given with future possibilities which are almost limitless.

In addition, the adaptation of two former Decontamination Stations at Aughton and Thrybergh has been completed and these two clinics are in commission bringing the total number of clinics in operation to 28.

Recruitment.—This continues to be laggard and it is unfortunate that a number of areas are still in existence where no more than a break-down service can be maintained. There has been, towards the end of the period under review, some slight improvement.

Part-time Dental Officers.—We have augmented our staff somewhat during the past year by employing a number of part-time officers. This expedient—and I like to think of it as no more than an expedient—was recommended by the Ministries of Health and Education. We are now employing 14 such officers at Todmorden, Sowerby Bridge, Brighouse, Castleford, and Wakefield. The sessions they are working are equivalent to those which would be worked by 3½ full-time officers.

Research.—It has always been the policy of the West Riding Dental Service to encourage and foster any researches into various aspects of dentistry. In 1948 the Ministry of Education invited certain Local Education Authorities to participate in a large investigation on the incidence of dental caries in school children, to be followed in five years time by a further investigation on identical lines. This investigation was proposed as a scientific enquiry into the observation which was made after the first World War that the incidence of caries had dropped materially among children whose early years had been spent under War conditions and a few years later had risen again to its customary level.

The figure which was used in this and similar researches and which has an international significance is known as the D.M.F., the initials standing for teeth which are decayed, missing, or filled, so that it represents the number of teeth which have been affected by dental caries in a mouth or in a group. A 5 year age group and a 12 year age group were examined. The results of the 1948 investigation were published in "The Health of the School Child" 1949 and it is expected that the investigation that was carried out in 1953 will be published, in the same publication, shortly. In the meantime, both sets of figures for the West Riding are available.

Incidence of dental caries in the West Riding of Yorkshire

Year	No. of Children Examined	No. of D.M.F. Teeth	No. of Children showing no D.M.F. teeth	Percentage of children showing no D.M.F. teeth	Average No. of D.M.F. teeth per child
		5 Year Age	Group		
1948	5,034	22,150	1,138	22.6	4 4
1953	4,934	24,507	781	15.8	5.0
		12 year Age	Group		
1948	1,876	5,440	364	19.3	2.9
1953	4,228	17,594	446	10.5	4.2

The figures for the West Riding in the 1948 investigation corresponded very closely indeed with the figures for all areas and there is every reason to suppose that the figures for all areas collected in 1953 will show a similar correspondence to the West Riding figures.

These figures are very interesting and significant. They confirm the observations that were made after the first World War and also confirm the observations which have been made in other countries during and after World War II that the severe rationing of certain foods which became essential because of world shortages, appears to have a beneficial effect upon the incidence of caries. In Norway, for instance, during the Occupation from 1940 to 1945 food rations in the country were very small and nutritional-hygienic conditions were poor. In spite of this situation which gave rise to anxiety in many respects the incidence of dental caries fell to half; it rose again rapidly as soon as the Occupation was over and rationing gradually ceased. The Channel Isles children who spent the war years under Nazi Occupation had, at the end of the War, better teeth than their brothers and sisters who had spent those years as refugees in this country where restrictions and shortages had been nothing like so severe as in their homeland.

There has been brought together, during the past half century, overwhelming evidence that the excessive consumption of sugar in various forms is one of the most important factors in the production of dental caries and it seems significant that a marked shortage of this substance was a characteristic of war-time diet. Although we cannot be absolutely certain, all the evidence seems to suggest that the increase in the incidence of dental caries which has occurred after the War is largely the result of the increase in sugar consumption.

It is very difficult to change the dietetic habits of a nation and it is not the function of the dental profession to suggest whether or how this difficult task should be attempted. It is, however, the duty and responsibility of all engaged in Public Health activities to warn the public of the dangers of excessive sugar consumption either in the form of cakes, pastries and biscuits, or in solution as soft drinks, many if not most of which products contain no highly important nutritional factors.

Dental Treatment of Expectant and Nursing Mothers.—There has been a substantial increase in the number of M. and C.W. cases referred for treatment. Nine hundred more than last year. It is interesting to remember that in 1948 when we were just beginning to develop this service after the War the number was 161. The following table indicates the work which has been carried out for expectant and nursing mothers by our own dental officers and private practitioners under the County scheme.

	County Dental Officers	Private Practitioners	Total
No. of cases referred for examination	822	2,603	3,425
No. of cases examined	677	2,050	2,727
No. found to require treatment	643	2,030	2,673
No. treated	479	1,264	1,743
No. made dentally fit	452	1,184	1,636
No. of extractions	3,661	9,292	12,953
No. of teeth conserved	508	2,190	2,698
No. of Local Anaesthetics	120	534	654
No. of General Anaesthetics	376	746	1,122
No. of Scalings	193	687	880
No. of Dentures—Complete	228	936	1,164
Partial	100	520	620

Analysis of the Work carried out during the Year.—The information concerning dental treatment provided for school children in Table V on Page 70 gives a very limited picture of the actual work done and the following implementations and refinements to the Table may be of interest.

EXTRACTIONS—The total of 75,998 temporary teeth and 13,816 permanent teeth extracted does not represent, as might be thought, so many teeth which it has been found impossible to save. No less than 11,270 temporary teeth and 2,857 permanent teeth have been extracted with a view to making room for the other teeth or to ensure in various ways that succeeding teeth shall grow in a regular order. Approximately 1 tooth in 6 is extracted with the object of preventing irregularity and ensuring the satisfactory future of the dentition.

FILLINGS—4,160 temporary teeth were conserved by the following means:— 1,257 cement fillings, 623 amalgam fillings, 2,280 combined cement and amalgam fillings. 31,526 first permanent molars and 15,486 other teeth, a total of 47,012 permanent teeth were conserved by the following means— 1,015 cement fillings, 11,961 amalgam fillings, 36,382 combined cement and amalgam fillings, 4,352 silicate (porcelain) fillings. Other treatments of a varied nature include 175 root fillings, 3,934 dressings, 194 crowns, inlays, etc., 5,237 scalings and gum treatments. Dentures were provided in 320 cases to replace teeth lost by accident or disease, 1,154 attendances being made for the necessary work incurred in the fitting of these dentures.

The very large figure of 30,757 other operations which appears in Statistical Table V merits some explanation. It represents an omnibus classification of all cases which receive dental attention of various kinds other than those falling into the categories specifically mentioned in the Table.

It includes such things as 11,994 attendances for orthodontic treatment, 1,154 attendances for prosthetic treatment, 5,237 scalings and gum treatments, 1,149 X-rays, 3,934 dressings, etc.

PART VII

CARE AND AFTER-CARE

Care and After-Care of the Hospital Patient

The link up between hospitals and public health departments is improving. In the south part of the Riding where the Health Visitor has been visiting the patients within the wards, the work is good. The number of visits to individual patients in hospital far exceeds the number requiring care after discharge, and perhaps the stage has now been reached whereby the ward sister and doctors could definitely state which patients wish to see the health visitor in hospital and so save some of the health visitor's time which is so needed in the homes of the people. Much hard work has been put into this liaison with hospitals, not only from the public health side but from matrons and sisters in the hospitals concerned.

In Knaresborough, the work in relation to care of the aged and rehabilitation of hospital aged has grown and the health visitor doing this work states:—

"Looking back over the reports furnished by me since I first undertook this work in 1950, I find there has been a steady increase in the number of cases dealt with. The figures show that there has been an average of twenty-five admissions into Knaresborough Hospital per month during the past year and an average of twelve discharges per month of patients to their own homes or placed in charge of relatives. The general practitioners and various organisations in the area are of the opinion that my work covers the field for the care of the aged, irrespective of whether they are hospital cases or welfare cases which has resulted in my visiting old people who do not require admission into hospital. I am experiencing great difficulty in rehabilitating cases who live alone. Although these old people are sufficiently well to be up and about during the day, owing to their age or disability, it is unsafe for them to be alone at night. If there was a half way house where they could be housed until suitable arrangements were made, this would be a means of relieving the pressure on hospital beds."

From Cleckheaton, the Divisional Medical Officer, Dr. Douglas states:—

"Effective liaison is obtained with the hospitals by personal contact between the Senior Health Visitor and the Almoners of the two Hospital Management Committees concerned. Background reports are rarely asked for formally and most of the after-care required is carried out by the Home Nurses. Notice of discharge of child patients with clinical notes are received from all these hospitals and from the hospitals of the Management Committee No. 11. Reports are also received on the discharge of elderly or chronic sick patients. These are frequently visited by the Health Visitors in the normal course of their work. Background reports for Mental Hospitals are supplied by the Mental Health Social Worker and visitation on discharge from these hospitals is also undertaken by the Mental Health Social Worker."

This same story, however, is not prevalent in all parts of the County and from Dr. Ward in Colne Valley comes this comment:—

"Information from the hospital is practically negligible. Information obtained is 'sought' rather than given. One health visitor continues to visit the Huddersfield Royal Infirmary and St. Luke's and one the Princess Royal. The hospitals could make considerably more of the field worker than they do but until the Hospital Management Committee agrees to co-operate it is doubtful if anything further can be accomplished."

During 1953, health visitors spent 934 sessions in hospitals in comparison with 1,219 the previous year and 708 in 1951. They made 608 special visits to hospitals (1,134 in 1952 and 470 in 1951). Background reports were asked for in 2,597 cases, 5,035 patients were interviewed in hospital and 3,026 were referred to local authorities for care after discharge from hospital. 1,905 were dealt with by Health Visitors, 1,189 by Midwives and 320 by Home Nurses, 93 by County Welfare Officer. 34 patients were referred to convalescent homes, 210 received home help; 102 patients were rehabilitated and 82 transferred to homes for chronic sick. 2,711 special environmental investigations were undertaken and nursing equipment was provided for 21 cases.

From hospitals where there is little or no liaison there were 279 requests for background reports, 51 environmental investigations and after-care was asked for in the following cases—midwifery 246, home nursing 174, health visiting 212. Nursing equipment was asked for in 31 cases and home helps were provided for 44 patients. These numbers have certainly grown since the previous year but for the size of some of the hospitals concerned, the numbers and requests should be as large as the other group.

Tuberculosis

The number of Voluntary Care Committees increased during the year and it is pleasing to report that there was a successful conclusion to the negotiations to expand the activities of the Rotherham Care Committee, hitherto restricted to the County Borough Area, to cover that part of the administrative county which is also served by the Rotherham Chest Clinic. This Committee has continued with little change since its inception in 1929, and demonstrates in a practical way the

link which can be established between the hospital and local health authority service in that its benefits are extended to sanatorium and domiciliary patients alike. Of particular interest amongst its many activities is the scheme whereby tuberculous patients are employed as car park attendants where a small deficit between expenditure on wages, etc. and income from the use of the car park is met by a grant from the care committee funds.

New care committees were established at Brighouse, Harrogate and Ripon, and Pontefract. For these committees and for those already established, the County Council authorised a payment of grants in aid approximating £1 per 1,000 population in the County area served by the respective committees.

Details of the care committees, the areas served and the grants authorised during 1953 are as follows:—

Voluntary Care Committee	*West Riding Divisional Health areas served*	*Grant in Aid*
		£
Brighouse.	Division 18.	60
Castleford.	Castleford only in Division 11.	45
Doncaster.	Divisions 27, 28, 29, 30 and Swinton U.D. and Wath upon Dearne U.D. in Division 26.	215
Goole.	Goole M.B. and R.D. in Division 10.	30
Harrogate & Ripon.	Divisions 7 and 8.	100
Morley	Division 14.	40
Normanton.	Normanton only in Division 11.	20
Pontefract.	Division 12.	55
Rotherham	Division 31 and Rawmarsh U.D. in Division 26.	100
		Total 665

9,497 grants of extra nourishment comprising two pints of milk daily for a period not exceeding two months were made to 2,417 patients during the year on the recommendation of the responsible chest physician. Domiciliary open-air shelters continue to be available for use as required.

A further seven patients were admitted to and eleven discharged from institutional training and resettlement centres leaving twelve at such institutions at the end of the year; at Derwen Cripples' Training College, Oswestry, Shropshire (1); Enham Alamein Village Centre, Andover, Hants. (2); Papworth Village Settlement, Cambridge (8); and British Legion Village, Preston Hall, Maidstone, Kent (1).

The amount of handicrafts instruction provided for the domiciliary tuberculous patient is at present limited. With a view to resolving the extent of the problem, discussions with the County Welfare Officer suggest that a pilot survey may indicate whether or not this work can be integrated with the handicrafts instruction to be provided for handicapped persons under the provisions of the National Assistance Act, 1948.

Recuperative Homes

501 applications were received for admission to recuperative homes and 139 (28%) were cancelled. Two remained on the waiting list at the end of the year and the remaining 360 comprising 94 men, 260 women (including 23 with children) and 6 children were admitted to Blackburn & District Convalescent Home, St. Annes-on-Sea; West Hill Convalescent Home, Southport; British Red Cross Convalescent Home, Reading; Men's Convalescent Home, Rhyl; N.E.C.F.S. Convalescent Home, Grange-over-Sands; Hunstanton Convalescent Home, Norfolk; Rockfield Convalescent Home, St. Annes-on-Sea; Shoreston Hall, Seahouses, Northumberland; Doxford Hall, Chathill, Northumberland; Binswood Convalescent Home, Didsbury, Manchester; Silver Jubilee Home, Heysham; Sydney House, Abergele, North Wales; Spofforth Hall, Spofforth; Brentwood Recuperative Centre, Marple, Cheshire; Boarbank Hall, Grange-over-Sands; St. Joseph's Convalescent Home, Freshfield; Ormerod Convalescent Home, St. Annes-on-Sea; Swanscoe House, Macclesfield.

Health Visiting

During 1953, the pattern of Health Visiting has established itself more firmly. The new duties which have come to the Health Visitor are now being carried out with ease. Discernment in visiting necessitous cases in place of routine visiting seems to be formulating in the new idea of things to come.

The Health Visitors have paid many visits to the aged and these have been greatly appreciated by the old people. In some areas there is a very good voluntary committee which helps with the aged and the Health Visitor is able to put them in touch with each other.

Health Education in schools and clinics is now growing, particularly in the former where the facilities are greater. Primarily the Health Visitor's work lies in the field but great value can be

obtained by group teaching both at Ante-natal clinics and Infant Welfare Centres. The majority of buildings used as Infant Welfare Centres are not suitable for adaptation for group teaching so on the whole very little is done except perhaps at the Ante-natal clinic or where a special mothercraft class is held apart from the Welfare Class. This means that individual teaching is given; this has its place but is not so useful as group teaching because from group teaching arise discussions which means the mothers are interested. More visual aids for teaching are needed in the clinics; progress has been made by some Health Visitors who have made their own. There would seem to be more value in having a small Health Visitor clinic weekly with a Doctor's session only once a month.

The Health Visitor is a welcome visitor in the homes of the people and there is no doubt she has won for herself, through her friendly advice and teaching, a place in the lives of the families which she visits. There does seem to be a higher standard of mothercraft throughout the County. Home Visits by Health Visitors increased again this year, the total number being 593,279; this number was made up of 12,460 pre-natal visits, 176,244 visits to 0—1 and 240,950 to children aged 1—5 years. There were 163,625 visits to other cases which include aged, hospitals, home helps and almost anything not dealing with the above categories.

The staffing position is stationary; students are not coming in for the training, possibly because the grant paid by the West Riding during training is not equable with other authorities. Under the County Council's Assisted Training Scheme, 23 students completed their training at Leeds University but the intake was only 18. Health Visitors from other authorities were appointed making 36 appointments in all. There were 4 retirements and 27 resignations, making a total of 31. This gives an increase of five qualified Health Visitors over the year but 33 more are needed.

Post Certificate Training of Health Visiting Staff.—A short week-end course on "The Study of Disease in Childhood" was held at Grantley Hall in November, 1953. Dr. Cedric Harvey gave the inaugural lecture on "Feeding Problems in Infancy". Dr. F. J. W. Miller, Lecturer in Paediatrics in the Department of Child Health, Durham University, was most helpful in his approach to "The Study of Illness in Early Childhood" and again on "The Natural History of Tuberculosis in Childhood". In both his talks and in the discussions which followed, his appreciation of the work of the Health Visitor in relation to research was shown. Miss Elsie Stephenson, Chief Nursing Officer to the City of Newcastle-on-Tyne gave a very interesting talk on "The Health Visitor's Part in the Prevention of Tuberculosis". This was ably illustrated by a flannel graph. Emphasis was placed on the Health Visitor being the whole-time Health Visitor and including tuberculosis with the other work; it had been found that Health Visitors doing this had been of infinite value in knowing possible contacts and of having a good link with the family.

Twenty-five Health Visitors attended other Post Certificate Courses during 1953; Royal College of Nursing, London, 4; Birmingham 1; Women Public Health Officers' Association, Cambridge 12; Edinburgh 3; Cardiff 3; Intensive Teaching Course, Leicester 2. Most of these Health Visitors have sent in letters of appreciation to the County Council. Five monthly conferences were held during 1953, four lectures given and one discussion group; the conferences were very well attended throughout the period. The programme was as follows:—

March.	"Treatment of Poliomyelitis" Miss Marion Pearson, F.R.C.S., Consultant Orthopaedic Surgeon, Wakefield.
April.	"Some recent advances in Children's Diseases" Dr. C. C. Harvey, Paediatrician, W.R.C.C.
May.	"The General Practitioner Service of To-day" Dr. Moray Melvin, Lofthouse, Wakefield.
June.	"Asthma" Dr. Maxwell Telling, Consultant Physician, Leeds.

Supervisory Staff.—Miss A. M. Clarke has continued doing the organisation and supervision of the student Health Visitors' work in the field and the tutoring at Leeds University. Miss A. Carey and Miss R. O'Brien have been able to concentrate on any new Health Visitors, to help in special problems in the Divisions and to give guidance in teaching Health Education in Clinics. Miss O'Brien has done a complete survey of all the Health Visitors' work in her area; she has paid 254 visits to Health Visitors, 6 to Tuberculosis Visitors, 5 to School Nurses, 242 to Child Welfare Centres, 40 to Ante-natal clinics, 27 to School Clinics, 5 to U.V.R. Clinics, 4 to Chest Clinics and 24 to Cleanliness Inspections. She has also visited Divisional Offices to assist in appointment of staff and the Department of Preventive Medicine, Leeds University, in relation to appointing Student Health Visitors. Miss Carey was able to do a complete survey of all her divisions during 1953; she has paid 195 visits to Health Visitors, 11 to Tuberculosis Nurses, 9 to School Nurses, 173 to Infant Welfare Centres, 36 to Ante-natal Clinics, 25 to School Clinics, 4 to U.V.R. Clinics, 4 to Chest Clinics, 13 to Cleanliness Inspections in Schools, 36 to Divisional Medical Officers and 7 for staff appointments.

The work in connection with the after-care of premature babies discharged from Leeds Maternity Hospital has gone very smoothly during the past year. Miss Carey has paid 27 visits to the hospital and 15 to Health Visitors in connection with this work, 13 special visits to homes where there was an expected discharge from hospital and 8 visits to Divisional Medical Officers. There were 37 premature babies discharged during 1953 and 6 who were not premature but needed a special follow up. Health Visitors doing this work have co-operated with general practitioners and all has gone well. The main need, however, is nursing care and mothercraft and the Health

Visitors have coped with this satisfactorily. There have been no discharges of premature babies from hospital before the 14th day but quite a few before the weight had reached 5 lbs. In these cases the babies were vigorous and thriving, the home conditions satisfactory and parents anxious and willing to look after the baby.

Home Nursing

The work of the Home Nurse has expanded slightly during 1953 but there is now a good foundation on which to build. The trend in many areas is still to increase further the number of injections given by Home Nurses. Some difficulty has been experienced in the housing of Home Nurses particularly where there is no furnished accommodation. There has also been some anxiety over Home Nurses being non-car drivers; many have had to pay for lessons and no facilities for practice are offered to them.

There were 294 Nurses on the staff in December, 1953; of these, 71 were Home Nurse/Midwives. There were 35 resignations and 38 new appointments; of these, 18 were trained under the West Riding Scheme.

In the six months from July to December, 1948, the Home Nurses undertook 220,830 visits to 36,784 patients since when, the annual figures alone shew the marked expansion of the service as follows:—

1949	604,154	visits to	38,688	cases.
1950	668,440	,, ,,	32,745	,,
1951	716,996	,, ,,	31,603	,,
1952	740,426	,, ,,	34,308	,,
1953	755,864	,, ,,	39,102	,,

A revised classification adopted by the Ministry of Health gives the following analysis of the work during the past year.

Type of Case Attended.	*No. of cases attended*	*No. of Visits by Home Nurses*
Medical	27,173	559,030
Surgical	10,852	177,250
Infectious Diseases	169	1,448
Tuberculosis	506	14,314
Maternal Complications	402	3,822
Total	39,102	755,864
Age Groups.		
0—5	3,496	28,178
5—65	21,111	322,333
Over 65	14,495	405,353
Total	39,102	755,864
Patients included above who have had more than 24 visits during the year	4,603	300,147

Post Certificate week—Grantley Hall.—Another successful study week was arranged for Home Nurses. In addition to lectures on modern treatments and drugs, they were also given demonstrations of nursing technique which has proved very helpful to the nurses when they went back to the district.

Supervisory Staff.—Miss Jones and Mrs. Taylor have continued doing the supervision of Home Nurses and Home Nurse/Midwives. Miss Jones did 154 routine inspections, 42 special visits and 58 visits to Divisional Medical Officers. Mrs. Taylor did 176 routine inspections, 81 special visits to nurses, 80 visits to Divisional Medical Officers. Both Supervisors attended Divisional Nurses' Meetings and interviewed new staff in divisions when necessary.

Home Help Service

It is now five years since this service was inaugurated during which time, there has become a greater realisation of the importance of the home help; in fact, it can now be regarded that in essence, she is a key social worker. Her work may involve the aiding of the sick, attending the mother during confinement and lying-in, in addition to which she will make the necessary arrangements for the feeding of other members of the family. In respect of the aged who come within her care, she renders cleanliness and comfort within their homes and may often assist in household budgeting. She is in daily contact with the Health Visitor, Home Nurse or Midwife with whom she must work in close co-operation.

During the year, 8,348 cases received help through the service on which 1,272,556 home help hours were expended as against 7,499 cases and 1,090,923 hours for the year 1952. By far the greatest number of hours was utilised in cases of chronic sickness and aged and infirm, representative of 72.3% of the total. The number of cases still in receipt of help on the 31st of December was 3,674. The statistical details are as follows:—

A. Number of Home Helps employed at 31st December.

(i)	Whole-time	3
(ii)	Whole-time by part-time workers	69
(iii)	Part-time	1,298
	Total	1,370

B. Cases provided with Home Help during the year:—

		No. of Cases	*Hours Employed*
(i)	Maternity	1,959	158,860
(ii)	Tuberculosis	113	28,216
(iii)	Chronic sick, aged and infirm	4,977	921,166
(iv)	Others	1,299	164,314
	Total	8,348	1,272,556

PART VIII

THE AMBULANCE SERVICE

This Service is not under the control of the County Medical Officer. It is in charge of Mr. V. Whitaker, O.B.E., the County Ambulance Officer, who has supplied the following report:—

Demand on the direct Ambulance Service in the period 1st April, 1953 to 31st March, 1954, compared with that for the same period in the year 1952/53, shows increases, calculated in accordance with Ministry requirements, as follows:—

Type of Case	*Year* 1952/53	*Year* 1953/54	*Increase*	*Decrease*
Admissions	37,628	39,444	1,816	
Discharges	30,067	30,378	311	
Transfers	7,539	8,271	732	
Out-patients	290,931	315,780	24,849	
M.D. Children to Special Schools	16,829	1,005		15,824
Accident Patients	6,783	9,254	2,471	
Total	389,777	404,132	30,179	15,824
Total Patient Increase			14,355	
Mileage	2,650,684	2,769,547	118,863	

Admissions.—25% of the admissions increase is accounted for by the rise in the number of road accidents and the remaining 75% from an increase in the number of hospital beds and improved bed "turnover".

The Transfer item refers to the transfer of patients between Hospitals, Annexes and Convalescent Homes and because of an increase in the two latter establishments, more patients need moving.

Out-patient user, in common with other Authorities, has increased yearly since the appointed day and is a problem which cannot continue indefinitely without seriously affecting the availability of ambulances for other classes of patients, a problem with which the Ministry is very concerned. As Hospitals expand facilities, particularly physiotherapy, so the number of authorised users increases. An unusual feature of this latest 8.5% increase is the inclusion of almost 4,000 stretcher cases, which is an indication that more patients who would otherwise occupy hospital beds, are now being treated as out-patients.

For the purpose of the Ministry Costing Returns, each out-patient is calculated as two persons, one to hospital and one from. The actual increase, therefore, is approximately 11,750 actual out-patients, after allowing for those who only need transport home after making their own way in for treatment. This figure, broken down on an ambulance depot basis, represents an average increase of 9 per week per depot. When broken down further, between 210 hospitals of all kinds served (excluding clinics), the approximate average hospital increase is 1 actual out-patient per week, showing that a small increase, which may appear unimportant at Hospital level, has a serious cumulative effect on the Ambulance Service as a whole. It also demonstrates that too much importance cannot be attached to the need to make sure at hospital and clinic level that *every case* is vetted before transport is authorised.

M.D. Children to Special Schools.—In the year 1952, the County Council considered the question of transporting children by ambulance vehicles to Special Schools and approved the policy of using hired transport as being less costly and also giving much needed relief to improve the Service to patients in general by reducing the length of journeys and numbers of patients per vehicle.

Some measure of gain has been made by not having to provide a number of vehicles on school days on a strict time table basis, which previously interfered with the necessary flexibility of the Service. The principal anticipated gain, however, has been taken up by the increase in out-patient work.

Accident Patients.—The increase in this important section of Ambulance work is the result of attending 1,362 more incidents than in the previous period and reflects the serious rise in the accident rate within the County and also the additional responsibility placed on the Service.

Mileage.—Of the additional 118,863 miles run this year, 25,650 miles are connected with vehicle maintenance which is a reduction of 3,666 miles on the previous period, when maintenance miles per vehicle per week were 3.86 miles, now reduced to 3.4 miles.

The administration of operational control has much improved and with the assistance of a further 18 mobile radio sets, making a total of 92, one very important step forward has been made in that all stretcher case Admissions and Discharges are now conveyed individually or limited to two stretcher cases of the same sex per vehicle. This policy gives the highest priority to patients in real need of transport by ambulance, by providing a direct and personal service between home and hospital.

Hospital development, particularly the upgrading of hospitals, such as Goole Bartholomew, is having an effect on the direction of "patient flow". This is reducing the importance of some Ambulance Depots and increasing that of others, a feature which is going to change original plans considerably in the future. An example is the upgrading of the already mentioned hospital in Goole from which area practically 90% of patients previously travelled to Leeds. Today a large proportion attend the local hospital, others travel to Pontefract Hospital and a reduced number attend at Leeds. The result has been a decrease in journeys to Leeds, with fewer patients per vehicle, which has been offset by the additional regular journeys to Pontefract. This change, plus the additional local work is creating more running time and mileage than hitherto and if expansion continues, depot staff and vehicle establishments will have to be reviewed. The real problem in connection with this change in the direction of "patient flow" now taking place in several parts of the County is that a proportion only of patients from depot catchment areas are being taken to more hospital points than previously and it falls to the Ambulance Service to organise more journeys in different directions with facilities at certain depots designed to deal with a "patient flow" in one or two main directions. As far as can be assessed at the moment, this change can be met within the present limits of the Service and also would present no problem whatsoever if out-patient numbers could be reduced.

PART IX

MENTAL HEALTH

There has been little material change in the nature of the Mental Health Service during the year. Greater use has been made during 1953 in providing short stay care for defectives under Section 28 of the National Health Service Act, 1946 as suggested in Circular 5/52 of the Ministry of Health and whereas 33 defectives were provided with short stay care in 1952, there were 86 periods of short stay care during 1953. The demand for this service whereby care is provided for short periods for defectives owing to illness or confinement of the mother or for sickness in the family is increasing rapidly and many requests are now being received, (all of which cannot be met.) for short periods of care to allow the parents to take a holiday or to have a much needed rest from the care of a low grade and often helpless child.

The County Council's Scheme under Section 28 of the National Health Service Act, 1946 has been extended to enable care and after-care and the provision of occupations to be provided for persons suffering from mental illness. By the end of the year 454 persons were receiving care and after-care.

Authority has been given for the staff of Home Teachers to be increased from 18 to 24; one of the Home Teachers returned during the year after taking the 12 months' course of training provided under the County Council's Scheme by the National Association for Mental Health for Supervisors of Occupation Centres etc., and another Home Teacher commenced a similar course in September, 1953.

Lunacy and Mental Treatment Acts.—During 1953 action was taken under the Lunacy and Mental Treatment Acts by the Duly Authorised Officers as follows:—

Lunacy Act, 1890. Patients admitted under Section 16, 487; under Section 20, 177; under Section 21, 19. Assistance with admissions under Section 11 of the Lunacy Act, 1890, in 6 cases; under the Criminal Justice Act, 1930, in 2 cases; under Section 1 of the Mental Treatment Act, 1930, in 191 cases, and under Section 5, in 7 cases. The Duly Authorised Officers were also consulted by general medical practitioners and relatives in 243 cases where action under the Lunacy and Mental Treatment Acts was not considered necessary.

The following table gives the number of certified patients dealt with by the Duly Authorised Officers during the last 4 years and also the number of voluntary and temporary patients who were assisted by the Duly Authorised Officers during the same period.

Year	Lunacy Act, 1890			Mental Treatment Act, 1930	
	Sect. 16:	Sect. 20:	Sect. 21:	Sect. 1:	Sect. 5:
1950	415	162	54	176	13
1951	420	180	71	209	19
1952	421	82	38	246	50
1953	487	177	19	191	7

Some of the increase in certified patients may be attributed to the difficulties experienced by the general medical practitioners in obtaining appropriate accommodation for their mentally infirm older patients, when in desperation they called in the Duly Authorised Officers. Even so, the general medical practitioners were most reluctant to certify their aged patients under the Lunacy Acts but when the Duly Authorised Officers also failed to obtain suitable care and the patients were living alone and their mental condition such that they were a danger to themselves, the Duly Authorised Officers were driven to take Lunacy proceedings.

About two-thirds of the 243 patients where the Duly Authorised Officers took no action under the Lunacy and Mental Treatment Acts were of pensionable age. Quite an appreciable number of these old people lived alone and were found to be physically ill and undernourished. Their sense of loneliness and isolation caused by lack of visits by relatives and friends was often a considerable cause of the deterioration in their mental and physical condition. Relatives and friends were persuaded to visit at regular intervals to offset this feeling of isolation and loneliness; Health Visitors, and others of the County Council Staff visited them weekly or bi-weekly and as they improved they were encouraged to join the old folks clubs. Others, by the efforts of the Duly Authorised Officers, were admitted to chronic sick or Part III accommodation; some to private Nursing Homes whilst some were provided with Home Helps. The problem of these old persons is recognised as one which is growing rapidly and there is urgent need for concerted action by all who can assist in preventing or delaying this decay of physical and mental powers with the aim of keeping these old people at home and happy in their own surroundings.

The reduction in the number of admissions as voluntary patients under Section 1 of the Mental Treatment Act, where assistance was given by the Duly Authorised Officers, clearly indicates the general appreciation of the benefit of early treatment. More patients are now being admitted as voluntary patients without the need to consult the Duly Authorised Officer, some by direct admission from Psychiatric Out-patient Clinics, others by the general practitioners who are now using more frequently the arrangements for such admissions and by many patients re-entering Hospital on their own initiative.

The shortage of Mental Hospital accommodation is still felt. Occasionally, although suspended, Orders have lapsed prior to accommodation being available. The Medical and other staff at the Mental Hospitals are very helpful and if the Duly Authorised Officer experiences difficulty in removing a patient the Hospitals will often provide nursing staff for the removal. The liaison at the out-patient clinics is improving and, when the County Council can obtain the Psychiatric Social Workers they need, it will, no doubt lead to still closer co-operation.

The Mental Health Social Workers furnished background information to the Mental Hospitals in respect of 110 patients and the Medical staff of the Hospitals are most helpful in advising the Social Worker on the after-care needed by patients discharged from the Mental Hospitals. At one of the Mental Hospitals monthly meetings are held for the benefit of the Mental Health Social Workers to discuss with the Mental Hospital staff the patients discharged or about to be discharged and one Social Worker attends the Psychiatric Out-patient clinic on two afternoons per week as liaison officer. There is, however, still need for closer co-ordination of the catchment areas of the Psychiatric clinics and Mental Hospitals.

Mental Deficiency Acts.—During 1953, 294 alleged mentally defective persons were reported to the Local Health Authority or otherwise ascertained, of whom 108 were reported by the Local Education Authority under Section 57 (3) of the Education Act, 1944 and 84 under Section 57 (5); 1 was reported by the Police and 101 were otherwise ascertained. The 287 defectives found "subject to be dealt with" were dealt with as follows:—

Placed under Statutory Supervision 229; placed under Guardianship 2; admitted to Institutions for defectives 14; action not yet completed 42. Of the 7 alleged mental defectives reported during the year and found to be not "subject to be dealt with", 6 were placed under Voluntary Supervision and 1 was found not to be certifiable as a mentally defective person within the meaning of the Acts.

During the year 96 defectives were admitted to Institutions as follows:—

Under Section 6 of the Mental Deficiency Act, 1913, 76; under Section 8, 10; under Section 7 (1), 10. Of these 96 defectives, 67 were admitted to Institutions in the area of the Leeds Regional Hospital Board and 29 to Institutions in the area of the Sheffield Board.

At the 31st December, 1953, the total number of ascertained defectives in the West Riding "subject to be dealt with" or where voluntary action was agreed was as follows:— In Institutions for defectives or on licence therefrom 1,614; under Guardianship 84; under Voluntary Supervision 374; action not yet completed 42; in places of safety 3; under Statutory Supervision 2,071; making a total of 4,188 defectives.

TRAINING.—The County Council have established two Occupation Centres for mentally defective persons, one at Castleford and the other at Keighley, each with accommodation for 45. During the year the temporary Centre at Bingley was closed and transferred to the newly adapted premises at Keighley.

The County Council Scheme provides for the provision of 15 Occupation and Industry Centres in various parts of the Riding and a site has been purchased at Hemsworth and plans approved for an Occupation Centre. Agreement has been reached for the purchase of a site at Wath upon Dearne. When the Divisional Health Office at Wombwell is transferred to Barnsley it is proposed to take over the Wombwell premises as a small Centre, and consideration is being given to the use of other County property for Centre purposes.

In addition, West Riding patients are admitted to the Centres provided by the Leeds, Bradford, Doncaster, Barnsley, Dewsbury, Wakefield, Huddersfield, Oldham and Burnley County Borough Authorities. During the year the Dewsbury County Borough Council offered 12 places for West Riding children in their new Centre and Wakefield County Borough Council offered 19 places in their new Centre. These places were filled and in both cases the number of places allocated to West Riding children were increased before the end of the year.

Arrangements have also been made with the Hospital Management Committee for a few children living within easy reach of the Westwood Hospital, Bradford, to attend the Hospital daily for training.

The meals supplied to the children attending the County Occupation Centres and also a few of the group classes, are obtained through the School Meals Service, which the Minister of Education has now decided must be charged at the full cost and credited to the School Meals Account. When the cost to the parents of School meals was increased from 7d. to 9d. per meal the Mental Health Sub-Committee decided that the charge to the parents of the children attending Occupation Centres should remain at 7d.

In addition to the two Occupation Centres provided by the County Council and the use of the other centres referred to, the Authority have a staff of 18 Home Teachers. In addition to visits to individual patients in their own homes for training purposes, group classes of a few children have been established. There are now 38 such classes, which are held for periods varying from half a day to four whole days each week. These small groups are proving very popular and are an excellent form of providing training, whereby small groups of children can be brought together. As the new Occupation Centres are provided by the Authority, most of these group classes will, of course, be closed and the children will attend the new Centres.

Appended are reports by the Divisional Medical Officers on the Castleford and Keighley Occupation Centres.

Castleford Occupation Centre

(Dr. J. M. Paterson, Divisional Medical Officer.)

Owing to an outbreak of Dysentery in the district and also to the inauguration of a scheme of staggered holidays for miners, the attendances at the Centre were rather lower than in the previous year. In 1952 the total attendances were 6,647 whilst in 1953 they were 5,897.

The year opened with 42 children on the register but by the end of the first term, five of the children were transferred to the newly opened Centre at Wakefield. The balance, however, was soon restored by the admission of further new cases and by the end of the year there were the names of 44 children on the register. One child left to be admitted to an Institution.

In view of their ever growing commitments, the ambulance service was experiencing increasing difficulty in being responsible for the continued transport of children to the Centre and on the re-opening after the Christmas recess, a new transport system came into being whereby children in the Castleford and Pontefract areas were transported from various focal points in the district by a private 'bus service, with a paid escort in attendance.

For a variety of reasons there were no open days and no sale of work at the Centre during the year but a grant from the County Council enabled a trip to Filey to be possible. Needless to say, this was a very great success, enjoyed by all, and especially so by those children who had never previously been privileged to go to the sea.

The Harvest Festival held at the Centre attracted a generous and varied display of produce and the service conducted by the Curate was much appreciated by the staff, parents and friends alike.

Later in the year, just before the holiday, the usual Christmas party was held and was attended by quite a large number of parents, friends and visitors. Each child received a toy contributed by the Yorkshire Evening Post Fund as well as sweets and fruit from other interested persons.

The annual visit of Inspection from the Board of Control fell due on the 2nd December and the Inspector, after an exhaustive survey of the work done at the Centre, and the conditions existing therein, expressed herself well satisfied with the high standard of handwork as well as with the general tone of the Centre.

This Centre continues to fill a very definite need in regard to the social rehabilitation of these poor unfortunates by breaking down the barriers of loneliness and not infrequently instilling in them a degree of socialisation not previously thought possible. One of the main difficulties, however, militating against the full accomplishment of this objective lies in the fact that proper classroom accommodation is sadly lacking and although much can be effected by way of improvisation, the continued need to be observing such a policy can lead to frustration. The County Council, however, are alive to the needs of the Centre and it will probably be only a process of time before this problem will be solved.

Branshaw View Occupation Centre, Keighley.

(Dr. H. M. Holt, Divisional Medical Officer.)

The Occupation Centre at Branshaw View, Oakworth Road, Keighley, was opened on the 28th September, 1953. The Bingley Occupation Centre which it replaced was closed on the 22nd September, 1953; the time which elapsed between this date and the date of opening of Branshaw View was utilised for the collection and transport of equipment and the completion of arrangements for the transfer of the children.

Branshaw View was previously occupied as a Children's Home, though it had remained out of use for some considerable time it was found admirably suited to its new purpose after repairs, renewals and alterations had been carried out. The building stands in its own grounds at the end of a quiet side street, there is an asphalted playground with a round-about and two swings; there is in addition a playing field and ground which may be developed as a garden for the occupational activity of the children.

The Centre is open during term time between the hours of 9.30 a.m. and 3.30 p.m. Meals are supplied by the Keighley Education Committee from their School Canteen at Ingrow, Keighley. For the conveyance of children to and from the Centre, satisfactory arrangements have been entered into with a local firm of transport contractors and a rota of escort duty is operated by the staff. The staff consists of a Supervisor, an Assistant Supervisor, two Nursery Assistants and a Caretaker.

Attendance at the Occupation Centre is optional. Every effort is made to interest the parents in the activities of the Centre and an Open Day to which they are all invited is held at the end of each term. A Parents' Association has been formed and it meets once a month in the evening at the Centre, the staff are usually invited. The aim of the Centre is to develop habit training, physical training, speech training and interest in simple activities within the limitations of individual or small groups of children; little or no emphasis is laid on purely academic subjects.

The number of children in attendance at the Centre on the 30th December, 1953, was 24, the number on the register 34 in age groups as follows:—

YEARS:											
5	6	7	8	9	10	11	12	13	14	15	16
	1M	4M	2M	4M	3M	2M		2M	1M	1M	2M
		1F	1F	3F		3F			1F	1F	2F

The children are under regular medical supervision, the Senior Assistant County Medical Officer pays a visit to the Centre during term time once a week. The Divisional Medical Officer under whose general direction the Centre operates visits once a month.

The Centre, though recently opened, shows every promise of success, it is admirably equipped and the staff show remarkable interest in a task which calls for patience, love and devotion. The parents are highly appreciative of what is being done for their children, their attendance and their expressions of gratitude on open days is evidence enough of this.

PART X

ENVIRONMENTAL HYGIENE

Milk

The County Council, as a Food and Drugs Authority (Section 64 of the Food and Drugs Act, 1938), has completed another year as a Licensing Authority for the Milk (Special Designation) (Pasteurised and Sterilised Milk) Regulations, 1949.

The following list gives the names and addresses of licensees at the 31st December, 1953:—

PASTEURISED MILK.

Busfield & Hargreaves, Rawson Dairy, Rawson Street, Old Fold, Farsley, Nr. Leeds; H. A. Button, Micklethwaite Dairy, York Road, Wetherby; Co-operative Wholesale Society, Ltd., Maxwell Street, Morley; Dobson's Dairies, Ltd., Coates Factory, Barnoldswick; Doncaster Co-operative Society, Ltd., York Road, Doncaster; Goole Co-operative Society, Ltd., Centenary Road, Goole; R. H. Harrison, Manor Farm, Conisbrough, Nr. Doncaster; Kirkby Malzeard Dairy Co., Ltd., Kirkby Malzeard, Nr. Ripon; Knowles Bros., 59, Strawberry Avenue, Garforth, Nr. Leeds; N. L. & J. E. Laurence, The Dairy, Breary Lane, Bramhope, Nr. Leeds; J. Mawer & Sons, Glentworth House, Skellow, Nr. Doncaster; A. E. Maxfield, Ivanhoe Dairy, 37, Church Street, Conisbrough; Miss B. J. Mudd, Aldborough Dairy, Aldborough, Boroughbridge; J. E. & E. Oates, Ltd., North Eastern Road, Thorne, Nr. Doncaster; H. D. Peirson, Victoria Road Dairy, Burley-in-Wharfedale, Nr. Leeds; Pontefract Industrial Co-operative Society, Ltd., Horsefair, Pontefract; Rotherham Co-operative Society, Ltd., Progress Drive, Bramley, Nr. Rotherham; P. Salmon, Orchard House, Littlethorpe, Nr. Ripon; Stocksbridge Co-operative Society, Ltd., Shay House Lane, Stocksbridge; West Marton Dairies, Ltd., West Marton, Skipton; West Riding Dairy Farmers (Wholesale), Ltd., Allan Park Dairy, Sowerby Bridge; Wharfedale Creamery Co., Ltd., Bolton Bridge Road, Ilkley; Whittakers Wholesale Dairies, Ltd., 77, Tenterbalk Lane, Adwick-le-Street; Wholesale Dairies (Rotherham & District) Ltd., Claypit Lane, Rawmarsh; A. Wild, Prospect Farm, Grotton, Nr. Oldham; Windhill Co-operative Society, Ltd., Thomas Place, Windhill, Shipley; A. Yates, 822/824, Halifax Road, Hightown, Liversedge.

STERILISED MILK.

Wholesale Dairies (Rotherham & District) Ltd., Claypit Lane, Rawmarsh.

During the year two licensees ceased to pasteurise milk.

Regular visits and inspections were carried out to the premises of licensees in order to ascertain whether the conditions attached to the licences were being observed and for the purpose of checking the temperatures of milk under treatment, cleanliness of premises, etc., and, in general, to see that the plant and other equipment were satisfactory.

The following conditions apply to milk in relation to which the special designation "Pasteurised" is used:— The milk shall be pasteurised, i.e.:— (a) retained at a temperature of not less than 145°F. and not more than 150°F. for at least 30 minutes and be immediately cooled to a temperature of not more than 50°F., or (b) retained at a temperature of not less than 161°F. for at least fifteen seconds and be immediately cooled to a temperature of not more than 50°F., or (c) retained at such temperature for such period as may be specified by the licensing authority with the approval of the Minister.

Samples of pasteurised milk are subject to the phosphatase and methylene blue tests. The former is to prove the efficiency of the treatment as to whether or not the milk has been properly pasteurised, or whether any raw milk has become mixed after treatment. The methylene blue test shows the keeping quality.

Sterilised milk shall be filtered or clarified, homogenised, and heated to, and maintained at such a temperature, not less than 212°F. for a period as to ensure that it will comply with the prescribed turbidity test.

The test for sterilised milk shall be satisfied by milk which shows no signs of turbidity.

Samples obtained during the year, with results of the examinations are as set out below:—

PASTEURISED MILK

Number	Phosphatase Test			Methylene Blue Test		
	Satisfactory	*Unsatisfactory*	*Invalid*	*Satisfactory*	*Unsatisfactory*	*Invalid*
682	675	7	—	681	1	—

STERILISED MILK

Number	Turbidity Test	
	Satisfactory	*Unsatisfactory*
24	24	—

In the case of the 7 unsatisfactory phosphatase results, immediate visits were made to the dairies concerned and enquiries made regarding the probable causes of the failures.

Sampling of Milk produced at Hospital Farms.— During the year, at the request of the Ministry of Health, samples of milk were obtained at the farms attached to the following hospitals:— Menston, Nr. Leeds; Middleton, Ilkley; Middlewood, Nr. Sheffield; Scalebor Park, Burley-in-Wharfedale; Stanley Royd, Nr. Wakefield; Stansfield View, Todmorden; Storthes Hall, Kirkburton; St. John's, Keighley.

During the prescribed period — March to November — 12 samples were obtained at each farm and these were submitted to the Public Health Laboratory for examination. All the 96 samples were subjected to the methylene blue test and, on four occasions, samples from each farm were subjected to biological examination for the presence of tubercle and brucella abortus. Copies of the reports on the samples were forwarded to the Ministry of Health and the Hospital Boards concerned.

Arrangements are made whereby immediate notification is given to the Ministry of Agriculture and Fisheries in the event of any positive tubercle results. During the year no such notifications were necessary.

Specified Areas for the Sale of Milk.—Section 19 of the Food and Drugs (Milk, Dairies and Artificial Cream) Act, 1950 provides for the compulsory use of special designations for the purpose of all sales of milk by retail for human consumption where the place of sale is in an area specified under Section 23 of the Act by the Ministry of Food to be known for the purposes of the Act as a "Specified Area". The Section has the effect in a "Specified Area" that no milk other than milk of a special designation (pasteurised, sterilised, tuberculin tested and "accredited" milk, from a single herd, until the 30th September, 1954) may be sold in that area, and any person who sells milk without it being milk to which a special designation applies is guilty of an offence. Special arrangements apply to the sale of milk for catering purposes.

A "Specified Area" came into operation on the 1st May, 1953, consisting of the County Boroughs of Barnsley, Rotherham and Sheffield, with the Urban Districts of Cudworth, Darfield, Darton, Dodworth, Hoyland Nether, Rawmarsh, Royston, Swinton, Wath-upon-Dearne, Wombwell and Worsborough, and the Rural District of Rotherham. This Area is the first to be declared in the West Riding.

It is the duty of the Food and Drugs Authorities within the "Specified Area" to carry into execution and enforce the provisions of the Act relating to the sale of designated milk and it became necessary for arrangements to be made in the County Administrative Area for the duties to be carried out.

The County Sanitary Inspectors made approximately 600 visits in connection with this "Area" to ascertain whether or not the regulations were being complied with. In general it was found that the requirements were being observed, with the exception of seven cases, these being subsequently satisfactorily dealt with. Further visits will require to be made from time to time regarding any new milk retailers and catering establishments.

The County Sanitary Inspectors were ably assisted by the Sanitary Inspectors of the County Districts in several instances and I wish to accord my sincere thanks to them for their valued co-operation, also to the officials of the Ministry of Food Regional Offices who similarly gave assistance in furnishing certain details.

Supply of Milk to School Children (Milk-in-Schools Scheme).—The provision of Milk and Meals Regulations, 1945, state:— "1. The source and quality of the milk supplied for drinking shall be approved by the Medical Officer of Health for the County or County Borough concerned after consultation with the Medical Officer of Health for any County District concerned and, if the School Medical Officer is a person other than either of the two officers first mentioned, with that officer. 2. If milk which satisfies the requirements (1) of this Regulation is not available, the Minister may approve the substitution thereof of an equivalent quantity of full-cream dried milk suitably prepared for drinking, and if he so approves the Authority shall make that substitution."

Milk is supplied in one-third pint bottles, with drinking straws. The only exceptions to this arrangement are a few isolated schools, which, of necessity, must be supplied with liquid milk in bulk, distributed by the staff at the school, who supervise the cleansing of the crockery used. The greater part of the milk supplied is pasteurised.

41 visits were made to contractors' premises, apart from the regular routine visits to 13 contractors who hold licenses issued by the County Council under The Milk (Special Designation) (Pasteurised and Sterilised Milk) Regulations, 1949.

The number of samples obtained and results are as set out below:—

	Total	Satisfactory	Unsatisfactory
Pasteurised	461	457 (99.1%)	4
Raw	147	125 (85.0%)	22
Total	608	582 (95.7%)	26

Atmospheric Pollution

SMOKE ABATEMENT—The responsibility for dealing with nuisances arising from smoke emission rests with the County District Councils and the following table shows the work carried out during the year:—

	No. of observations each of 30 minutes duration	*No. of these showing excessive emission of black smoke*	*No. of cautions issued*	*No. of statutory notices served*	*No. of prosecutions*	*Bye-laws in force*	*Districts with colliery spoil-banks*	*Firing of spoil-banks*
Municipal Boroughs and Urban Districts (68)	2,843	345	295	36	—	37	30	16
Rural Districts (21)	126	25	15	1	—	6	9	7

It is pleasing to note that the officials of the National Coal Board are keen to co-operate with the local authorities in dealing with burning spoilbanks and much good work has been carried out during the year.

The Acting Chief County Sanitary Inspector was re-elected a co-opted member of the West Riding of Yorkshire Regional Smoke Abatement Committee, which enables him to keep in touch with the representatives of the various local authorities who serve on this Committee.

THE MEASUREMENT OF ATMOSPHERIC POLLUTION is done throughout the County in co-operation with the Department of Scientific and Industrial Research and the Medical Officers of Health and Sanitary Inspectors in some County Districts give considerable assistance in looking after the recording instruments situate in their respective Districts. All the instruments are of standard pattern being in accordance with the specifications laid down by the Department of Scientific and Industrial Research who were also consulted on the siting of each instrument.

The deposit gauge is for ascertaining the amount and nature of deposited matter from the atmosphere; the lead peroxide instrument is for estimating the amount of atmospheric sulphur dioxide. Chemical examinations in connection with these two instruments are made monthly, and the results thus obtained form a month-to-month record of variations in pollution. The smoke filter is for making regular observations of the daily average concentration of smoke and suspended impurity. Suspended impurity has been found to contain about 14 per cent. by weight of tarry matter and 71 per cent. of other combustible matter. It must therefore be composed largely of the smoke which is produced when coal is incompletely burnt.

The results of the analyses in connection with the deposit gauges and the lead peroxide instruments and the values of the average daily suspended impurity obtained with the smoke filters are shown in the following table:—

Situation of Instruments	Deposit Gauge				Sulphur Measurements by Lead Peroxide Method	Situation of Daily Smoke Filter	Average Daily Suspended Impurity
	Rainfall in inches		Total solids deposited in Tons per sq. mile		Milligrams SO(3) per 100 sq cms. per day		Milligrams per cubic metre
	Monthly Average	Total*	Monthly Average	Total*	Average		Average
Skipton—Behind Town Hall in industrial and residential area.	2.80	33.57	17.06	204.68	0.65	On top floor of Town Hall, in industrial and residential area.	0.182 for 11 months
Keighley—Abattoir, Hardings Road in mainly open country.	2.17	26.06	13.44	161.30	1.49	First floor of Public Health Dept., in a built-up area in centre of town.	0.315
Keighley—Oldfield, Oakworth in windy moorland country.	1.98	21.79 for 11 months	8.05	88.53 for 11 months	1.39		
Keighley—Low Bridge, dense industrial area.	2.47	29.65	16.56	198.66	1.77		
Keighley—Library, built-up area in centre of town.	2.58	30.95	20.14	241.63	1.66		
Bingley—St. Ives Research Station in parkland and residential area.	2.44	29.23	8.58	102.99	1.09	In grounds of St. Ives Research Station, in parkland and residential area.	0.071
Bingley—Town Hall in manufacturing and residential area.	2.33	27.95	8.90	106.78	0.59 for 11 months		
Shipley—Somerset House Clinic in manufacturing and semi-residential area.	1.93	21.18 for 11 months	12.89	141.76 for 11 months	1.33		
Horsforth—Broadgate Walk, residential area.	2.00	24.00	14.55	174.62	1.44		
Aireborough—Yeadon Moor, Yeadon Waterworks. Agricultural N.W. to S.E., manufacturing S.E. to W.	1.43	17.11	12.80	153.60	1.47 for 11 months	Sanitary Inspector's Office, Yeadon High Street, residential to W., open country to E.	0.172 for 10 months
Otley—Nursery Gardens, Westgate, manufacturing and semi-residential.	1.86	22.29	11.49	137.89	0.96	First floor of Council Offices, in town centre, mainly manufacturing.	0.099
Ripon—Engineer's Depot, residential area.	1.67	20.00	7.72	92.60	0.83	Health Dept., High Skellgate, in centre of country town.	0.111
Harrogate—Meteorological Station, Valley Gardens. Inland Spa.	2.05	24.63	8.47	101.69	0.61	Laboratory, Royal Baths. Inland Spa.	0.097
Wetherby—Council Offices, residential, surrounded by open country from ½ to ¾ mile distant.	1.58	17.36 for 11 months	10.16	111.78 for 11 months	0.75	Council Offices, residential, surrounded by open country from ½ to ¾ mile distant.	0.158
Goole—Health Centre, Bartholomew Avenue, residential and industrial.	1.73	20.81	10.18	122.20	0.96	Div. Health Office, in residential and industrial area.	0.217 for 6 months
Castleford—Roof of Marks and Spencer's shop, Carlton Street, in centre of industrial town.	1.39	16.65	14.90	178.75	2.37	First floor of Div. Health Office, in residential area.	0.198 for 11 months
Castleford—Roof of Cleansing Station, Cinder Lane. manufacturing area.	1.44	12.97 for 9 months	15.78	142.00 for 9 months	2.36		
Castleford—U.D.C. Pumping Station, Ings Lane, manufacturing area.	1.15	13.78	14.10	169.16	1.90		

* For period of full year unless stated otherwise.

Situation of Instruments	Deposit Gauge: Rainfall in inches — Monthly Average	Deposit Gauge: Rainfall in inches — Total*	Deposit Gauge: Total solids deposited in Tons per sq. mile — Monthly Average	Deposit Gauge: Total solids deposited in Tons per sq. mile — Total*	Sulphur Measurements by Lead Peroxide Method — Milligrams SO(3) per 100 sq. cms. per day — Average
Castleford—U.D.C. Housing Depot, Redhill Road, Airedale. Industrial and residential area.	1.31	15.76	10.48	125.81	1.92
Horbury—Carr Lodge Park, residential and manufacturing to north, open country to south.	1.59	19.07	13.08	156.92	1.27
Morley—Flat roof of Co-operative Society premises, residential, commercial and manufacturing.	2.03	24.40	18.63	223.60	1.82
Batley—Flat roof of one storied building at rear of P. H. Dept., Market Place. Centre of town. Mixed residential, commercial and manufacturing.	1.93	23.18	17.85	214.15	1.63
Rothwell—Central Clinic, Oulton Lane, residential.	1.57	18.88	11.69	140.25	2.00
Spenborough—Council's Depot, Marsh. North, south and west—manufacturing area, open country to east.	1.88	22.50	13.91	166.97	1.68
Elland—"Ellen Royd," Public Library in manufacturing area.	2.49	29.29	12.06	144.72	1.72
Hebden Royd—Redacre Sewage Works, Mytholmroyd, residential and manufacturing area.	3.00	36.02	14.14	169.72	1.49
Colne Valley—Sewage Works, Slaithwaite, in mixed residential and textile manufacturing district.	2.81	30.94 for 11 months	13.47	148.12 for 11 months	1.68
Colne Valley—Marsden Park, residential and manufacturing area.	3.32	36.48 for 11 months	14.26	156.84 for 11 months	1.24
Holmfirth—Sewage Works, Neiley, Brockholes, residential and manufacturing.	2.41	28.95	11.59	139.08	0.88
Saddleworth—Sewage Works, Shaw Hall Bank, Greenfield. Open country.	2.76	30.31 for 11 months	11.83	130.14 for 11 months	1.56
Wortley—Hallwood Hospital Grounds, Grenoside, open country and woodland.	1.66	19.96	7.38	88.51	0.76
Hemsworth—Vale Head Park, parkland, surrounded by open country.	1.37	16.46	12.12	145.42	1.31
Darton—Grounds of Council Offices, semi-residential, colliery district.	1.59	19.03	12.34	148.09	0.94
Wombwell—Grounds of Divisional Public Health Office, The Gables, semi-residential, colliery district.	1.53	18.41	16.24	194.85	0.97
Rawmarsh—Roof of Clinic, Barbers Avenue, residential and industrial.	1.36	16.31	18.04	216.47	1.84
Rawmarsh—Grounds of Granby House, Aldwarke Road. Blast furnaces 200-300 yards distant.	1.46	17.51	117.78	1,413.39	3.04
Bentley-with-Arksey—Bentley Park, Askern Road, semi-residential, colliery district.	1.37	16.49	11.84	142.03	1.04
Doncaster—Between Church and Vicarage, Askern. Industrial and residential. Colliery district.	1.20	14.40	38.05	456.61	1.28
Thorne—Grounds of Council Offices, semi-residential, colliery district.	1.23	13.56 for 11 months	11.34	124.73 for 11 months	1.21

Situation of Daily Smoke Filter	Average Daily Suspended Impurity — Milligrams per cubic metre — Average
Sewage Works, ¼ mile south of town centre, north manufacturing and residential, south open country.	0.126
Ground floor P. H. Dept., in centre of mixed residential, commercial and manufacturing town.	0.190
Public Health Dept., Market Place, in centre of mixed residential, commercial and manufacturing area.	0.224
Div. Health Office, Oulton Lane, in residential district.	0.107
Div. Health Office, Elm Bank, in industrial and manufacturing area.	0.188
First floor of Council Offices in manufacturing area.	0.192
Redacre Sewage Works, Mytholmroyd, residential and manufacturing area.	0.126
Town Hall, Slaithwaite, in mixed residential and textile manufacturing district.	0.130
Sewage Works, Shaw Hall Bank, Greenfield. Open country.	0.107 for 10 months
Health Department, Council Offices, Grenoside, industrial and manufacturing area.	0.110
Div. Health Office, Adiscombe House, in residential district.	0.142
Council Offices, semi-residential, colliery district.	0.205
Div. Health Office, semi-residential, colliery district.	0.244
Sanitary Inspector's Office, in centre of residential and industrial area.	0.319 for 10 months
Council Offices in centre of semi-residential area, colliery district.	0.190
Council's Depot, Kirk Sandall, in open country, with large glassworks approx. 1 mile to north.	0.136
Council Offices, town centre in semi-residential and colliery district.	0.186
Maltby—Council Offices, one mile west of town centre, semi-residential, colliery district.	0.098 for 11 months

* For period of full year unless stated otherwise.

Situation of Volumetric Sulphur Dioxide Apparatus	Sulphur Measurements by Volumetric Method — SO(2) in parts per million — Average
Hebden Royd—Redacre Sewage Works, Mytholmroyd, residential and manufacturing area.	0.039
Aireborough—Sanitary Inspector's Office, Yeadon High Street—Residential to W... open country to E...	0.044 for 10 months

Food and Drugs Acts, 1938-50

All County Inspectors of Weights and Measures are appointed Sampling Officers for the purpose of the above Acts, and the work of sampling is carried out under control of the Chief Inspector of Weights and Measures, Mr. J. W. Hopkinson, who has supplied the following details.

During the year 1st January to 31st December, 1953, Inspectors of Weights and Measures, duly appointed Sampling Officers under the Food and Drugs Act, procured a total of 4,725 samples. Of these 4,340 were taken formally, 295 informally and 90 "Appeal to Cow" samples were also procured. All were submitted to the Public Analyst who certified 4,090 formal and 259 informal as genuine and 250 formal and 36 informal as not genuine. Of these samples 3,472 were milks, 1,092 other foods and 161 drugs. The 1,092 other foods comprised in the main, milk products, meat products, soups, sauces, beverages, condiments, fruits and preserves, flour and sugar confectionery, oils, fats and cereals. Care has been taken not to duplicate unnecessarily sampling of well-known proprietary brands of food which had already been classified genuine by the County Analyst. 161 drugs comprising mainly medicinal preparations have been sampled.

In the administration of the Act legal proceedings were instituted in 39 cases of which 33 related to alleged fat deficiencies and/or extraneous water in milk. Warnings were issued to 166 persons by the Clerk of the County Council in those cases where, after consideration of Inspectors' reports, he did not consider such cases warranted proceedings before the Justices.

The revocation of the Meat Products Order by the Ministry of Food, which among other things provided for minimum meat content in sausage and other meat products, was a test of the integrity of the trade, which proved very satisfactory on the whole, as in 59 samples only 6 were below the original prescribed minimum meat standard. In one instance the deficiency was sufficiently serious to warrant proceedings.

As I reported last year considerable gallonage of milk is now being pasteurised and it is essential for Sampling Officers to work in harmony with the milk testers at the various pasteurisation depots in the County. Several cases of prosecutions were taken arising from information given or as a result of sampling from churns at dairies and pasteurisation depots. The usual procedure is that where milk arrives at a dairy or depot for pasteurisation, if found consistently sub-standard, arrangements are made for a Sampling Officer to take representative samples either whilst the following day's milk is in possession of the producer or in transit.

The following is the Annual Report for 1953, to the County Council, of the Public Analyst, Mr. Raymond Mallinder, B.Sc., F.R.I.C., who has kindly consented to its inclusion in this Report:-

At the close of my first complete year of office, I have the honour to present a Report of my work as Public Analyst to the West Riding County Council.

During the year, a total of 4,725 samples were submitted by your Inspectors under the Food and Drugs Acts, 1938-1950. The statistics are provided in the four Quarterly Reports, but are simply grouped as follows:—

	Total samples	Adulterated or below standard	Percentage adulterated
Milk	3,472	261	7.5 per cent.
Food and Drugs	1,253	25	2.0 per cent.
All samples	4,725	286	6.1 per cent.

These rates of adulteration compare satisfactorily with those of other Authorities.

The year has been notable for improvement in supplies of Food, and particularly for the de-rationing of Sugar.

Labelling—The Labelling of Food Order requires certain pre-packed foods to bear a label stating the various ingredients in the proportion in which they are used, the ingredient in the greatest proportion (by weight) being specified first. This requirement calls for analytical checking of the ingredients and their proportions. In the majority of cases the labels are correct.

Beer—It used to be customary to convey beer from the barrel to the pumps in the bar, in lead or tin-lined lead pipes. Consequently, analysis of draught beer often revealed dangerous amounts of lead in beer which had stood for a few hours in the pipes. Nowadays most of these lead pipes are replaced by glass or plastic, and it is most unusual to find any appreciable metallic contamination. Besides testing for metals and preservatives, the "original gravity" is determined; an abnormally low gravity would indicate dilution with water. All 18 samples tested in 1953 were genuine.

"Butter" Sweets—In 1951, the Ministry of Food and representatives of the Chocolate and Sugar Confectionery Trade agreed to a code of practice that where the word "butter" is used without qualification in the description of sugar confectionery, the latter should contain at least 4 per cent. of butter fat. If less butter fat were present, the word "butter" should be qualified by the term "flavoured". Several samples of "butter" sweets have been submitted and in only two cases has a deficiency of butter fat been found.

Cream—Since April 1st, 1953, Cream has been available in all parts of the country, and standards for fat content have been laid down by the Ministry of Food, namely:—18 per cent. in "Single" Cream, 48 per cent. in "Double" Cream, and 23 per cent. in "Sterilised" Cream. All samples were found to comply with the appropriate standard.

Foreign Bodies in Food—The Public are becoming increasingly sensitive to "foreign bodies" such as broken glass, wire, nails, oil stains, cigarette ends, pieces of bandage, rodent droppings, beetles and many other potentially harmful foreign bodies in food. Numerous proceedings have been instituted as a result of finding these unwholesome articles and substances. Only one example has been submitted by your Inspectors—a bar of Chocolate containing two living grubs of the Ephestia Moth. Ensuing correspondence with the manufacturers made it clear that the eggs which hatched out to produce these grubs were deposited on the chocolate some weeks after it had left the factory.

Ice Cream—Most of the 120 samples of Ice Cream complied with the standards required by the Food Standards (Ice Cream) Order, 1953. These standards are 5 per cent. fat, 7.5 per cent. of non-fatty-milk-solids, and 10 per cent. of sugar. Made to these requirements, Ice Cream is a valuable article of food. Only five samples failed to comply, being low in fat.

Ice Lollies—Attention has been drawn in the Press and in Parliament to Ice Lollies. It appears that samples in certain areas were found to be contaminated with traces of lead, copper and tin, presumably from the metal moulds used in their manufacture. Two samples of Ice Lollies were submitted to me, and in neither case was metallic contamination found.

Milk—By far the largest proportion of unsatisfactory or adulterated samples are of milk. Some 261 samples of Milk were reported as adulterated or below standard. It is customary in the West Riding to follow up unsatisfactory samples by taking samples in course of delivery or else by "Appeal to Cow". In this way it can be decided whether the vendor could be blamed for the deficiency, or whether the cows were producing milk low in quality. Whenever adulteration by added water is suspected, the Hortvet Freezing Point Test is employed as a confirmatory measure.

Channel Island Milk—is a superior grade sold at a higher price, and must contain at least 4 per cent. of fat, whereas the lower limit for ordinary milk is 3 per cent. Of the 31 samples analysed, 7 contained less than 4 per cent. of fat, but were well above 3 per cent.

Mincemeat—The quality of Mincemeat is controlled by the Food Standards (Preserves) Order, 1953. Three samples of Mincemeat out of 15 were found to be low in this respect and were adversely reported. This standard is important both as a guide to quality and also to ensure good keeping properties. A mincemeat low in soluble solids is liable to ferment or to become mouldy.

Preservatives—The Public Health (Preservatives, etc. in Food) Regulations prohibit the addition of any preservative to milk, butter and many other foods. The Regulations allow the addition of sulphur dioxide or benzoic acid up to definite limits to specified foods. Nearly all samples of food therefore require to be tested for preservatives both permitted and prohibited, and if found their proportion must be determined. Sausages may contain 450 parts of sulphur dioxide per million, provided that a prominent notice or label declares the fact. Two samples of sausages were unsatisfactory in that they contained undeclared preservative.

Prohibited Colouring Matter—Another function of The Public Health (Preservatives, etc. in Food) Regulations is to forbid the addition of certain dyestuffs, and colours containing poisonous metals to food. Coloured foods must be tested first of all for artificial colouring, and then for prohibited substances. In no sample during 1953 have these forbidden colours been detected.

Sausage—Meat is more plentiful and on March 1st, the Ministry of Food released Sausages from control of composition and price. Just prior to the de-control, Pork Sausages were required to contain at least 65 per cent. of Meat, and Beef Sausages 50 per cent. After de-control, in the absence of a legal standard, many Public Analysts held that it was reasonable to expect these limits for the composition of Sausages to serve as a basis of appraisal. Our experience has shown that most manufacturers have improved their product and have not exploited de-control.

Suet Shredded—The composition of Shredded Suet is controlled by The Food Standards (Suet) Order, 1952, and must contain at least 83 per cent. of Beef Fat. The rest consists of ground rice or flour, added to prevent the granules of fat from sticking together. Of the 18 samples submitted, only one sample was found to be deficient in beef fat.

Sultanas—A sample of Sultanas was found to consist of seven parts sultanas and one part currants. Attention was drawn to this irregularity. The explanation was as simple as it was inexcusable; the shop-assistant, having weighed up currants, and finding he had a small quantity left over, mixed them with sultanas to use them up.

Vinegar and Non-brewed Condiment—All 34 samples of Vinegar were found to be genuine, but two of the 6 samples of Non-brewed Condiment were sub-standard in that they contained less than 4 per cent. of acetic acid.

A scheme is in operation whereby the County Council pays the fees of the Public Analyst for all samples of milk taken by Sampling Officers of West Riding County District Councils in accordance with regulations made under the scheme, and also conducts all legal proceedings and defrays all consequential legal expenses. The number of samples of milk submitted for analysis under the scheme in 1953 was 383 of which 21 were found to be adulterated or below standard.

Sanitary Circumstances

Housing.—In the Municipal Boroughs and Urban Districts there were 376,981 dwelling houses and in the Rural Districts 127,040, giving a total number of 504, 021.

New houses have been provided during the year as follows:—

	Provided by Local Authority		*Provided by Private Enterprise*	*Totals*
	Permanent	*Temporary*		
Municipal Boroughs and Urban Districts	5,240	56	2,191	7,487
Rural Districts — — —	2,332	—	1,921	4,253

HOUSING CONDITIONS—The County Medical Officer has, during the year, continued to receive many letters and personal requests from those in need of housing accommodation. In every instance, the Medical Officer of Health for the County District concerned was supplied with details, particular emphasis being stressed in cases where any members of a family were suffering from the effects of tuberculosis.

The following details have been extracted from the Housing Returns furnished by the County Districts:—

Total Number of Municipal Boroughs and Urban Districts	Number of Districts giving details	Unfit Houses	Houses not in all respects reasonably fit for habitation	Demolition Orders made	Houses demolished following Demolition Orders	Closing Orders made	Closing Orders determined	Number of cases of overcrowding at end of year	Cases of overcrowding relieved during the year	Number of defective dwelling houses rendered fit in consequence of Informal Action by their Officers
68	56	2,366								
	63		16,353							
	39			271						
	31				182					
	15					51				
	3						18			
	35							2,666		
	43								1,106	
	66									15,905
Total Number of Rural Districts										
21	18	2,714								
	21		6,811							
	11			89						
	10				90					
	3					6				
	1						1			
	13							1,401		
	15								351	
	18									1,997

The approximate number of back-to-back and some single back types of houses in the Municipal Boroughs and Urban Districts is 32,000 and in the Rural Districts 984.

HOUSING ACT, 1936: SECTIONS 25 AND 26 —*Brighouse M.B.*—20 houses were represented under Section 25, and 4 were pulled down in pursuance of Clearance Orders. *Mexborough U.D.*—Near 400 houses for Clearance Areas as soon as possible. *Morley M.B.*—An official representation was made in respect of two Clearance Areas, comprising 22 houses. Clearance Orders were made in respect of these houses and as there were no objectors, the Orders were confirmed by the Minister of Housing and Local Government without the holding of a Local Inquiry.

HOUSING ACT, 1949: SECTION 20—"Grants to persons other than local authorities for improvement of housing accommodation."

Aireborough U.D.—4 applications for grants rejected: 3 applications for grants approved. *Batley M.B.*—3 grants approved. *Brighouse M.B.*—1 application granted in respect of the conversion of one house into two. *Denby Dale U.D.*—4 schemes submitted; 3 schemes approved; 1 scheme completed; 4 schemes in progress at end of year. *Holmfirth U.D.*—6 applications and 4 approved. *Keighley M.B.*—One grant approved by Ministry involving 2 houses. *Knaresborough U.D.*—2 applications received; 1 grant made; 1 grant under consideration at end of year. *Penistone U.D.*—3 applications were received—all refused. *Queensbury and Shelf U.D.*—3 applications received but turned down pending determination of the Council's policy in regard to Section 20. *Royston U.D.*—1 application received—not approved. *Selby U.D.*—The Council have made grants for improvement of dwellings. *Wombwell U.D.*—Grants made in 3 cases. *Kiveton Park R.D.*—7 applications approved. *Osgoldcross R.D.*—1 application made in 1951, work completed; 1 application made in 1953, work completed; 2 applications made in 1952, disapproved in 1953; 5 other applications made in 1953—3 approved, 2 under consideration. *Rotherham R.D.*—4 grants made. *Selby R.D.*—No grants paid, but several applications pending. *Settle R.D.*—Approval given to schemes to 2 houses. *Tadcaster R.D.*—14 applications received and 9 approved. *Wakefield R.D.*—3 applications made. *Wortley R.D.*—2 applications received; one is still under consideration and the other case was withdrawn; 1 application under consideration at end of 1952 was withdrawn in 1953.

HOUSING (RURAL WORKERS) ACTS, 1926-1942—The County Sanitary Inspectors made 245 inspections regarding cottages for which grants have been given under the above Acts. These cottages are to be found in the following Rural Districts:— Bowland, Doncaster, Goole, Hemsworth, Hepton, Kiveton Park, Nidderdale, Ripon and Pateley Bridge, Rotherham, Selby, Settle, Tadcaster, Wakefield, Wetherby and Wharfedale, also to cottages situated in the outlying parts of Todmorden B. and Bingley U.D. The cottages were inspected regarding their structural conditions, tenancies, rents, etc. Detailed reports were made and forwarded to the Clerk of the County Council, who informed the owners of any matters requiring attention. In certain cases, the Owners, or Agents for the cottages, were met on the site for discussions regarding the structural conditions and remedies for defects.

Closet Accommodation.–

	Total number of closets of all types	*Number of closets on the water carriage system*	*Percentage of closets on the water carriage system*
Municipal Boroughs and Urban Districts (68)	413,878	402,387	97.2
Rural Districts (21)	138,145	118,743	86.0
Administrative County	552,023	521,130	94.4

There are approximately 13,500 pail or tub closets in the County Administrative Area.

12,958 closets were constructed for new houses.

Public Cleansing.—The following tables show the methods in use during the year for refuse disposal:—

Municipal Boroughs and Urban Districts	*100% controlled tipping*	*Part controlled tipping and part non-controlled*	*Controlled tipping, separation and salvage*	*Controlled tipping and destruction*	*Controlled tipping and disposal to farmers*	*Part controlled tipping, destruction and disposal to farmers*
68	53	5	1	5	3	1

Rural Districts	*100% controlled tipping*	*Part controlled tipping and part non-controlled*	*Controlled tipping and disposal to farmers*	*Controlled tipping, destruction and disposal to farmers*	*Part controlled tipping and disposal to farmers*
21	10	6	2	1	2

Water Supplies.—The following table shows the approximate number and percentage of dwelling houses on public water supply:—

	Municipal Boroughs and Urban Districts	*Rural Districts*	*Total*
No. of houses	376,981	127,040	504,021
No. of above on public supply	365,883	116,491	482,374
Percentage on public supply	97.1	91.7	95.7

Houses not on public supplies are to be found mainly in the outlying and isolated parts of the districts.

Regular sampling of water supplies is carried out by the officials of the County Districts and, in the case of pollution, etc., action is taken to remedy matters. The number of samples obtained during the year, with results, is as follows:—

	Chemical Analysis			*Bacteriological Examination*		
	Number obtained	*Satisfactory*	*Unsatisfactory*	*Number obtained*	*Satisfactory*	*Unsatisfactory*
Municipal Boroughs and Urban Districts (68)	412	395	17	3,172	2,703	469
Rural Districts (21)	155	144	11	1,521	1,055	466

Particulars regarding the quality, quantity, extensions, closures or restrictions etc., of water supplies are as follows:—

	Quality			
	Satisfactory	*Not Satisfactory*	*No Comments*	*Hard Water*
Municipal Boroughs and Urban Districts (68)	64	2	1	1

	Quantity				
	Satisfactory	*Not Satisfactory*	*Generally Fair*	*Shortage at times*	*No Comments*
	58	6	1	2	1

	Quality		
	Satisfactory	*Generally Satisfactory*	*Not Satisfactory*
Rural Districts (21)	18	2	1

	Quantity			
	Satisfactory	*Not Satisfactory*	*Satisfactory in normal times*	*No Comments*
	14	5	1	1

MUNICIPAL BOROUGHS AND URBAN DISTRICTS:—

Extensions

42 authorities have reported extensions to new housing estates during the year and the following authorities have given other details viz:—

Denby Dale U.D.	1,100 yards 3″ main at Leys Lane, Emley.
Maltby U.D.	3⅛ miles of main to new housing site.
Saddleworth U.D.	Extensions for 8 houses.
Selby U.D.	Extension of 800 yards.
Sowerby Bridge U.D.	221 yards 2″, 665 yards 3″, 240 yards 4″, 212 yards 6″, to new houses.
Todmorden M.B.	230 yards.

Closures, Restrictions etc.

Batley M.B.	Poor supply in parts being rectified by works almost complete.
Conisbrough U.D.	Yes! As a means of conserving water during nights.
Denby Dale U.D.	Pumping restricted to 6 hours daily in Emley area.
Knaresborough U.D.	Yes! From storage tank, supply made temporarily from main.
Knottingley U.D.	At Low Green for a two-week period.
Maltby U.D.	Part of higher level of district had poor pressure due to low level in service reservoir.
Mexborough U.D.	Supply of 12 hours per day only.
Silsden U.D.	Outflow from reservoir was restricted during summer.
Swinton U.D.	One common pump. 4 houses closed.
Worsborough U.D.	One house demolished by arrangement with owner after drinking well became heavily polluted with sewage.

RURAL DISTRICTS:—

Extensions

Bowland	500 yards 2″ iron main replaced by asbestos pipe at Tosside. 100 yards 2″ asbestos main laid to Newton housing site. 80 yards 2″ asbestos main at housing site, Gisburn.
Goole	Maybland water supply scheme commenced whereby 10 miles of pipes will be laid to increase pressure to Swinefleet and all villages up to Fockerby, and also supply water to isolated farms and cottages on Swinefleet and Reedness Common. The figure — 118 — without piped water will be considerably reduced.
Hemsworth	To new housing estates.
Hepton	To additional properties.
Nidderdale	Small extensions only.
Osgoldcross	Extensions at Monk Fryston and Fairburn for new houses.
Penistone	Copster and Thurgoland.
Ripon and Pateley B.	Galphay Scheme.
Skipton	Extensions made.
Tadcaster	Little Fenton link main. Barwick-in-Elmet, Healaugh Farms, Acaster Malbis Farms, Hook Moor Scheme. Biggin Horticultural Station. West Milford Farm.
Thorne	Extension of 3,770 yards.
Wharfedale	179 yards 4″ main at Bramhope.
Wortley	Extension to 8 houses.

Closures, Restrictions, etc.

Nidderdale	Numerous wells to private houses superseded by piped water supplies.
Osgoldcross	Shortage at Monk Fryston and Fairburn — lack of pressure.
Wakefield	Supply to Woolley Village restricted due to failure of well supply.

PLUMBO-SOLVENT WATER SUPPLIES—The periodical examination of water supplies which are known or suspected to possess plumbo-solvent properties has been carried out. There are 64 such supplies. The samples were obtained in pairs:— (a) after standing for 30 minutes in a lead service pipe and (b) after standing all night in such a pipe. Examinations were made to determine the presence or absence of lead. It is generally considered that a water supply which is plumbo-solvent to the extent of taking up 1/10th of a grain or more of lead per gallon is deleterious to health and that the plumbo-solvency of such water should be neutralised. During the year 276 samples were obtained from the 64 supplies. In the case of 5 supplies lead was found to be present in quantities considered to be injurious to health and appropriate action was taken. One supply from which consistently bad results had been obtained for some years in the past was discontinued.

Drainage and Sewerage.—Of the 68 Municipal Boroughs and Urban Districts, 58 have given details regarding approximately 9,000 houses not connected to sewers and, of the 21 Rural Districts, 13 state that approximately 11,500 are not so connected. The reasons given are (a) No available sewers; (b) Outlying farms and houses; and (c) Houses below sewer levels.

From the returns made by the 68 Municipal Boroughs and Urban Districts for the year under review, 48 authorities report that sewer extensions were carried out. 49 report that portions of their districts still require sewering. 27 report that improvements are required to existing sewers. 7 state that extensions, etc. have been made to existing sewage works and 33 report inadequacy of their works.

In the 21 Rural Districts, 14 Authorities report sewer extensions etc. 20 report that portions of their districts still require sewering. 10 state that improvements to existing sewers are required. 3 report extensions to their existing sewage works and, in 2 cases, additional new works were provided. In 17 cases it is reported that the existing sewage works are inadequate.

Nuisance Inspection and Action.—

	Total No. of Inspections made in 1953 for nuisances only	Notices for Abatement of Nuisances						Total No. of Summonses etc.
		Informal			Statutory			
		Outstanding at 31.12.52	Issued in 1953	Abated in 1953	Outstanding at 31.12.52	Issued in 1953	Abated in 1953	
Municipal Boroughs and Urban Districts	54,546	3,554	14,037	14,611	474	2,342	2,188	58
Rural Districts	6,172	686	3,000	3,008	112	290	267	11
Totals	60,718	4,240	17,037	17,619	586	2,632	2,455	69

Swimming Baths, Pools etc.—

	Public Swimming Baths or Pools	*Privately owned Baths or Pools open to the Public*	*Paddling Pools*	*Baths in use for Schools*	*Holiday Camp Baths*
Municipal Boroughs and Urban Districts	31	2	2	5	1
Rural Districts	2	5	—	—	—

The reports regarding these baths and pools show that filtration and chlorination plants are generally in use and that regular supervision and sampling takes place. 112 samples of water (apart from routine Public Health Laboratory samples) were obtained during the year.

One of the baths used for schools was closed during the whole of the year, awaiting a filtration and chlorination plant. The bath in use at a Holiday Camp is owned by an outside County Borough Education Authority.

Prevention of Damage by Pests Act, 1949.—During the year 35 joint inspections by the County Sanitary Inspectors and the Sanitary Inspectors of the County Districts were made at school kitchens regarding rats and mice infestation. Reports on the structural conditions were prepared and forwarded to the Chief Education Officer. Disinfestation treatment was undertaken by the County District Sanitary Inspectors and their staffs. Again I wish to record my appreciation to these officers for their willing co-operation.

Table showing action taken by the County Districts.

	Number of Inspections	*Infestations dealt with*
Municipal Boroughs and Urban Districts (68)	25,793	5,156
Rural Districts (21)	7,737	2,393

Attention has also been given in several instances to the control of rat infestation in sewers.

Rural Water Supplies and Sewerage Act, 1944.—During the year applications were made for grants as follows:—

Name of Authority	Description of Scheme	Date of Application	Estimated Cost	Remarks
Elland U.D.C.	Stainland Water Scheme.	29.6.53.	—	Ministry not prepared to make grant.
Hepton R.D.C.	Water Supply to Charlestown.	10.7.53.	—	
Kirkburton U.D.C.	Raising of Flockton reservoir.	13.5.53.	—	
Kiveton Park R.D.C.	Water supplies to farms: Braneliffe, Langold etc.	6.1.53.	£14,575	Ministry approval 4.8.54.
Ripon and Pateley Bridge R.D.C.	Kirkby Malzeard Sewage Scheme.	22.1.53.	£17,160	
do.	Grewelthorpe Sewage Scheme.	22.1.53.	£6,420	
do.	Sharow and Copt Hewick Sewerage.	23.5.53.	£14,920	
do.	North Stainley Sewerage Scheme.	17.6.53.	£10,200	
Skipton R.D.C.	Extension to sewer, Eshton Road, Gargrave.	6.5.53.	£1,211	
Sowerby Bridge U.D.C.	Drainage of Norland Town and District.	29.8.53.	£9,264	Ministry decline to make a grant.
Tadcaster R.D.C.	Extension of water main at Kirkby-cum-Milford.	5.5.53.	£446	
Thorne R.D.C.	Hatfield Chase Area Water Scheme	6.5.53.	£22,000	
Wetherby R.D.C.	Scarcroft and Thorner Water Supply.	22.8.53.	£3,114	
do.	Boston, Bramham and Clifford Water Supply.	4.11.53.	£2,333	No grant — application withdrawn.
Wharfedale R.D.C.	Blubberhouses, Fewston and Clifton-cum-Norwood Water Supply, Extension Scheme.	29.12.53.	£2,500	Declined by Ministry.

Summary of Visits and Duties carried out by the County Sanitary Inspectors.—Inspections at dairies under the Milk (Special Designation) (Pasteurised and Sterilised Milk) Regulations, 1949, 706; number of samples obtained, 706; number of samples of school milk obtained, 608; visits to school milk contractors' premises, 41; visits to Hospital farms for milk sampling purposes on behalf of the Ministry of Health, 96; enquiries regarding school milk supplies, 8; milk complaints investigated, 6; visits regarding milk supplies at school kitchens, 2; visits in connection with the Food and Drugs Acts, "Specified Areas", designated milk, 600; detergent experiments carried out at school kitchens, 16; visits regarding water supplies, 7; water sampling at special and other schools, 20; investigations regarding suspected food poisoning outbreaks at schools, 6; inspections regarding rats and mice infestation at school kitchens, 35; visits regarding general insanitary conditions in the County, 7; general public health visits, 5; investigations regarding nuisance from coke oven fumes, 4; visits to refuse tips, 3; poultry keeping complaints investigated, 2; Pharmacy and Poisons Acts visits, 1,041; Ministry of Housing and Local Government Inquiries attended, regarding water supplies and sewerage, 3; inspections made at cottages in connection with the Housing (Rural Workers) Acts, 245; meetings held between the County Sanitary Inspectors, Divisional Medical Officers and Sanitary Inspectors etc., 54; West Riding of Yorkshire Regional Smoke Abatement meetings attended, 6.

PART XI

OTHER SERVICES

The Welfare of the Epileptic and Spastic

The number of epileptics and spastics in the County is not definitely known. An attempt was made in 1949 to assess the incidence of epilepsy with a view to the need to provide for the welfare of the epileptic. At that time it was considered that the number of epileptics (excluding those in mental deficiency institutions) was probably as high as 2,000. This estimate was made following a survey amongst children of school age, the survey revealing that there were 247 educable epileptic children in a school population of some 240,000. Of these 247 children, the majority were suffering from minor degrees of epilepsy and presented no real problem in school; no special facilities were considered necessary for their education, and no doubt most of them will eventually be placed in settled employment on leaving school through the combined efforts of the Youth Employment and the School Health Services. 44 of the 247 were considered to be so handicapped that they required to be educated in special schools, and they will, in all probability, need such welfare services as are provided by the Authority on leaving school.

At the end of 1953, there were in the County 222 known educable spastic children of school age. The incidence of this condition in the total population may, therefore, be as high as 1,500 or 2,000. Of the 222 children, 57 were accommodated in special schools, 114 were attending ordinary schools (35 of these were in need of special school placement), 17 were receiving home tuition and 34 were receiving no education. It is reasonable to assume that those in the last two categories, plus a proportion of those accommodated in special schools, are likely to require help in after-school life from the services provided by the Local Health Authority.

The following are particulars of known epileptics and spastics at the present time:—

	Number	
Adults.	*Epileptics*	*Spastics*
1. Provided with accommodation under Part III of the National Assistance Act, 1948:—		
(a) in colonies for epileptics	58	—
(b) in County establishments and establishments where County Council has "right of user".	52	—
2. Registered under the County Council's Scheme of Welfare Services for Handicapped Persons.	38	35
Children.		
Number ascertained as handicapped:—		
(a) Attending ordinary school	Not known	114
(b) Attending special schools	26	57
(c) Receiving home tuition	1	17
(d) Receiving no education	—	34

With regard to welfare services for the handicapped epileptic and spastic, the following is an extract from the County Council's approved scheme under Sections 29 and 30 of the National Assistance Act, 1948, the scheme being administered through the County Welfare Committee:—

"Social Welfare.

4. The Council so far as reasonably necessary to meet the needs of handicapped persons shall:—

(1) assist handicapped persons to overcome the effects of their disabilities, and to obtain any available general, preventive or remedial medical treatment which they appear to require;

(2) give advice and guidance to handicapped persons on personal problems and in connection with any services whether provided under any enactment or rendered by any voluntary organisation, which appear to be available to them and of which they wish to take advantage;

(3) encourage handicapped persons to take part in the activities of social centres, clubs or institutions, whether provided by the Council under this scheme or otherwise or provided or established by any other person under any enactment or otherwise;

(4) use their best endeavours to arrange for voluntary workers to visit handicapped persons with a view to affording them comfort and encouragement and assistance in the solution of domestic and other problems confronting them, to accompany them to places of worship, social centres, clubs and similar places of recreation and otherwise to assist in the carrying out of the purposes of this scheme; and

(5) use their best endeavours to secure the co-operation of the responsible bodies in facilitating the admittance of handicapped persons carried in wheel-chairs or spinal-chairs to places of worship, entertainment or recreation and in making suitable provision for them while there.

5. In addition the Council may:—
   (1) provide practical assistance for handicapped persons in their homes;
   (2) provide, or assist in obtaining, wireless, library, and similar recreational facilities for handicapped persons;
   (3) provide for handicapped persons lectures, games and other recreational facilities in such social centres as aforesaid and elsewhere, and also outings;
   (4) provide facilities for, and assistance to, handicapped persons in travelling to and from their homes to participate in any of the services provided under this scheme;
   (5) assist handicapped persons in arranging for the carrying out of any works of adaptation in their homes or the provision of any additional facilities, designed to secure the greater comfort or convenience of such persons, and if the Council so determine defray any expenses incurred in the carrying out of any such works or in the provision of any such facilities; and
   (6) facilitate the taking of holidays by handicapped persons, in particular at holiday homes, whether provided by the Council under this scheme or otherwise, or provided or established by any other body under any enactment or otherwise, and if the Council so determine defray any expenses incurred in or in connection with the taking of such holidays."

The scheme also provides for the establishment of sheltered workshops, home employment, assistance in handicrafts, crafts and other skilled activities, the marketing of produce of handicapped persons, and the establishment where necessary of hostels, social centres, and holiday homes. The Council may also take such steps as are practicable to assist handicapped persons who appear to be capable of benefiting from training under the Education Act, 1944, or the Disabled Persons (Employment) Act, 1944.

For the discharge of the County Council's functions under the Scheme, the duties of officers include the following:—

(a) to ascertain the existence of and the needs of handicapped persons;
(b) to visit handicapped persons in their homes, or elsewhere if necessary;
(c) to instruct handicapped persons in methods of overcoming the effects of their disabilities;
(d) to encourage handicapped persons to participate in handicrafts, crafts and other skilled activities, and so far as practicable to instruct them or arrange for them to be instructed in the practice thereof;
(e) to advise handicapped persons of any social health or medical services or facilities, whether provided under any enactment or made available by any voluntary organisation, of which they appear to be in need and of which they wish to take advantage;
(f) to give special attention to the needs of handicapped persons suffering from multiple disabilities, in consultation where necessary, with any officers of the Council who may be specially concerned with any one of those disabilities; and
(g) to organise social centres, classes and individual and other recreational facilities for handicapped persons, and to recruit voluntary workers to assist in the performance of this duty and to perform other duties in connection with the discharge of the Council's functions under this scheme.

The arrangements concerning the provision of social centres, classes and workshop facilities have not yet been implemented, having regard to the wide dispersal of known cases throughout the County Administrative Area, but consideration will be given as and when these facilities become a practical proposition.

Certification and Treatment of Blind and Partially Sighted Persons

The following table gives particulars of new registrations during 1953 of blind and partially sighted persons (other than handicapped school children):—

	Disabilty (B. — Blind, P.S. — Partially Sighted)									
	Cataract		Glaucoma		Retrolental Fibroplasia		Others		Total	
(i) No. of cases registered during the year in respect of which para. 7(c) of Form B.D.8 recommends:—	B.	P.S.	B.	P.S.	B.	P.S.	B.	P.S.	B.	P.S.
(a) No treatment									315	173
(b) Treatment (Medical, Surgical or Optical)	71*	41†	13	7	—	1	25	19	109	68
(ii) No. of cases at (i)(b) above which received treatment.	23‡	19§	13	6	—	1	19	16	60	42

* Includes 6 cases of cataract with glaucoma.
† " 2 " " " " "
‡ " 5 " " " " "
§ " 2 " " " " "

Removal of Persons in need of Care and Attention

Where a person is suffering from a grave chronic disease or being aged, infirm or physically incapacitated, is living in insanitary conditions and is unable to devote to himself, or herself, and is not receiving from other persons, proper care and attention, steps can be taken by the Medical Officer of Health, under the provisions of Section 47 of the National Assistance Act, 1948, as amended by the National Assistance (Amendment) Act, 1951, for the removal of the person to a suitable hospital or other place, and maintenance there; it was necessary so to remove three men and two women

to hospital, and 1 man and 3 women to accommodation provided under Part III of the National Assistance Act, 1948. The provisions are only used in those cases where other suitable steps have failed, or cannot be taken, and a number of aged people were removed without resort having to be made thereto.

Health Education

In the National Health Service Act, Health Education comes under the heading of prevention of illness which could be somewhat misleading, because the ultimate aim of Health Education, or more properly "Education for Health", should be not only to teach people how to avoid ill-health, but also how to achieve perfect health of mind and body.

During the year under review, 42,700 leaflets were distributed to the public through the health visitors, infant welfare centres, clinics, Divisional Health Offices and other agencies. Also 700 posters were displayed in infant welfare centres and clinics, on outdoor hoardings, or in other places such as shop windows. A number of picture display sets provided by the Central Office of Information were also shown. Six Health News Stands provided by the Central Council for Health Education were in use in six of the Divisional Areas, the topics displayed thereon being changed from time to time. In collaboration with the Central Office of Information advertisements were placed in weekly newspapers circulating locally in various parts of the West Riding, giving information as to the times and places at which children could be immunised against diphtheria and emphasising the safeguard given by immunisation. The information included in the advertisements was varied to suit the localities in which the different newspapers circulate.

The film strip, particularly if supported by a talk or verbal explanation, is an effective medium of health education for the smaller ready-made audiences such as those at infant welfare centres and meetings of parent-teacher associations. Unfortunately, a number of the health film strips available are partially or wholly out of date, and it is only of recent years that more adequate numbers of satisfactory films are being issued. A representative collection of film strips is maintained at headquarters from which the Divisional Medical Officers and other staff can borrow. Strips are also loaned occasionally to the County District Sanitary Inspectors, especially in connection with propaganda as to clean food. The number of sound films on health suitable for the general public is small but a few have been shown in the Administrative County during the year under arrangements made by Divisional Medical Officers.

The Administrative County contains wide areas which are very sparsely populated in parts and others which are highly industrialised and densely populated. It follows that activities in Health Education must necessarily vary, e.g. in sparsely populated areas the chief responsibility for propaganda in the principles of healthy living must rest with the health visitor when making domiciliary visits, reinforced with teaching of children in school. Habits of health, or healthy habits, particularly those relating to personal hygiene, inculcated in childhood and adolescence cannot be entirely forgotten in later life, and whilst the greater responsibility for inculcating these rests on parents, nevertheless education for health should have a prominent place in the school curriculum, and it should be remembered that the children are the parents of the future.

The following extracts from the Annual Reports for 1953 of four of the Divisional Medical Officers on health education in different types of area for which they are also Medical Officers of Health, convey a fairly adequate picture of the varied activities in the Administrative County:—

Dr. J. Battersby writes in his Annual Report on the health of Bingley which is an Urban District of nearly 22,000 population where the staple industry is textile manufacture:—

> Use was made of the facilities provided by the Central Council for Health Education. Propaganda material was provided by the West Riding County Council. The following are examples of the steps taken to promote Health Education in the population:—
>
> 1. Posters were exhibited on the principal hoardings centred in the Division.
> 2. Leaflets were distributed in Clinics to mothers on matters related to Maternity and Child Welfare.
> 3. Lectures were given by Medical Officers and Sanitary Inspectors to the General Public, Parent Teacher Associations, Clubs and other organisations.
> 4. Distribution of leaflets at Exhibitions and in Public Works on Industrial Health.
> 5. Information has been passed to the Press in relation to Infectious Disease and other subjects when appropriate.
>
> These steps are, of course, additional to intensive propaganda in the home through the various health workers of the Department.

Dr. D. P. Lambert writes as follows in connection with the Rural Districts of Bowland, Sedbergh and Settle which have an area of about 450 square miles and a widely scattered population of 23,000 chiefly engaged in farming:—

> The Health Education programme is based on the Child Welfare Centres, where, in addition to the specific advice given to regular attenders, special poster displays, talks and demonstrations are given from time to time. The topics of Home Accidents and Clean Food have been particularly stressed. Health Visitors, Nurses, Sanitary Inspectors and doctors all share in educational work, and carry it on wherever they go in the course of their daily duties. At Sedbergh special sessions of the Child Welfare Clinic were devoted to health teaching. At Sedbergh and at Ingleton Health Visitors have taught health at special school classes, and at all other secondary schools talks have been given or demonstrations arranged. The Divisional Medical Officer has conducted a Workers Educational Association class on "Health One and Indivisible". At two schools the children have prepared a play "King Alfred" written by Dr. R. A. Hoey of Bedwellty, Glam., to teach the importance of clean food: the King's famous burning of the cakes was deliberate, not accidental; they were contaminated. Production of the plays will take place in the New Year.

Ilkley Urban District with a population of about 17,000 is an inland health resort and residential district and Dr. R. A. W. Procter reports:—

During the past five years there has been a growing realisation of the importance of health education. It has become increasingly essential that the Health Visitor should be able to convey to parents and children a knowledge of the principles of healthy living.

For the past two years, classes have been held regularly in the Modern Schools at Otley and Ilkley. At these classes a Health Visitor has given instruction to older girls in elementary hygiene and mothercraft. Much more needs to be done, but the staff with the necessary training and flair for teaching is lacking. This lack has so far made it impossible to introduce systematic group teaching of parents, although much individual instruction is given. Occasional showings of films and film strips have been moderately successful, and is a means of propaganda which will be further developed in future.

The Hoyland Nether Urban District is a coal mining town with an area of 1,998 acres and a population of nearly 16,000, and Dr. J. Main Russell states:—

Health Education should be a matter of the utmost interest to everyone. About the most valuable possession a person can have is good health. It behoves Practitioners of Preventive Medicine to exercise every effort to bring home to the people exactly what good health is, how it can be acquired, and how it can be maintained. Let us forget about the idea that because we are not ill we must obviously be in good health. Good health and living healthily is not only a physical state, but a mental state. It should be the desire of everyone to be interested in this subject, but I find that it is not easy to get the man in the street interested in health matters. When there is an outbreak of devastating infectious disease, an interest is kindled and folk are prepared to listen to any suggestions about preventive measures. Yet it is a fact that the average person is interested in health when taught the fundamentals of healthy living. I welcome every opportunity I get to talk on health subjects, and during the year I have had the privilege of talking in Hoyland at Parent-Teachers' Meetings, and to some of the senior pupils in School. We are always prepared in this Department to discuss health education with any interested group or groups of persons.

Leaflets bought from the Central Council for Health Education were made available to the public. The leaflets cover a wide range of subjects and are both informative and interesting. Posters dealing with clean food and other health subjects have been exhibited.

It is now accepted as a regular engagement for the Chief Sanitary Inspector to visit the Kirk Balk Modern Secondary School to address the senior girls on the subject of Environmental Hygiene. The Headmistress, Miss K. M. Dunnett, M.A., is keenly interested in the subject of hygiene in particular and civics in general. It is extremely encouraging to see such interest taken by the Headmistress of such a large School and to observe the interest and eagerness of the scholars to hear of the work and activities of the Health Department.

Registration and Inspection of Disabled and Old Persons' Homes

(National Assistance Act, 1948)

The undermentioned premises which are inspected in conjunction with officers of the Welfare Department, are registered as Disabled and Old Persons' Homes:—

	Number of Residents	*Type of Home *(Part I, II, or III)*
Congregation of Sisters of Charity of our Lady of Good and Perpetual Succour, St. Anne's Convent, Burghwallis	15 females	I
Mrs. Bessie Fox, "Moor Lane House", Moor Lane, Gomersal	10	I
Harrogate Old People's Home, 66-68 Cold Bath Road, Harrogate	26	I
Skelldale Housing Society, Ltd., Borrage House, Ripon	11	I
Ernest Aycliffe Home for Deaf and Dumb Men, Fulford Grange, Rawdon	18 males	II
North Regional Association for the Blind, "Oaklands", Huddersfield Road, Holmfirth	20 females	II
Keighley and District Institute for the Blind, 13-15 Scott Street, Keighley	12	II
Misses Mary Emily and Elizabeth North, The Woodlands, Farrar Lane, Oulton	19	I
Mrs. Evelyn Berry, 23 Ash Mount, Keighley	5	III
Methodist Homes for the Aged, "Glen Rosa", Grove Road, Ilkley	32	I

	Number of Residents	Type of Home *(Part I, II, or III)*
Methodist Homes for the Aged, Berwick Grange, 5 Otley Road, Harrogate	28	I
Highfield Home for the Blind, Soothill Lane, Batley	14	II
Miss Rose Seery, Mayfield, 18 Beech Grove, Harrogate	11	I
Harlow Grange Cripples' Home, Otley Road, Harrogate	19	II
Catholic Women's League, Clitherow House, 49 Valley Drive, Harrogate	17	I
Mrs. Bertha Miller, "Greylands", Forest Moor, Knaresborough	6	I
Mrs. Anna F. Schramm, "Moor Top", 43 Harlow Moor Drive, Harrogate	8	I
Mrs. I. Brearley, Haversham Court, Ben Rhydding Road, Ilkley	16	III

*Part I — Homes for Old Persons.
Part II — Homes for Disabled Persons.
Part III — Homes for Old and Disabled Persons.

Registration of Nursing Homes

(Public Health Act, 1936, Sections 187-195).

One Home was registered during the year and the number of Homes on the Register at 31st December, 1953 was 35 providing 37 beds for maternity cases and 267 beds for other cases. Forty visits of inspection were carried out during the year.

Agencies for the Supply of Nurses

The Nurses Acts, 1943 and 1945 provide that no person shall carry on, on any premises in the Administrative County, an agency for the supply of nurses, unless he is the holder of a licence from the County Council authorising him to do so on those premises. Licences are granted on conditions regulating the suitability of the premises and the conduct of the agency. There is one licensed agency in the Administrative County and this has been carried on satisfactorily during the year.

Medical Examination of County Staff

An appointment to a superannuable post is subject to the applicant passing a medical examination. The examinations are carried out by Medical Officers on the County Council's Staff except where the successful candidate resides far outside the geographical County when arrangements are made either for examination by another Local Authority on a reciprocal basis or by a medical practitioner, the fee of 25/- being paid by the County Council. In cases where the medical certificate proves inconclusive a specialist's opinion is obtained at the expense of the County Council and the findings are made available to the family doctor.

During the year 1,578 persons were medically examined as set out in the table below and of these 99 were not approved.

Examined by County Council Medical Officers	1,511
Examined by Medical Officers of other Local Authorities	26
Examined by General Medical Practitioners (Fee of 25/- payable by County Council)	41

In 51 cases a specialist's opinion was obtained.

In addition 65 Special Medical Examinations were arranged at the request of employing Departments and 10 medical examinations were undertaken at the request of other Local Authorities.

PART XII

STAFF

(April, 1954)

J. Wood-Wilson, T.D., M.D., Ch.B., D.P.H.
(County Medical Officer and Principal School Medical Officer).

HEADQUARTERS

Vacancy	Deputy County Medical Officer.
J. M. Anderson, M.R.C.S., L.R.C.P.	Senior Medical Officer.
Vacancy	Senior Medical Officer for School Health.
J. A. Burgess, M.D., Ch.B., D.P.H.	Venereologist (Part-time).
C. C. Harvey, B.Sc., M.D., B.S., F.R.C.S., M.R.C.P.	Paediatrician (Part-time).
B. R. Townend, F.D.S.,R.C.S., L.D.S.	Chief Dental Officer, Principal School Dental Officer and Orthodontic Consultant.
Vacancy	Psychiatrist.
M. M. MacTaggart, M.A., B.Ed., Ph.D.	Child Guidance Psychologist.
Miss D. Walker, S.R.N., S.C.M., H.V. Cert.	Superintendent Nursing Officer.
Miss A. Carey, S.R.N., S.C.M., H.V. Cert.	Superintendent Health Visitor.
Miss A. M. Clarke, S.R.N., S.C.M., H.V. Cert.	do.
Miss R. O'Brien, S.R.N., S.C.M., H.V. Cert.	do.
Vacancy	do.
Miss E. M. Taylor, S.R.N., S.C.M.	Supervisor of Midwives.
Miss N. M. Everitt, S.R.N., S.C.M.	do.
Miss G. Jones, S.R.N., S.C.M., H.V. Cert.	Supervisor of Home Nurses and Midwives.
Mrs. W. Taylor, S.R.N., S.C.M., H.V. Cert.	do.
Miss C. Bellamy, S.R.N.	Supervisor of Day Nurseries and Child Minders.
Miss M. E. Baumann, S.R.N., S.C.M., R.M.P.A.	Nursery Nurse Tutor.
Vacancy	Chief Speech Therapist.
L. Butterworth (1), (2), (4), (5), (11)	Acting Chief County Sanitary Inspector.
H. Tayler (1), (2), (6)	County Sanitary Inspector.
R. D. Irving (1), (2), (7), (9), (10)	do.
F. C. Brookes (1), (2)	do.

CLERICAL STAFF

J. Colman (1), (3), (8)—Chief Clerk

Sectional Senior Clerks—J. W. Beaumont(1), G. Richardson(7), H. Bywater, J. H. Milne(7), R. S. Marshall, H. Beatson, W. J. Battye.

DIVISIONAL MEDICAL OFFICERS (25% School Health)

M. Hunter, M.B.E., M.D., Ch.B., D.P.H.	Division No. 1 (Skipton).
D. P. Lambert, M.D., Ch.B., D.P.H., D.T.M. & H.	,, No. 2 (Settle).
H. M. Holt, T.D., M.B., B.S. (Lond.), M.B., Ch.B. (Leeds), D.P.H.	,, No. 3 (Keighley).
J. Battersby, M.B., Ch.B., D.P.H.	,, No. 4 (Shipley).
G. P. Holderness, M.B., Ch.B., D.P.H.	,, No. 5 (Horsforth).
R. A. W. Procter, M.C., M.A., M.B., B.Chir., M.R.C.S., L.R.C.P., D.P.H., D.T.M. & H.	,, No. 6 (Otley).
N. V. Hepple, M.D., B.S., B.Hy., D.P.H.	,, No. 7 (Ripon).
D. D. Payne, M.D., B.S., M.R.C.S., L.R.C.P., D.P.H.	,, No. 8 (Harrogate).
R. G. Smithson, M.D., Ch.B., D.P.H.	,, No. 9 (Wetherby).
S. K. Appleton, M.D., Ch.B., D.P.H., D.T.M.	,, No. 10 (Goole).
J. M. Paterson, M.B., Ch.B., D.P.H.	,, No. 11 (Castleford).
J. F. Fraser, M.B., B.S., D.P.H., D.Obst.R.C.O.G.	,, No. 12 (Pontefract).
Vacancy	,, No. 13 (Ossett).
F. G. E. Hill, D.S.O., M.B., Ch.B., D.P.H.	,, No. 14 (Morley).
J. F. Caithness, M.B., Ch.B., D.P.H.	,, No. 15 (Batley).
A. L. Taylor, M.D., Ch.B., D.P.H., L.D.S.	,, No. 16 (Rothwell).
W. M. Douglas, M.B., Ch.B., D.P.H.	,, No. 17 (Spenborough).

(1) Sanitary Inspectors' Cert. Royal Sanitary Inst.
(2) Cert. as Inspector of Meat and Other Foods, Royal Sanitary Inst.
(3) Exam. in Sanitary Science as applied to Buildings and Public Works, Royal Sanitary Inst.
(4) Final Cert. Builders' Quantities, London City and Guilds.
(5) Final Cert. (Distinction) Builders' Quantities, Lancashire and Cheshire Inst.
(6) Testamur—Inst. of Municipal and County Engineers.
(7) Diploma in Public Administration.
(8) Associate Chartered Inst. of Secretaries.
(9) Sanitary Science Cert. (Liverpool University).
(10) Cert. in Advanced Knowledge of Sanitary Inspectors' Duties, Royal Sanitary Inst.
(11) Building Trades Course Certificate, Lancashire and Cheshire Inst.

DIVISIONAL MEDICAL OFFICERS—continued

F. Appleton, M.B., Ch.B., D.P.H.	Division	No. 18 (Brighouse).
J. Lyons, M.B., Ch.B., M.R.C.S., L.R.C.P., D.P.H.	,,	No. 19 (Todmorden).
E. Ward, M.R.C.S., L.R.C.P., D.P.H.	,,	No. 20 (Colne Valley).
J. Main Russell, M.B., Ch.B., B.Hy., D.P.H.	,,	No. 22 (Wortley).
J. S. Walters, M.C., M.B., Ch.B., D.P.H.	,,	No. 23 (Hemsworth).
Vacancy	,,	No. 24 (Barnsley).
R. S. Hynd, M.B., Ch.B., D.P.H.	,,	No. 25 (Wombwell).
D. J. Cusiter, M.B., Ch.B., D.P.H., D.T.M. & H.	,,	No. 26 (Wath).
J. Ferguson, M.B., Ch.B., D.P.H.	,,	No. 27 (Adwick-le-Street).
A. Penman, M.D., Ch.B., D.P.H.	,,	No. 28 (Doncaster).
G. Higgins, B.Sc., M.B., Ch.B., D.P.H.	,,	No. 29 (Thorne).
J. Leiper, M.B.E., M.B., Ch.B., M.R.C.S., L.R.C.P., D.P.H.	,,	No. 30 (Mexborough).
J. M. Watt, M.D., Ch.B., D.P.H., D.C.H., D.Obst.R.C.O.G.	,,	No. 31 (Rotherham).

ASSISTANT COUNTY MEDICAL OFFICERS AND SCHOOL MEDICAL OFFICERS

(50% School Health)

J. J. Ashley, M.B., Ch.B.	Division	No. 12 (Pontefract).
P. A. G. M. Ashmore, M.R.C.S., L.R.C.P.	,,	No. 7 (Ripon).
R. Barnes, B.A., M.R.C.S., L.R.C.P.	,,	No. 25 (Wombwell).
E. M. R. Bell-Syer, M.B., B.S.	,,	No. 10 (Goole).
R. M. Bowker, B.A., M.B., Ch.B.	,,	No. 16 (Rothwell).
M. M. Brearley, M.B., Ch.B.	,,	No. 17 (Spenborough).
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*H. M. Mitchell, M.B., Ch.B.	,,	No. 5 (Horsforth).
M. Pullan, B.Sc., M.B., Ch.B., D.Obst.R.C.O.G.	,,	No. 8 (Harrogate).
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R. R. Stoakley, M.B., B.Ch., B.A.O.	,,	No. 1 (Skipton).
*W. P. B. Stonehouse, M.A., M.R.C.S., L.R.C.P., D.P.H.	,,	No. 20 (Colne Valley).
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E. M. Whitehead, M.B., Ch.B.	,,	No. 17 (Spenborough)
M. H. Witt, L.R.C.P., L.R.C.S.	,,	No. 14 (Morley).

*Senior Assistant County Medical Officer and School Medical Officer.

OBSTETRICIAN (Joint Appointment with Hospital Services).

J. C. MacWilliam, L.R.C.P., L.R.C.S., L.R.F.P. & S., D.Obst.R.C.O.G.

ORTHODONTIC SPECIALIST

R. Sclare, L.D.S.

SENIOR DENTAL OFFICERS (95% School Health)

J. M. Enderby, L.D.S.
O. A. Long, L.D.S.
H. Marshall, L.D.S.

SCHOOL DENTAL OFFICERS (95% School Health)

W. Brier, L.D.S. (part-time).
H. Britton, L.D.S. (part-time).
W. J. Brown, L.D.S.
G. H. Bulcock, L.D.S.
F. W. Buzza, L.D.S.
B. C. Clay, L.D.S.
S. S. Cooper, L.D.S. (part-time).
K. R. Cowell, L.D.S.
P. Cummings, L.D.S. (part-time).
J. M. Davison, L.D.S.
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M. M. Gibson, L.D.S.
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S. Henry, L.D.S.
E. B. Hoffbrand, L.D.S. (part-time).
A. M. Holburn, L.D.S.
J. I. Jagger, L.D.S. (part-time).
F. Kershaw, L.D.S.
S. Levinson, L.D.S.
R. O. Librowicz, L.D.S. (part-time).
J. Lynn, L.D.S. (part-time).
E. S. Midgley, L.D.S.
E. Millward, L.D.S.
S. Mitchinson, L.D.S.
D. B. Owen, L.D.S.
M. H. Platford, L.D.S.
H. Rawnsley, L.D.S. (part-time).
F. H. Sanderson, L.D.S.
S. S. Sanderson, L.D.S.
J. R. Slater, B.Ch.D. (part-time).
B. Sleight, B.Ch.D.
H. Taylor, L.D.S.
M. M. Thom, L.D.S.
G. A. Thompson, L.D.S.
E. Thornton, L.D.S.
P. W. Thornton, L.D.S.
J. Todd, L.D.S.
B. Watts.
D. Willings, L.D.S. (part-time).
G. O. Wood, L.D.S.
H. M. Yuile, L.D.S.

DENTAL LABORATORY

J. O. Ford, Senior Dental Technician.
5 Senior Technicians.
2 Boy Dental Apprentices.

HEALTH VISITORS, MIDWIVES, MEDICAL AUXILIARIES, etc.

6 Divisional Superintendent Health Visitors.
303 Health Visitors and School Nurses.
6 Orthopaedic Nurses and Physiotherapists (three part-time).
15 Tuberculosis Visitors.
290 Home Nurses and Home Nurse Midwives.
204 Midwives.
1,434 Domestic Helps (86 whole-time; 1,348 part-time).
4 Venereal Diseases Social Workers (Qualified Health Visitors).
10 Speech Therapists.
1 Chiropodist (part-time).
1 Supervisor of Mental Health Occupation Centres and Home Teachers (Vacancy).
16 Mental Health Social Workers.
18 Mental Health Home Teachers (one part-time).
43 Dental Attendants.

COUNTY ANALYST (part-time)

R. Mallinder, B.Sc., F.R.I.C.
J. C. Harrel, F.R.I.C. (Deputy).

DAY NURSERIES

30 Day Nurseries—total nursing staff 235.
1 Nursery Nurses Training Hostel, One Oak, Ilkley.

MENTAL HEALTH OCCUPATION CENTRES

Castleford. Staff—1 Supervisor; 1 Assistant Supervisor; and 2 Nursery Assistants.
Keighley. Staff—1 Supervisor; 1 Assistant Supervisor; and 2 Nursery Assistants.

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